

# Cardiology Practice Survival Strategies 2010

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# Threats to Cardiovascular Practice Viability

- Center for Medicare and Medicaid (CMS) Rule
- Sustainable Growth Rate (SGR) Formula
- Health Care Reform
- Imaging (Reimbursement, Utilization, Appropriateness)
- National Debt
- Other Medical Specialties
- Burnout and Apathy
- Political Disengagement
- Failure to adopt EHR and other Quality Initiatives

# CMS Rule

- ▣ Based on AMA Practice Expense Survey (PPIS)
- ▣ Medicare only but other carriers usually follow suit
- ▣ Only 55 surveys completed out of 3,700
- ▣ Contention that overhead fell 42% since last survey
- ▣ Short Comment Period
- ▣ Original Data not disclosed (confidentiality cited)
- ▣ Pre-set threshold of 100 surveys/specialty ignored
- ▣ Zero sum (winners and losers)
- ▣ Implemented 1/1/10

# CMS Rule

- ▣ ACC filed a protest resulting in 4 year phase in
- ▣ Nuclear cuts felt immediately ( bundled codes no phase-in)
- ▣ Other specialties (Gang of 17) opposed phase-in
- ▣ By sheer numbers 650,000 to 30,000 physicians
- ▣ Despite Congressional (and some Senate) pressure on Health and Human Services cuts began 1/1/10
- ▣ ACC filed Injunction against HHS Secretary Sebelius
- ▣ Judge in Florida Circuit Court refused to hear case on Jurisdictional grounds

# Sustainable Growth Rate (SGR)

- Medicare expenses allowed by law to increase a fixed amount/year
- Each year the rate has exceeded it
- Each year Congress approves “patch” but debt grows
- This year Medicare payments could drop additional 21.4% to bring curves in line
- These cuts were on hold until March assuming Health Care Reform happened
- Multiple short term fixes passed this year
- Charges were held by Medicare creating cash-flow problems in practices
- Current patch expires December

# Health Care Reform

- ▣ PQRI-extended through 2014 with penalties in 2015,2016
- ▣ Independent Payment Advisory Boards
- ▣ Tort reform demonstration projects
- ▣ Physician Feedback Program and Physician Compare
- ▣ Imaging Equipment Use Rate and Ownership Disclosure ( currently applied to CT, MR, and PET)
- ▣ Bonuses for adoption of EHR (up to \$44,000 over 5 years)
- ▣ Innovative Reimbursement Models (e.g.. ACOs and Bundled Payments
- ▣ Specialty Hospitals ( prohibited if no provider agreement by year end)
- ▣ Sunshine Provisions ( public disclosure of relationships with industry in 2013)

# Myocardial Perfusion Imaging

- 36% reduction in RVUs for multiple study SPECT (78452) as compared to the unbundled (2009) codes
- Related to multiple payment policy issues
- CMS considered these to be new codes – implemented the PPIS 100% rather than phasing in the payment reductions as for other services

# Practice Survival Strategies

- Physician-Hospital Integration
- Use of Mid-Level Providers
- Analyze impact of re-imburement on your practice
- Think carefully about investment in new technologies
- Consider mergers for economy of scale
- May need to forego value-added programs

# Future Models of Reimbursement

## Traditional Fee-for-Service

- Paid on a unit basis for care delivered
- Theoretically the more you do, the more you make, but .....
- Higher utilization leads to downward price pressure

## Risk-Sharing or Gain-Sharing

- ▣ Usually part of an integrated system
- ▣ An institution gets paid a negotiated fee for a service e.g.. CABG, usually based on past history
- ▣ A portion of the fee is discretionary depending on utilization of services
- ▣ Gain is shared if cost is lower than target

# Incentive Payment for EHR

	2011	2012	2013	2014	2015 and beyond
2011	18,000	-	-	-	-
2012	12,000	18,000	-	-	-
2013	8,000	12,000	15,000	-	-
2014	4,000	8,000	12,000	12,000	-
2015	2,000	4,000	8,000	8,000	0
2016	0	2,000	4,000	4,000	0
TOTAL	44,000	44,000	39,000	24,000	0

# Changing CV Practice Landscape - Pennsylvania

Findings from ACC Cardiovascular  
Practice Census

Presented to the ACC Pennsylvania Chapter

September 2010

# Methodology

- Survey sent to physicians in each state from the Chapter Governors.
- Initial invitation sent 5/5 with reminders on 5/19, 6/2, and 6/9. Telephone interviews were conducted 7/28 – 8/9 to solicit responses from those who did not initially respond to the survey.
- A total of 2,413 unique practices in the U.S. and 128 in the commonwealth of Pennsylvania participated in this study after surveys were cleaned and duplicate practices eliminated.

