

CARDIOLOGY PRACTICE TRENDS 2011

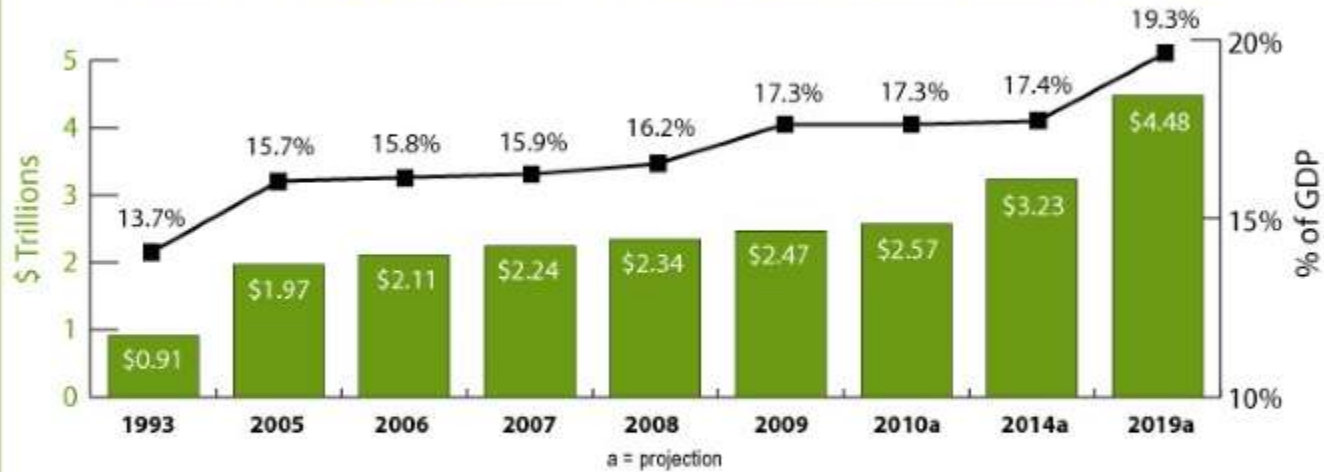
THE IMPORTANCE OF ADVOCACY

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Challenges to Cardiovascular Practice Survival

- ⦿ Sustainable Growth Rate
- ⦿ Imaging Cuts (CMS)
- ⦿ Radiology Benefit Managers
- ⦿ Self-Referral Legislation
- ⦿ Tort Reform
- ⦿ Alternative Payment Models
- ⦿ Health Care Reform (IPAB)
- ⦿ Changes in Medicare due to Deficit Reduction

Actual and Projected National Health Expenditures, Selected Years



Sources: For 1970 – 2008: Micah Hartman, Anne Martin, Olivia Nuccio, Aaron Catlin and the National Health Expenditure Accounts Team (2010). Health Spending Growth At A Historic Low In 2008. Health Affairs, January. (www.healthaffairs.org)

For 2009: CMS Office of the Actuary (2011). Annual Report of National Health Spending. January

For 2010– 2019: Christopher J. Truffer, Sean Keehan, Sheila Smith, Jonathan Cylus, Andrea Sisko, John A. Poisal, Joseph Lizonitz, and M. Kent Clemens (2010). Health Spending Projections Through 2019: The Recession's Impact Continues. Health Affairs, March, Exhibit 1. (www.healthaffairs.org)

Sustainable Growth Rate

- Began in 1997, the brainchild of Rep Bill Thompson, House Ways and Means to balance cost growth and productivity
- Cost curve for Medicare has always outstripped projections
- In 2002 a 5% cut in payment and since then Congress has acted 12 times to prevent cuts, 5 separate times in 2010
- To balance this would require a 29.5% cut which could happen 1/1/12
- The cost of this reconciliation is 300B, the cost will be 600B

