


# ARIN/AVIR

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# **Mid-Revolution Update: the ups and downs of change in the US healthcare system**



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# Experience

- SIR Health Policy and Economics Councilor
- Hospital System Chief Medical Officer
- SIR Advisor to the AMA CPT Editorial Panel
- President/managing partner of a ~37 physician DX/IR/RadOnc practice with 4 hospitals, 5 imaging centers, 2 outpatient radiation centers (incl Proton Therapy)
- Past Section Chief of IR and department Clinical Director at Yale, Associate Prof

# In an hour with questions ..

- the cost of healthcare in the US
- the mechanics and politics of reimbursement
  - Hospital inpatient, outpatient and freestanding
  - Costs, charges, and payments
- The rise of "consumer, retail healthcare"
- How hospitals and administrators make decisions on staffing, purchasing, and support for specific procedures and service lines

# Healthcare in the News

1 ACA

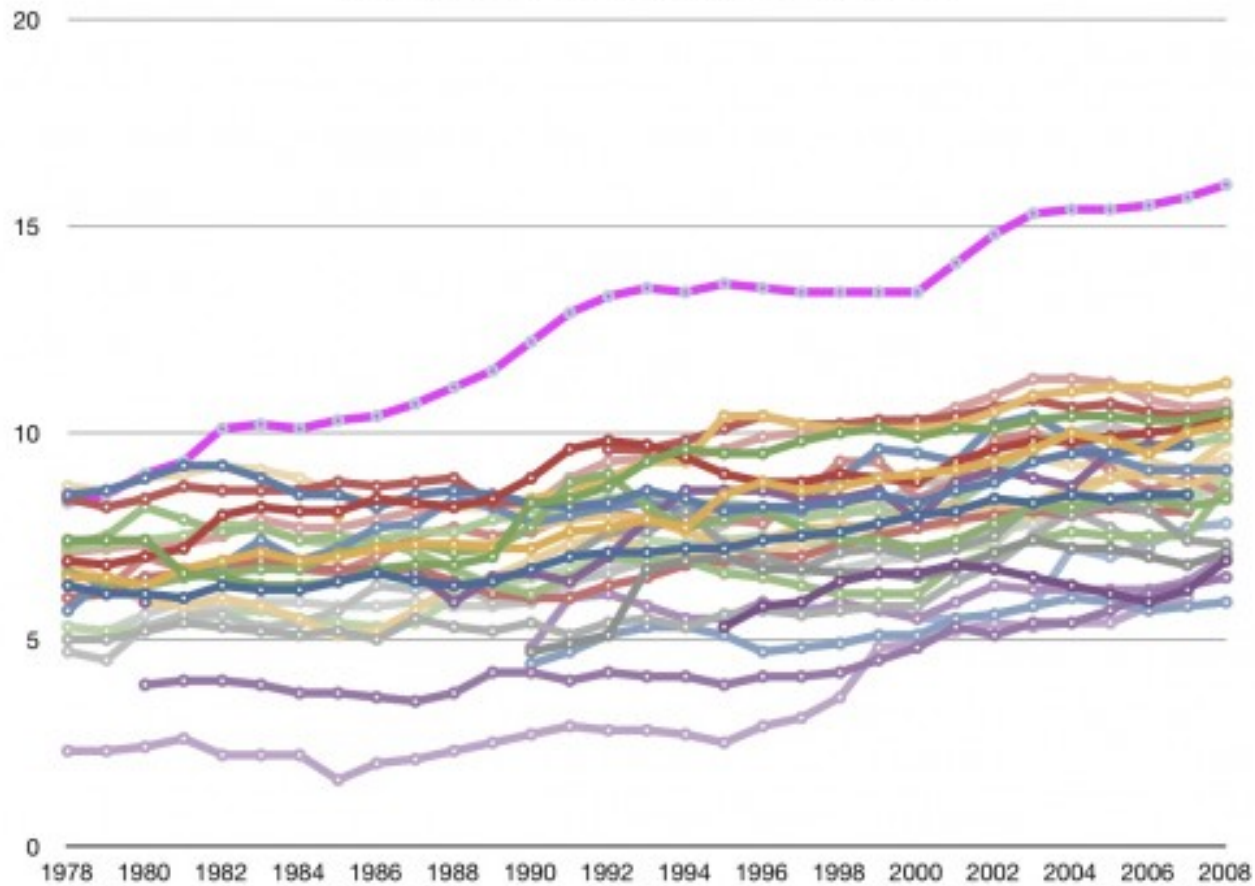
2 ACA

3 ACA

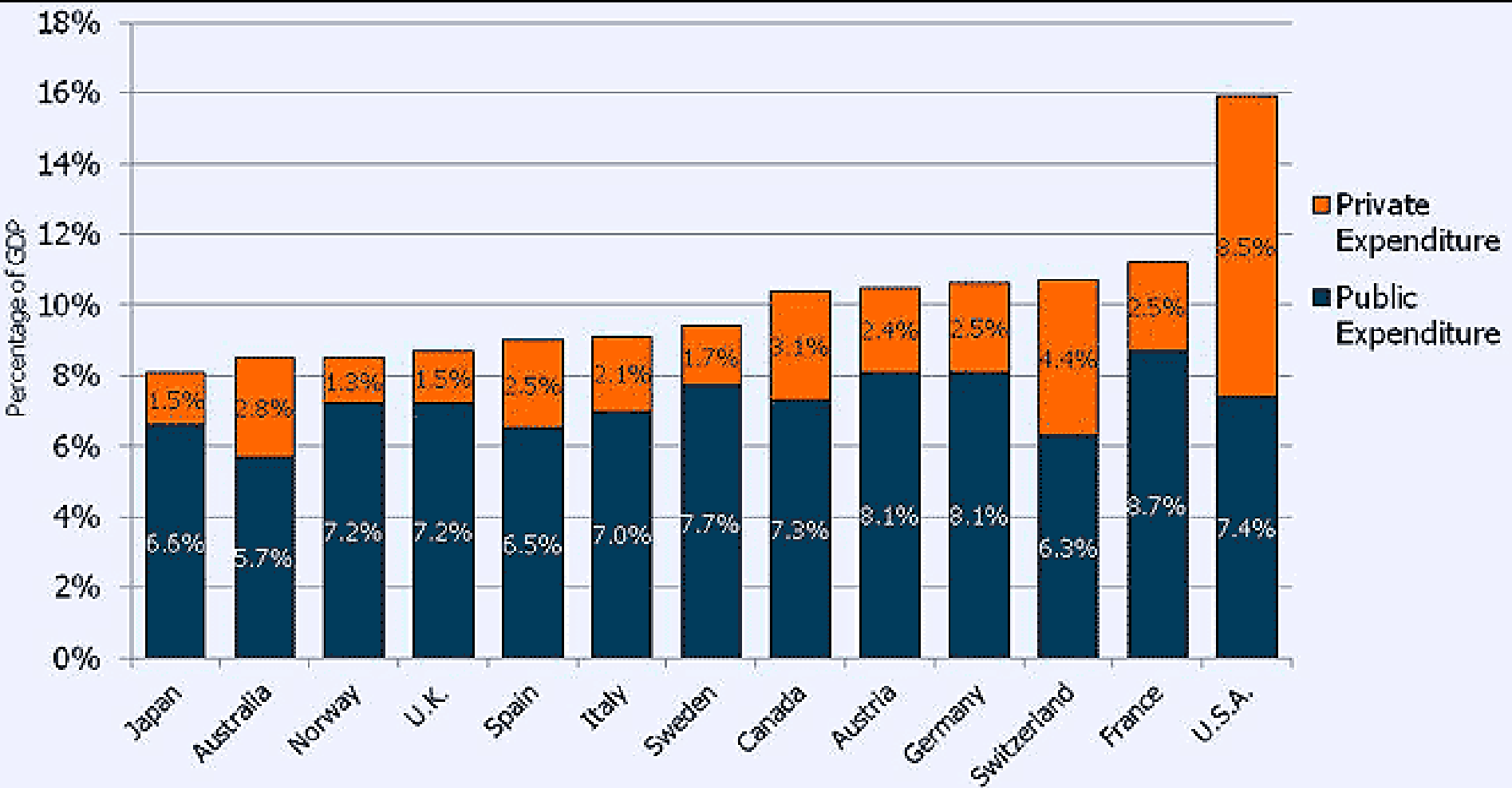
- The ACA is just one small part of everything that is happening to reduce health care costs and improve quality