# This research represents ....

	Total	Pennsylvania
CV Practices	2,413	128
Patients treated/week	800,486	35,730
Cardiologists	13,898	1,068
Other physicians	23,806	2,170
Nurse practitioners	4,434	584
Physician assistants	2,469	304
Clinical nurse specialists	1,589	155
Registered nurses	16,247	1,052
Pharmacists	844	111
Administrative support	35,599	3,924

# Practice Setting . . . .

	Total	Pennsylvania
CV Group	37%	42%
Solo practitioner	24%	15%
Multi-specialty	9%	9%
Medical School/University	10%	13%
Non-Govt Hospital	14%	18%
Govt Hospital	3%	0%
HMO	0%	0%
Industry	0%	0%
Other	2%	3%

	Total	Pennsylvania
No answer	13%	14%
Rural	11%	12%
Suburban	38%	42%
Urban	37%	32%

# Executive Summary

# Response to CMS Cuts

	<u>Total</u>	<u>Pennsylvania</u> <u>(n=128)</u>
No new equipment	43%	40%
Reduce staff to save expenses	39%	34%
Reduce MD income/salaries	35%	35%
Reduce benefits	29%	29%
Reduce non-MD salaries	20%	17%
Limit services	15%	13%
Reduce office hours and availability	10%	6%
Limit number of new Medicare patients	8%	5%
Increase non-MD staff for clinical	9%	10%
Other	14%	17%
None of these activities were related to CMS fee schedule change	27%	24%

# Staff Reductions

	<u>Total</u>	<u>Pennsylvania</u>
Physician	1,489	62
Mid-level Practitioners (RN, NP, CV Tech, CNS, Pharmacist, etc)	2,620	155
Administrative Support	4,275	212
<b>TOTAL LAYOFFS</b>	<b>8,384</b>	<b>429</b>
Increase in non-physician clinical support	309	11
Patients affected by limited Medicare coverage	12,253	270
Physician salaries reduced by ...	8.5%	8.4%
Non-physician salaries reduced by ...	5.3%	5.7%

