Heartache

The Political and Economic Complexities of Cardiology Post-SCOTUS
Political Econ 101

“Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family “ (Auerbach and Kellerman, Health Affairs)

Spending increases more attributable to growth in cost per case than rising disease prevalence (Roehrig and Rousseau, Health Affairs)

Power Curve Imperative: 4/5 health care $ spent on patients with chronic conditions
SCOTUS’ FRAMING OF THE DEBATE

• Everybody In’ (individual mandate) still in
  • But Most States in denial or not ready for Exchange deadline (thus kicking to Federal option)
  • Medicaid Expansion coercive, States can opt out
    • And 15 (R) States subsequently threaten
  • The Rest of ACA intact constitutionally
    • But so what?
Forget Repeal

- Congressional ‘balances’ not likely to tip
- Markets committed to key elements (Hospitals, PhRMAs, Plans..)
- Voter opinion continues to split, but underlying support for key provisions emerging as political offset
- ie, Texas poll this month: Oppose 59-31
  - “The candidate wants Texas to turn down billions of dollars in expanded Medicaid funding that would go to pay for health care for thousands of the state’s lower income working families because it is part of the Obama-care plan..”
Repeal Kabuki

- Republican House will ‘repeal’ (for nth time)
- Voters will think law has been repealed (and still don’t know what it does and doesn’t do)
- The Medicaid eligible/ soon –to- be- bait and switched historically don’t vote in sufficient %s (and everyone knows they don’t) or are packed into fewer congressional districts
- Congressional outcomes uncertain, but inside (close) bet is Senate Rs won’t reach repeal threshold, notwithstanding Presidential outcome;
Repeal Kabuki

• Death watch will continue via near-death experiences by a thousand budget cuts or via Budget Reconciliation process and/or implementation delays (HIX)

• Remaining/surviving features have constituencies that firewall insurgents, alter political dynamic, which remains evenly split

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Plans and Hospitals On Hook

• “…..Hospitals are watching these developments with mounting alarm. National hospital organizations actively supported health reform, even if grassroots hospital executives remained major skeptics. And they gave up $155 billion in future Medicare payment reductions to gain 30 million new paying patients, and consented to the reduction of disproportionate share payments (DSH) payments intended to compensate them for their bad debts and charity care. A cancelled Medicaid expansion would place the safety net hospitals in those states at serious economic risk, who would be forced to continue relying on Robin Hood economics to keep their doors open…"
Plans and Hospitals On Hook

• ...For several reasons, health plans will also have trouble with the newly “optional” Medicaid expansion. The only reason health plans agreed to unprecedented federal restrictions on their business practices was the promise of near-universal coverage.... How can health plans in states which decline the expansion be expected to absorb, through guaranteed issue and guaranteed renewal, the flood of adverse selection, not to mention the above discussed provider cost shifting? If the federal government enforces the rate controls in ACA, health plans could run out of cash and exit those markets. And if CMS declines to enforce ACA’s rate controls, employer health premium increases could head back north into the high teens or low twenties.

Jeff Goldsmith, Futurist
Darts to the Heart

• “oculostenotic reflex” (Recent national Headline re HCA)

• Writing in the journal *Circulation* in 1995, Eric Topol, MD, and Steven Nissen, MD, described this phenomenon as "an irresistible temptation among some invasive cardiologists to perform angioplasty on any significant residual stenosis after thrombolysis"—that is, after clot-busting medications have been used.
Darts to the Heart

- Last July, Paul Chan, MD, and colleagues updated information on oculostenotic reflex, although they did not call it that. They wrote in the *Journal of the American Medical Association* that inappropriate angioplasty still goes on, a lot. From their review of the American College of Cardiology's registry of percutaneous coronary interventions at 1,091 hospitals, they discovered that 11.6%, or 16,838, of 144,737 non-acute patients underwent a PCI that did not meet necessity criteria during a 15-month period ending Sept. 30, 2010.
Comparative Effectiveness
Stents as Exhibit A

- 2007 “Courage” Trial (NEJM 2007)
- “A Simple Health-Care Fix Fizzles Out” (WSJ 2010)
- “…Sanjay Kaul, prominent cardiologist and researcher estimates that the US could save $5 billion of the $15 billion it spends on stent procedures if all doctors followed Courage’s guidance—that is, putting certain heart patients on generic drugs and turning to stents only if pain persists..”
Medicare Study: EHRs facilitate overbilling, fraud

• “...experts blame a substantial share of the higher payments on the increasingly widespread use of electronic health record systems. Some of these programs can automatically generate detailed patient histories, or allow doctors to cut and paste the same examination findings for multiple patients — a practice called cloning — with the click of a button or the swipe of a finger on an iPad, making it appear that the physicians conducted more thorough exams than, perhaps, they did. ..
Medicare Study: EHRs facilitate overbilling, fraud

- Critics say the abuses are widespread. “It’s like doping and bicycling,” said Dr. Donald W. Simborg, who was the chairman of federal panels examining the potential for fraud with electronic systems. “Everybody knows it’s going on.”