Health care spending as a percentage of GDP



- |                   |               |                  |
|-------------------|---------------|------------------|
| ● Australia       | ● Austria     | ● Belgium        |
| ● Canada          | ● Chile       | ● Czech Republic |
| ● Denmark         | ● Finland     | ● France         |
| ● Germany         | ● Greece      | ● Hungary        |
| ● Iceland         | ● Ireland     | ● Italy          |
| ● Japan           | ● Korea       | ● Luxembourg     |
| ● Mexico          | ● Netherlands | ● New Zealand    |
| ● Norway          | ● Poland      | ● Portugal       |
| ● Slovak Republic | ● Spain       | ● Sweden         |
| ● Switzerland     | ● Turkey      | ● United Kingdom |
| ● United States   |               |                  |

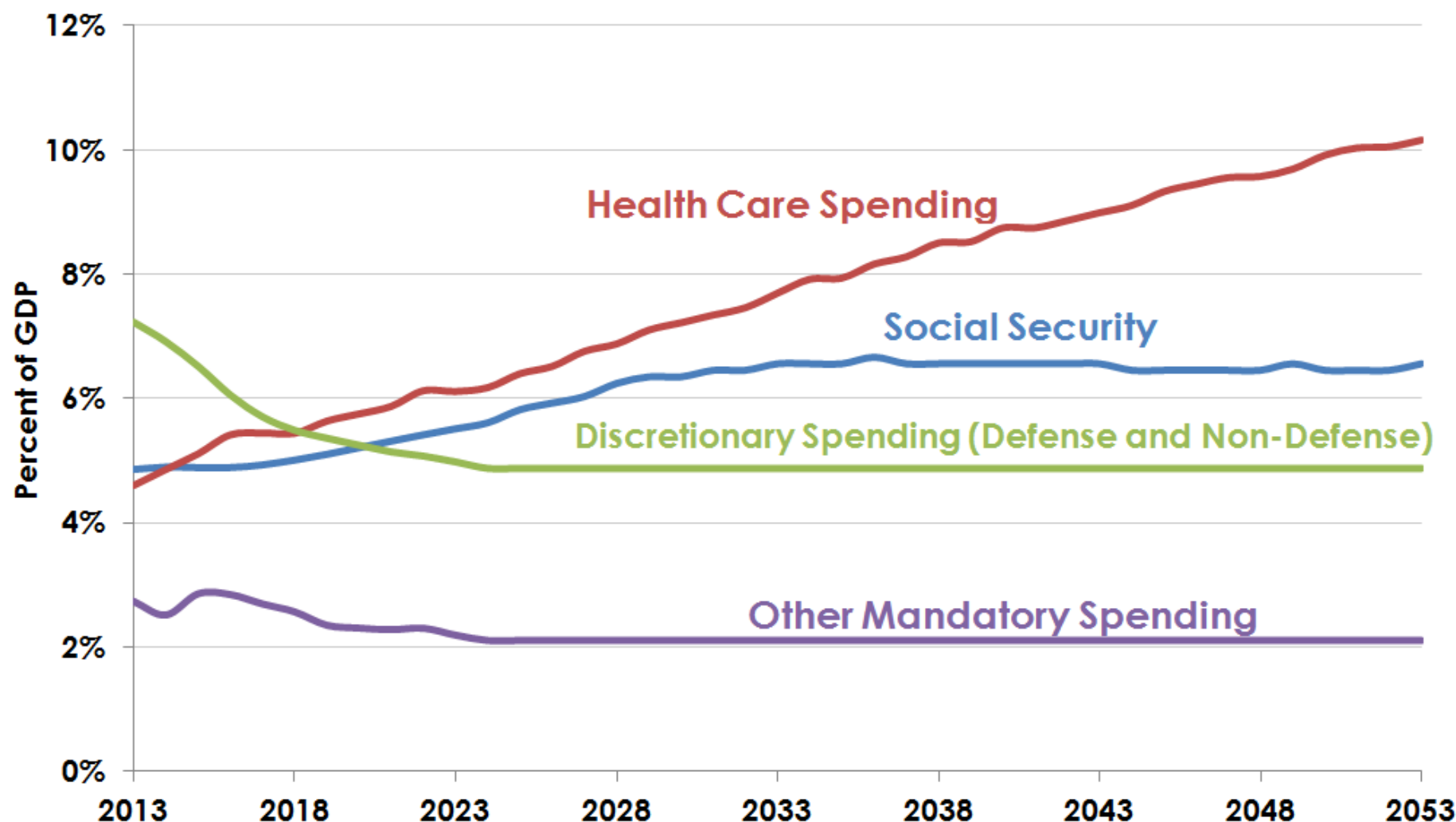




# Change in Healthcare spending over time as a % of GDP

	1970	2004
US	7	15.3
Canada	7	9.9
Germany	6.2	10.6
UK	4.5	8.1

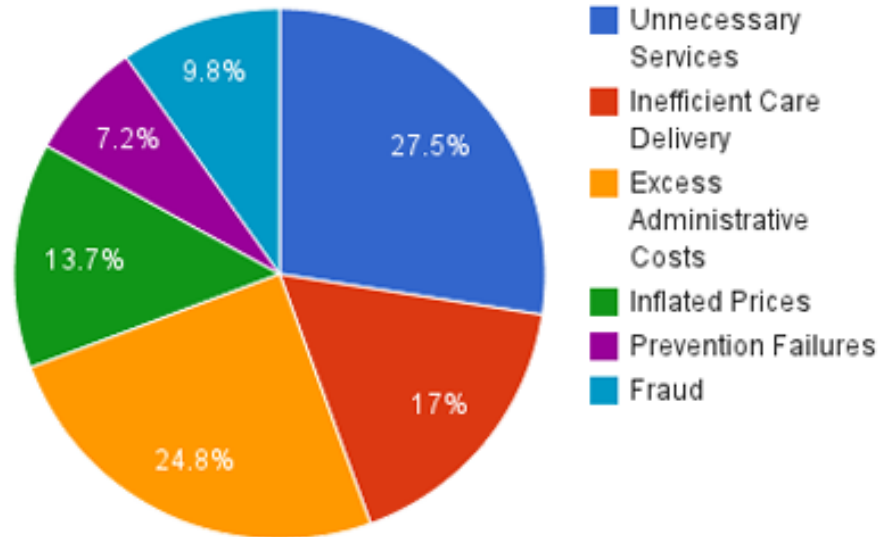
## HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE DEBT



Note: Health care spending includes Medicare net of offsetting receipts, Medicaid, the Children's Health Insurance Program (CHIP), and Affordable Care Act (ACA) exchange subsidies.