# Activity among Pennsylvania practices ...

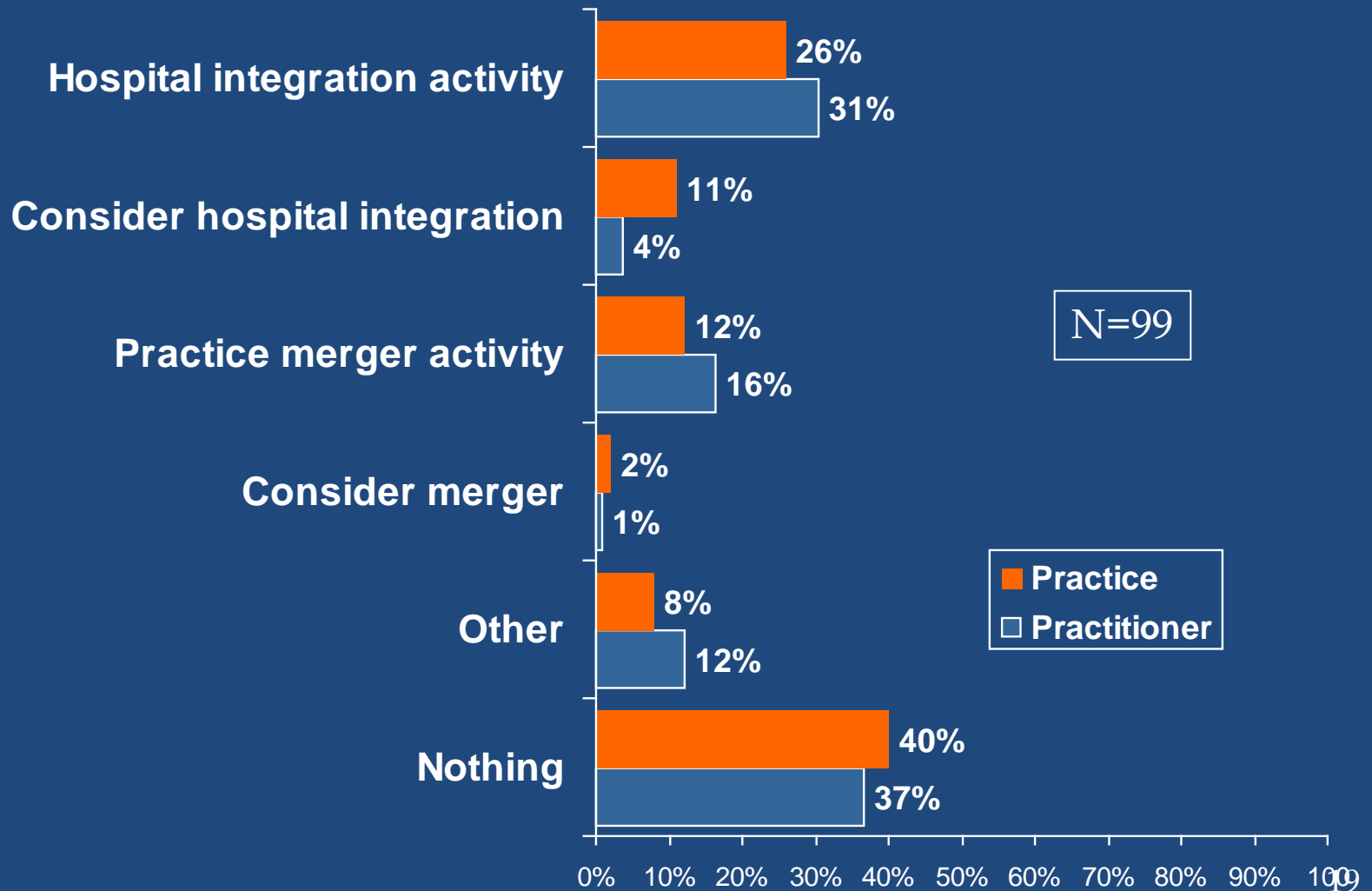
16 practices have integrated into a hospital system