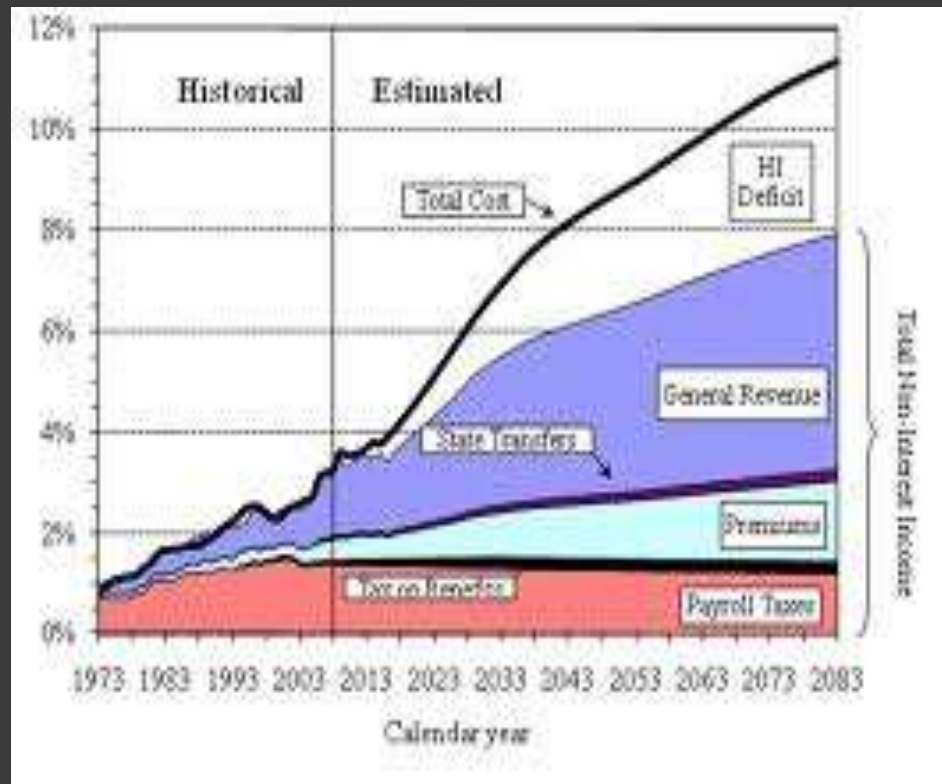
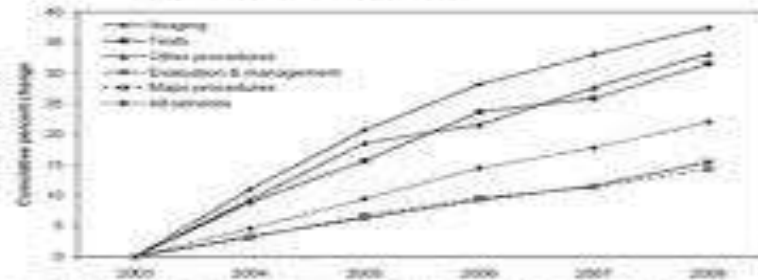


Chart 3-4. Continued growth in volume of physician services per beneficiary, 2003-2008



Note: Volume is unit of service multiplied by service value (relative to the average fee schedule) converted to 2003 dollars using the medical input cost index value for 2003.

Source: MedPAC, based on data from the 2008 Medicare Physician Fee Schedule.