Sic Transit Gloria Imaging
‘Self Referral’

• Health Affairs Dec 2010 29:12 Hughes, Bhargvan, Sunshine: “Imaging Self Referral Associated with Higher Costs and Limited Impact on Duration of Illness”

• “…Our study provides broad evidence that physician self referral for imaging typically is not associated with substantial benefits in treatment duration or costs. …is associated with significantly and substantially higher total care costs in the majority of medical conditions and imaging types …self referral is not associated with shorter illnesses.”
Sic Transit Gloria Imaging
‘Self Referral’

• Health Affairs Dec 2010: Baker “Acquisition of MRI Equipment by Doctors Drives Up Imaging Use and Spending:

• “…results show that physicians ordered substantially more scans once they began billing for MRI…not only did MRI spending increase, but spending for other aspects of care rose as well…”
DRA Plus ACA cuts = Migration to Employed Status

• Stark I and II, then DRA 2005: technical component of imaging exams reduced 20-40%; =12.7% spending decline/utilization increased; CT sales fell 27% (2008)MRI 36%; then, ACA: 25% reduction on imaging contiguous body parts; recalculation assumptions on high tech imaging frequency, revaluation of office expense component of technical fees;
DRA Plus ACA cuts=
Migration to Employed Status

“This reevaluation had a particularly dramatic effect on practicing cardiologists ..(who) relied upon imaging for 38% of its Medicare Part B fee billings in 2008. These new CMS technical fee reductions weakened office based cardiology… triggering a remarkably swift wave of practice acquisitions by hospitals

– Bruce Hillman and Jeff Goldsmith, Health Affairs December 2010
Now What

• Consolidation/employment considerations
  • Exacerbates maldistribution and probable shortages
  • Uncertain Hospital revenue outlook, plus never event/re-admit liabilities, and physician-acquired RAC liabilities mean:
    • Employment contracts subject to imbalances--widely varying work conditions and medical staff relationships on a 2-3 year fuse
Then What

- Realignments render consolidation more urgent—but Hospitals are the dog chasing the Dr car
  - Culture eats Strategy’s lunch (old dogs don’t like new tricks)
  - Payers ramp up network tiering (back to the 90s)
  - Decline of FFS, more ETG bundling experiments ‘value-based/performance-based payment;
  - Continued acceleration of Hospital-based ACOs
    - And increased anti trust scrutiny
  - Physician alignments divide unevenly between Plans and Hospital systems
  - Litigation by de-networked and disenfranchised after contracts lapse (next 18-24 months)
So What

• “...Here’s a flash for the policy wonks pushing ACOs: They only work if the provider gets paid less for the same patient population. Why would they be dumb enough to voluntarily accept that outcome?”
So What

…Oh, there will be some providers—particularly hospital administrators—who can’t wait to build an ACO but probably more because they want another excuse to corner the primary care docs as a marketing channel for their growing system. But spend millions to develop an ACO so they can get less money? Only in the policy wonk netherland does that compute…

The only people on the ball when it comes to this ACO idea are the anti-trust lawyers and with good reason.”

– Robert Lewzewski PhD from his Health Policy Blog April 2011
Meanwhile, back on the Potomac

• SGR still headed over Cliff, just in time for Bush Tax revisions and impending ‘Sequestration’

• OMB Sequestration Projection:
  – In the case of the cuts to Medicare, seniors would see no changes in their benefits, but providers, including doctors and hospitals, would see an across-the-board 2 percent cut to reimbursements. An estimated 496,000 healthcare jobs would be lost during the first year of cuts, according to a report funded by doctors, hospitals and nurses groups.
Meanwhile, back on the Potomac

- Hospitals would bear the largest share of the cuts. The Federal Hospital Insurance Trust Fund would be reduced by about $5.8 billion, while the National Institutes of Health would see a $2.5 billion reduction. The Centers for Disease Control and Prevention would face cuts of $490 million, and the Food and Drug administration would see reductions of about $318 million.

- Funding for the health law’s insurance exchange grants would decrease by $66 million while funding for the health law’s prevention fund would drop by $76 million.
Medicare Policy wags Dog

- Medicare Demos and payment realignments are already being adapted in commercial market space (think ‘never event’ syndrome)
  - Bundling of ETGs—w/uneven results
  - Extensive Prior Auth of procedures, devices, Rx, diagnostics
  - EHR rollouts and its impending liabilities (civil and criminal)
  - Collaborative experiments in post acute follow up
  - Increased inter-specialty tensions, PCP spills over into Residency funding and incentives, other policy conflicts (RNP scope, E&M upgrades at specialists’ expense..)
  - RAC audits ramp up, flag outliers for plans’ network tiers
What’s What
Practical Considerations

• Physician groups break three ways;
  • **Intractables**: Older specialists resistant to integration and all that entails
  • **Adaptables**: slightly younger and younger still who want help integrating w/out necessarily being employed
  • **Integrateds**: Been there, doing that, question value of organizations outside employer/institution
The Organizational Value Question

• As advocate for the employed physicians vs intractables and the adaptables
• As the broker and mediator between the administration/employer and physicians/managers
• As a practice support system for the employed
  – Vetting the explosion in informatics and technologies that enhance productivity, sharing best practices, etc
But...politics drives the process that sets policy

- Grassroots organizing basics
  - Every group transcends voting
    - Holds events, briefings, breakfasts, and volunteers in campaigns
    - ‘interns’ MC staff, local media, influencers in their practices
    - Rapid response briefings, on/off record to local, regional, national media on breaking news or impending news events