12 are in discussions about hospital integration

9 practices have merged with another practice

4 practices are in discussions about practice mergers

# Changing Pennsylvania Private Practice\* Landscape – Practice vs. Practitioner



\* Includes solo-practitioners

# Response to CMS Cuts

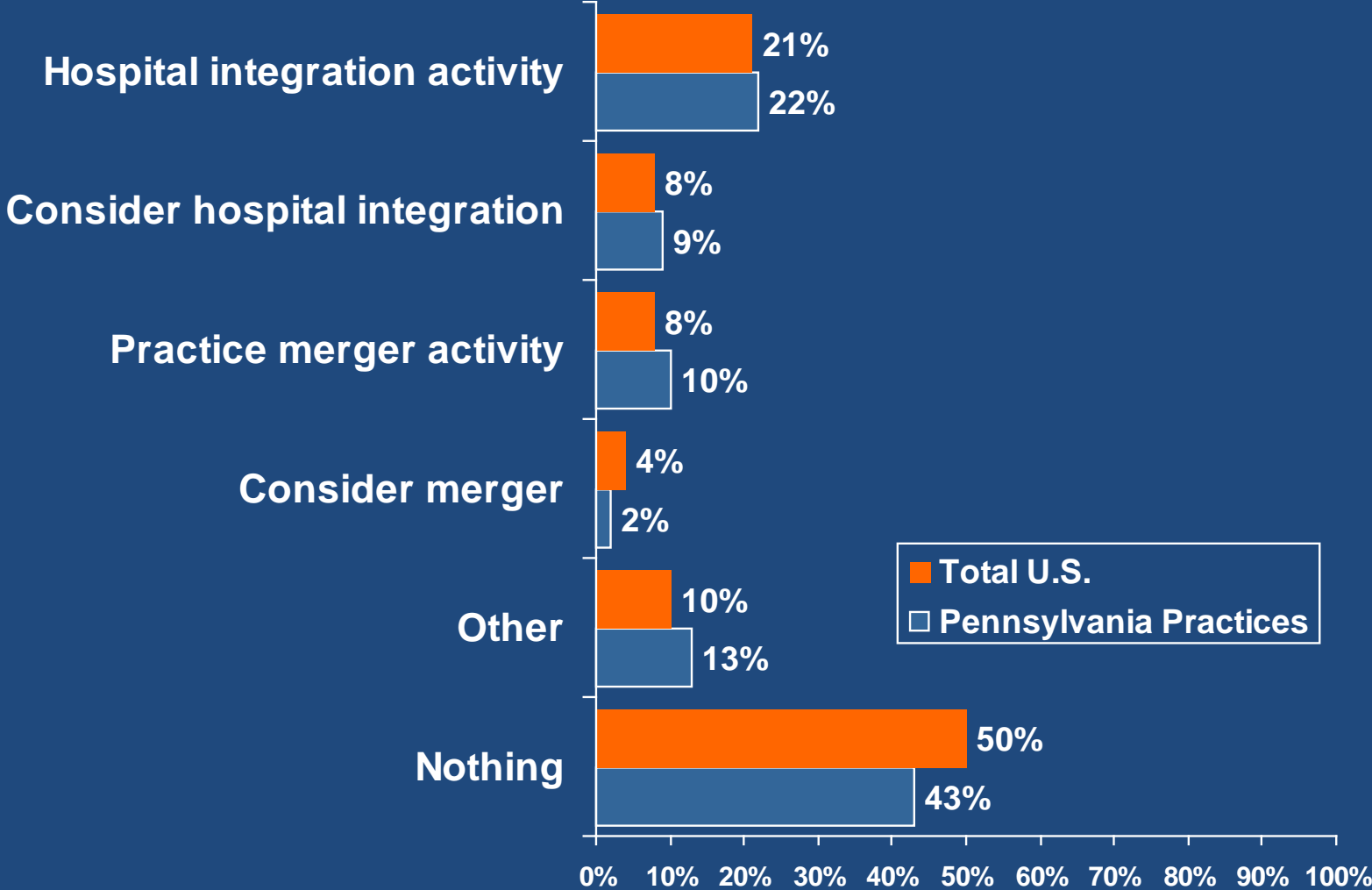
	<u>Total</u>	<u>Pennsylvania</u> <u>(n=128)</u>
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Other	14%	17%
None of these activities were related to CMS fee schedule change	27%	24%

# Detailed Findings

# Response to CMS Cuts – Private Practices\*

	<u>Total</u> (n=1678)	<u>Pennsylvania</u> (n=84)
No new equipment	51%	44%
Reduce staff to save expenses	45%	38%
Reduce MD income/salaries	43%	45%
Reduce benefits	37%	36%
Reduce non-MD salaries	26%	23%
Limit services	19%	19%
Reduce office hours and availability	13%	8%
Limit number of new Medicare patients	11%	7%
Increase non-MD staff for clinical	8%	12%
Other	15%	21%
None of these activities were related to CMS fee schedule change	19%	15%

# Changing Practice Landscape- Pennsylvania



# Changing Practice Landscape – All Practices

	<u>Total</u> (n=2413)	<u>Pennsylvania</u> (n=128)
<u>Hospital Integration Activity (Net)</u>	21%	22%
Have begun discussions on hospital integration	10%	9%
Have recently integrated into a hospital setting (within past 6 months)	3%	5%
Have integrated into a hospital – more than 6 months ago	9%	8%
<u>Considering hospital integration</u>	8%	9%
<u>Practice Merger Activity (Net)</u>	8%	10%
Have begun discussions on merging with another practice	4%	3%
Have recently merged w/another practice (within past 6 months)	1%	2%
Have merged with another practice – more than 6 months ago	3%	5%
<u>Considering a merge with another practice</u>	4%	2%
<u>Other</u>	10%	13%
<u>Nothing</u> , practice has no plans to merge/integrate	50%	43%