- The volume of physician services per beneficiary has continued to grow from year to year, with some services growing much more than others.
- From 2003 to 2008, the volume of physician services grew by 23.0 percent. By specific types of services, imaging, tests, and "other procedures" (procedures other than major procedures) each grew at a rate higher than 30 percent. The comparable growth rates for major procedures and evaluation and management services were only 14.3 percent and 11.5 percent, respectively.
- Volume growth has slowed in recent years but remains positive. From 2007 to 2008, services in the tests category grew the most, then increased 4.5 percent. "Other procedures" also rose, at 4.3 percent, followed by evaluation and management (3.5 percent), imaging (3.3 percent), and major procedures (2.7 percent).
- Volume growth increases likelihoods spending, displacing other priorities in the federal budget and requiring employers and beneficiaries to contribute more to the Medicare program. Current volume increases translate directly to growth in full-cost (i.e., spending) test procedures. They are also largely responsible for the negative updates required to the sustainable-growth rate formula. Rapid volume growth may be a sign that some services in the physician fee schedule are overused.

What will happen with SGR?

- Bold and comprehensive resolution in the context of deficit reduction
- Short-term fix
- 30% cut on Jan 1
- Intermediate fix while other payment models explored

Imaging and RBMs

- Deficit Reduction Act of 2005- cuts in imaging targeted by Congress and CMS
- Huge cuts in imaging due to CMS Rule in 2010
- Downward trend in imaging per beneficiary began in 2007; utilization in 2010 less than 2009
- Average practice spends 70,000 on pre-authorization process
- RBM criteria for denial are not transparent and deemed proprietary and not evidence-based

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 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

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 1st tier
 - 82% approval in 2nd tier
 - 65% approval in 3rd tier

Liability Reform

- ⦿ Estimated by Congressional Budget Office to represent potential of 50B in cost savings over 10 years
- ⦿ Health Act (HR 5), modeled on CA MICRA (1975) would have most impact with caps on non-economic damages and reduction in legal fees
- ⦿ Unlikely to pass Senate
- ⦿ Other “fall-back” provisions include Health Courts, Certificates of Merit, collateral source rule, periodic payments, adherence to guidelines, expert witness qualification, and “I’m sorry”.
- ⦿ None of these should usurp state laws that are more favorable

Independent Payment Advisory Board

- 15 member panel appointed by President
- Ability to adjust payments without congressional oversight
- Opposed by physician organizations, most republicans and many democrats
- Part of Affordable Care Act and can be implemented in 2013

Joint Select Committee on Deficit Reduction

- 6 Senators, 6 Congressmen (6 Democrats, 6 Republicans) aka the Super committee
- Need to find 1.2T in cuts
- Cuts identified by 11/23
- Vote in both Houses by 12/23
- If SGR were thrown in 1.5T, if Obama job stimulus 1.977T

The Stances (or Postures) Republicans

- Cap entitlement spending and achieve Medicare coverage through private plan competition, de-emphasizing traditional Medicare
- Raise eligibility age over time
- Income-indexed premium contributions
- ACA Repeal
- IPAB Repeal

The Democratic Stance

- Protect traditional Medicare, guarantee defined benefits
- Fund Medicare and Medicare Advantage with equal contributions
- Do not support raising age, Obama supports means testing
- Want ACA to survive with Amendments
- Divided on IPAB

Medicaid Reform

- ⦿ Republicans- block grants to states
- ⦿ Democrats- defined entitlement of benefits
- ⦿ States- reduce or cap
- ⦿ Traditional Medicaid least expensive
- ⦿ Dual eligible Medi-Medi- more expensive
- ⦿ Long term care services- most expensive

How Will Price Pressure on Medicare Affect Us?

- Caps on spending
- Price controls
- Rationing
- Hospitals positioning themselves to support means testing and increasing Medicare age to protect themselves
- GME will be threatened

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 |

Quality Improvement Not on the Agenda

- ⦿ Reduce unnecessary readmissions
 - (H2H)
- ⦿ Systematically improve quality
 - (PINNACLE Registry, AUC)
- ⦿ Reduce complications
- ⦿ Improve patient safety
- ⦿ Reduce unneeded utilization
 - (AUC, FOCUS)