\* Includes solo practitioners

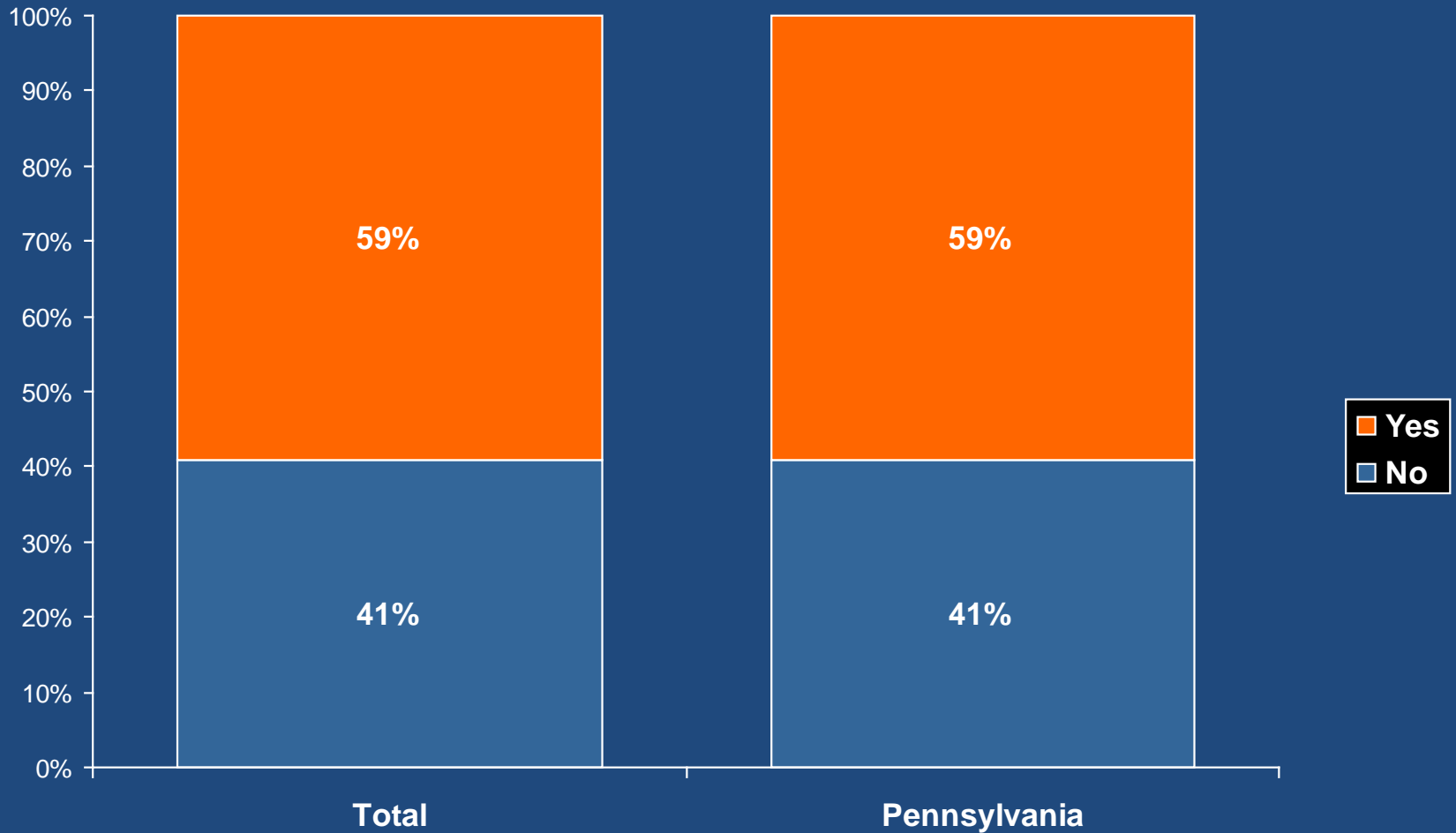
# Changing Practice Landscape – Private Practices\*

	<u>Total Private Practices</u> (n=1900)	<u>Pennsylvania Private Practices</u> (n=99)
<u>Hospital Integration Activity (Net)</u>	23%	26%
Have begun discussions on hospital integration	12%	11%
Have recently integrated into a hospital setting (within past 6 months)	3%	6%
Have integrated into a hospital – more than 6 months ago	9%	9%
<u>Considering hospital integration</u>	9%	11%
<u>Practice Merger Activity (Net)</u>	9%	12%
Have begun discussions on merging with another practice	5%	4%
Have recently merged w/another practice (within past 6 months)	1%	3%
Have merged with another practice – more than 6 months ago	2%	5%
<u>Considering a merge with another practice</u>	4%	2%
<u>Other</u>	8%	8%
<u>Nothing, practice has no plans to merge/integrate</u>	47%	40%

# Changing Practice Landscape – Group Practices\*

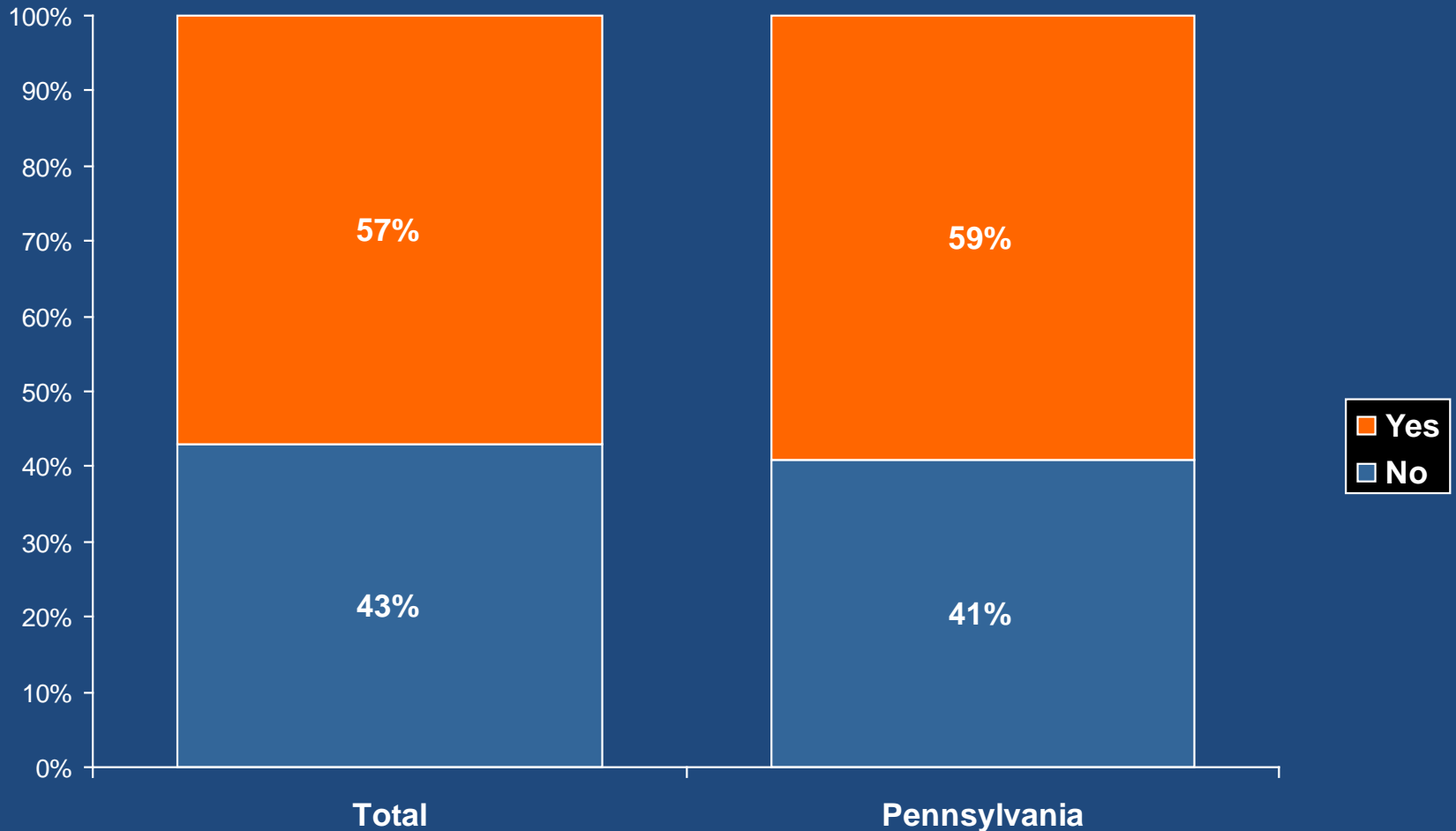
	<u>CV Group Practices</u> (n=1313)	<u>Pennsylvania Grp Practices</u> (n=79)
<u>Hospital Integration Activity (Net)</u>	30%	32%
Have begun discussions on hospital integration	14%	14%
Have recently integrated into a hospital setting (within past 6 months)	4%	8%
Have integrated into a hospital – more than 6 months ago	11%	10%
<u>Considering hospital integration</u>	9%	9%
<u>Practice Merger Activity (Net)</u>	10%	14%
Have begun discussions on merging with another practice	5%	4%
Have recently merged w/another practice (within past 6 months)	2%	4%
Have merged with another practice – more than 6 months ago	3%	6%
<u>Considering a merge with another practice</u>	4%	3%
<u>Other</u>	8%	8%
<u>Nothing, practice has no plans to merge/integrate</u>	40%	35%