Practice Landscape

- ⦿ We will be in an environment of increasing patient expectations and decreasing reimbursement
- ⦿ Based on aging population there is an anticipated physician gap of 124,000 by 2025 (859 vs. 734K)
- ⦿ There will be a gap in Cardiologists of 14,000
- ⦿ The number of physicians caring for a patient in the last 6 months of life is 8.9-16.9

Physician Satisfaction (I Can't Get No)

- 40% of specialists dissatisfied to very dissatisfied
- 40% satisfied to very satisfied
- 20% neutral
- Trend toward greater satisfaction in last 5 years (? Capitulation)
- Expectation that income will drop
- Younger physicians more satisfied than older

2012 Fee Schedule

- ⦿ Down 1% overall for average Cardiology practice
- ⦿ Year 3 of CMS cuts
 - (Practice Expense Transition)
- ⦿ Multiple Procedure payment reduction
 - (50% of professional component for advanced imaging provided on same day)
- ⦿ Reduction for “misvalued” services
 - (imaging, ICD and pacer services)
- ⦿ Partial offset with PQRS, Meaningful Use and E-prescribing

Payment Methods

- ⦿ Rewarding value over volume
- ⦿ Bundling doesn't equate to appropriateness
- ⦿ More efficient delivery of care needed
- ⦿ Metrics of price (P), quality (Q), and quantity (q)

The Interfaces and Drivers of Change

- Physician and Patient- point-of-service decision support that can be tied to MOC
- Patient and Payor- wellness programs and cost sharing
- Payor and Physician- payment reform (bundling, ACOs, global payments, pay-for-performance)

Payor Advocacy Legislative

- State and Federal
- Support or oppose legislation
- Establish relationships
- Contribute to PAC
- Identify Practice Champions
- Visit Member (Legislative Conference, Cardiologist for a Day, Harrisburg visits)

Meeting with Insurers

- Meeting regarding pre-authorization
- Collected cases of inappropriate denials
- Pushed FOCUS as an alternative to RBMs
- Persistence
- Align with other specialties and their societies (egg. PAMED, ASNC)

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

- 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.

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
 - Highmark agrees to pilot program of FOCUS in Western PA practices

Rebuttal Letter August 2010



- Lack of consistent embedding of AUC in NIA guidelines
- Stress echo and stress nuclear-not equivalent
- Second meeting with Highmark Feb. 2011
 - Agreed to FOCUS rollout after being presented with 40 cases of inappropriate denial
 - Would not agree to release algorithm NIA uses citing proprietary concerns
- Further steps July 2011
 - Met with State Insurance Commission , Secretary of Health and Lt. Governor
 - Issue to be taken up with PAMED Specialty Leadership Council 9/11

Regulatory

- ① State Dept of Health
- ① State Insurance Commissioner



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J.M.W. Turner
Rain, Steam, and Great Railway Bridge
1844
Oil on canvas
National Gallery, London







Small boat with a large sail on a choppy sea

1865

John Constable

Small boat with a large sail on a choppy sea

Small boat with a large sail on a choppy sea





Against the Wind

“ I find the greatest thing in the world is not so much where we stand, as in what direction we are moving...we must sail sometimes with the wind and sometimes against it- but we must sail, and not drift, nor lie at anchor.”

Oliver Wendell Holmes

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.

Activity among Pennsylvania practices ...

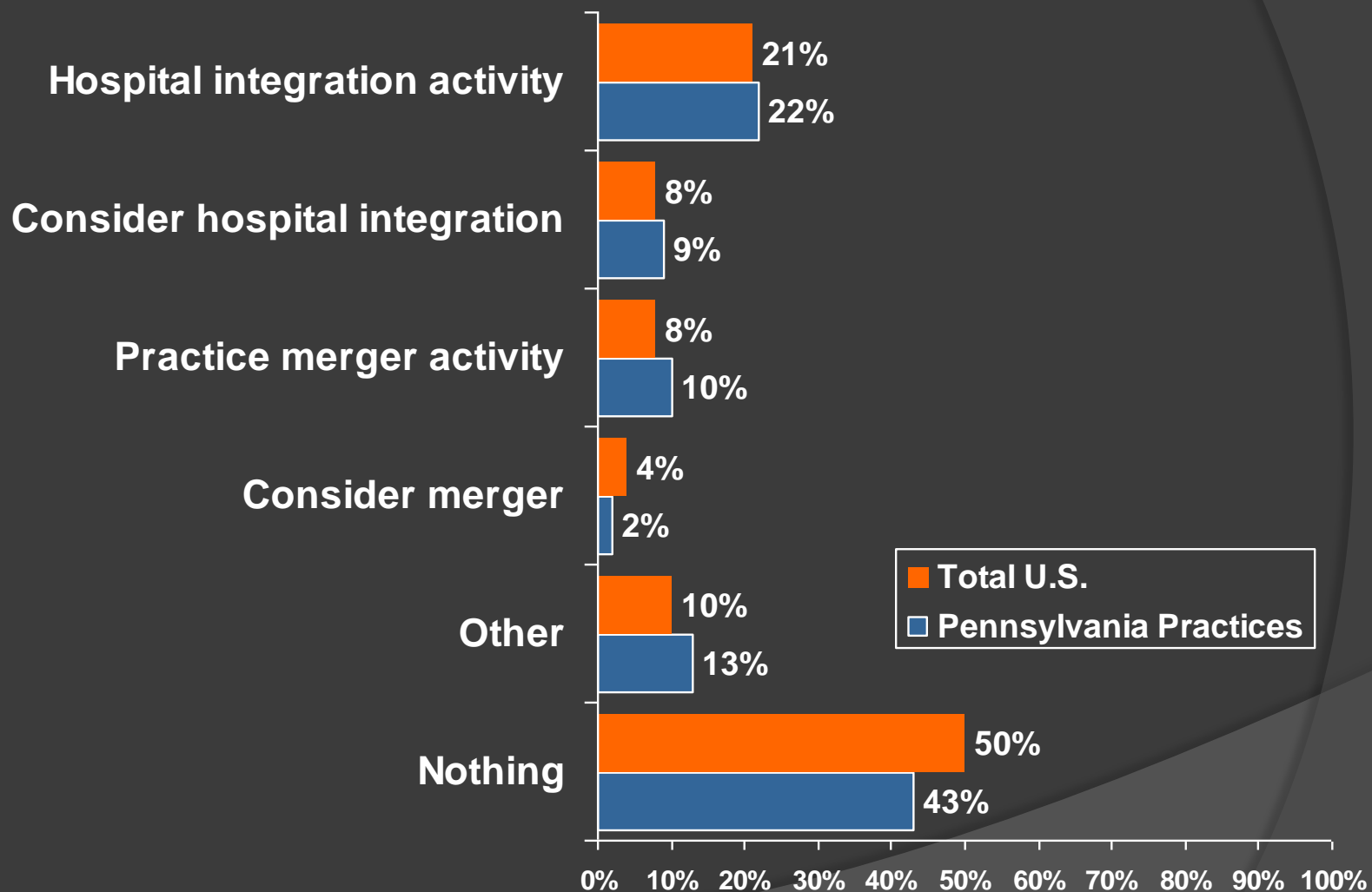
16 practices have integrated into a hospital system

12 are in discussions about hospital integration

9 practices have merged with another practice

4 practices are in discussions about practice mergers

Changing Practice Landscape- Pennsylvania



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% |

* Includes solo practitioners

* Includes solo-practitioners

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% |

* Includes solo practitioners

* Excludes solo-practitioners

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% |

* Includes solo-practitioners

But surely you agree that truth can be created by the repetition of a lie.



KARL ROVE and PLATO

Pepper ... And Salt

THE WALL STREET JOURNAL



*"Heads, you get a quadruple
bypass. Tails, you take a
baby aspirin."*