# EHR Usage



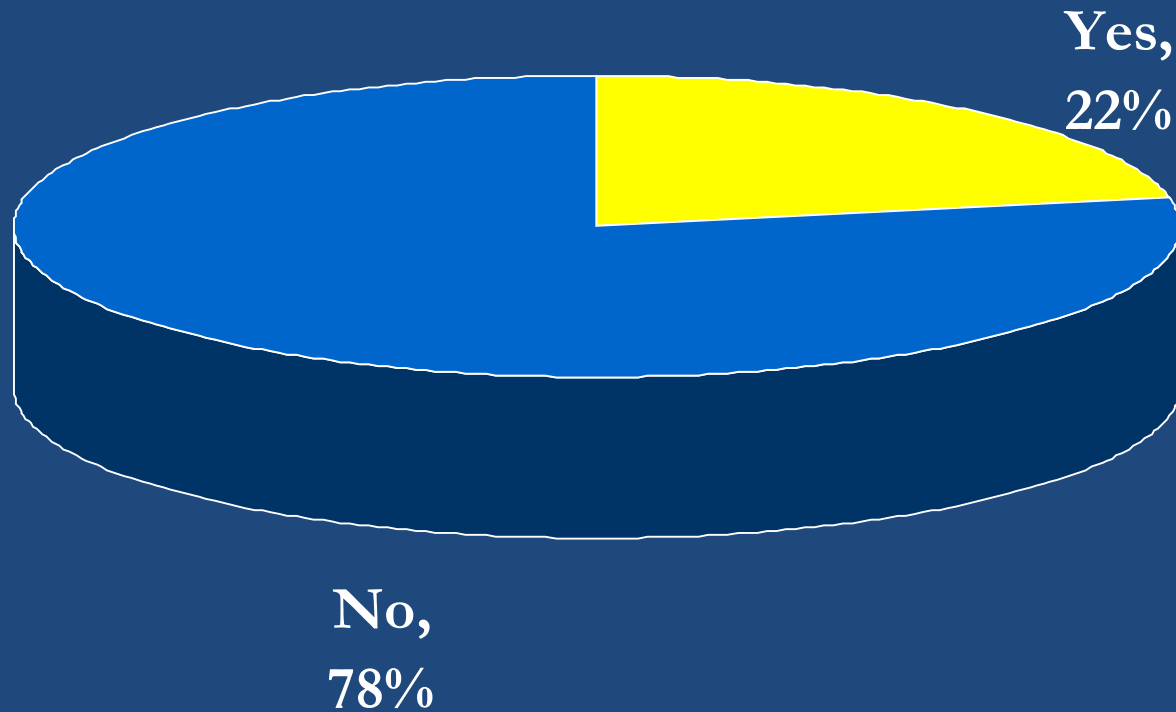
*Q: Does your main practice use an electronic health record (not including billing records)?*

# Prevalence of Team-Based Care Approach



*Q: A “team based” approach to care is one where there is a multidisciplinary group of professionals who have distinct roles but who participate together in decision making and coordination of care and share responsibility for the quality of care. Would you describe the approach to care delivery in your practice as “team based” using these non-physician practitioners and clinical staff?*

# Non-Participating MD for Medicare Patients



*Q: As a result of the CMS cuts, are you considering becoming a Non-Participating Physician for Medicare Patients?*

# Radiology Benefit Managers (RBMs) *WSJ 2008*

- Main Players
  - Core Care International
  - American Imaging Management
  - National Imaging Association
  - Medical Solutions
  - Health Help

# Characteristics of RBMs

- Focus-geographic variability
- Financial interest: reduce utilization
- Utilized by 90% of commercial health plans
- >50% of commercially covered lives under their purview (2007)

# Official Stance of Professional Societies toward RBMs

- American College of Radiology (ACR)-officially against, but generally accommodative. Main Issues:
  - Emergency procedures
  - Appeal process
  - Accreditation by ACR or equivalent
  - Inpatient study exclusion



# Official Stance of Professional Societies toward RBMs

- American Medical Association (AMA)
  - Conform to Best Practice Guidelines
  - Appropriate Use Criteria (all specialties)
  - Support a study assessing administrative cost, patient safety, and outcomes
  - RBMs should distribute diagnostic codes used to approve/disapprove
  - Oppose forced test substitution & denials that meet AUC
  - RBMs-need to be held accountable for harm due to substitution or delay of studies

# Official Stance of Professional Societies toward RBMs

- American College of Cardiology
  - Guidelines of RBMs recommend one test modality over another & incongruent with current literature and imaging guidelines
  - RBMs-making clinical decisions & hindering physician autonomy
  - RBMs selectively implement ACC AUC and practice guidelines
  - Test substitution: rationale not generally provided (Of note: ACC opposed to forced substitution)
  - Developing RBM alternative FOCUS

# Medicare is Next

- Medicare imaging increased from 7 billion to 14 billion in 2000-2006
- Obama administration-estimates that 260 million can be saved over 10 years
- Congressional action would be required for Medicare to use RBMs
- Demonstration projects-in the works

# ACC Foundation

- Survey regarding imaging
  - 70% appropriate
  - 15% inappropriate
  - 15% uncertain

# The RBM Process

- Structure includes: 3 Layers to Approval Process. Their staff training:
  - High school diploma, 3 weeks training
  - Nurse
  - Physician reviewer
- One study demonstrated:
  - 70% approval in 1<sup>st</sup> tier
  - 82% approval in 2<sup>nd</sup> tier
  - 65% approval in 3<sup>rd</sup> tier

# The Western Pennsylvania Experience-Timeline

- Highmark announces precert for nuclear and stress echo (& consider these studies to be interchangeable)
- Physician notification-3 months prior to implementation
- PaACC Task Force Convened over issue
- Highmark meets with ACC state and national leadership-asked to delay
- Highmark and NIA Meet with Task Force including ACC,ASNC

# The Western Pennsylvania Experience-Timeline

## – Results:

- Test substitution eliminated
- Precert for nuclear stress maintained
- Pre-notification –stress echo
- Reason cited-lack of availability of stress echo
- Door left open-use of ACC FOCUS tool

# Rebuttal Letter August 2010



- Lack of consistent embedding of AUC in NIA guidelines
- Stress echo and stress nuclear-not equivalent
- ACC recourses contemplated:
  - State Insurance Commission and Board of Health
  - Create database for inappropriate to. Currently under development denials that Cardiologists and Primary Care Physicians can submit
- ACC recourses contemplated:
  - State Insurance Commission & Board of Health
  - Data base-for inappropriate denials

# The Western Pennsylvania Experience-Timeline

- Cheap Shot- Pittsburgh Post Gazette article says-  
Highmark-Saving the World from radiation
- Response from Highmark-Uncertain classification of  
studies will be denied and RBMs will continue to be  
used for the foreseeable future
- Response currently being crafted; will pursue all  
avenues of redress
- Bottom Line:
- ACC-needs own precertification tool! Hopefully  
FOCUS can serve this need. Forced test substitution is  
a non-starter; it is putting the insurance company in  
the room with the doctor and patient.