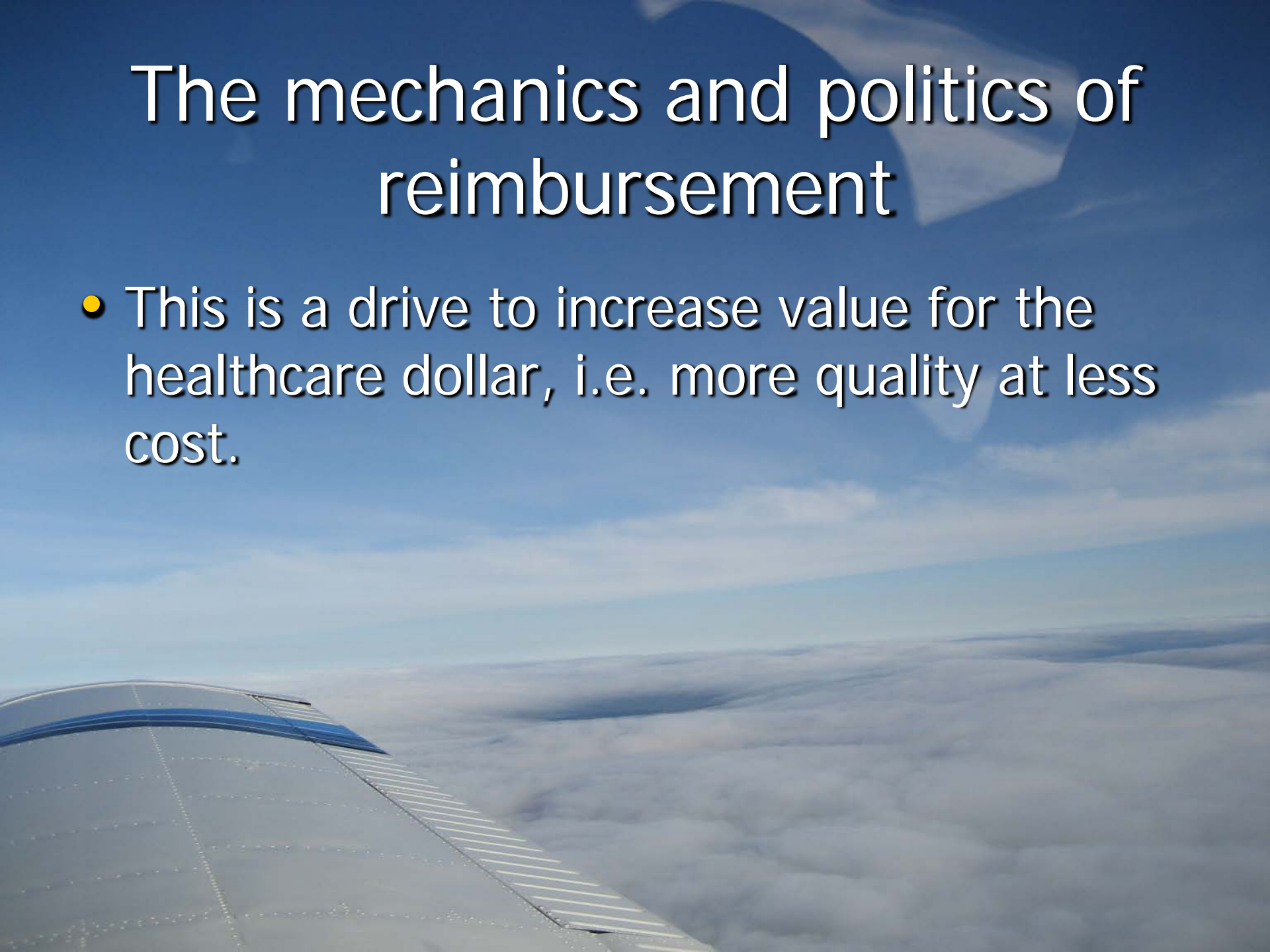
Source: Congressional Budget Office; Bipartisan Policy Center projections  
[WWW.BIPARTISANPOLICY.ORG](http://WWW.BIPARTISANPOLICY.ORG)

# IOM Sources of Waste in Healthcare – \$750B



# The mechanics and politics of reimbursement

- This is a drive to increase value for the healthcare dollar, i.e. more quality at less cost.





# How do we get paid?

- Doctors

- Medicare Physician Fee schedule (MPFS)
- Private payers
  - Participating (contracted) vs. Non-Par (in network vs out of network)

- Hospitals

- DRGs, HOPPS based on APCs
- Contracted case rates (inpatient, outpatient)
  - Per diem payments vs case rates

# Hospitals

- In NJ, the typical average "profit" in a non-profit hospital is 3%. This is what a hospital has for capital investment, new programs, equipment placement, etc.
- For a community hospital with a \$400M annual budget, that leaves \$12M
- EBID(T)A is very sensitive to patient volumes and increased expenses

# Doctors

- There has been a steady erosion of reimbursement for all proceduralists.
  - Cardiology (Echo, cath, PCI, nucs)
  - Vasc Surgery (bypasses, endovascular)
  - Radiology
- No one has been spared except pure E&M billers (e.g. primary care)

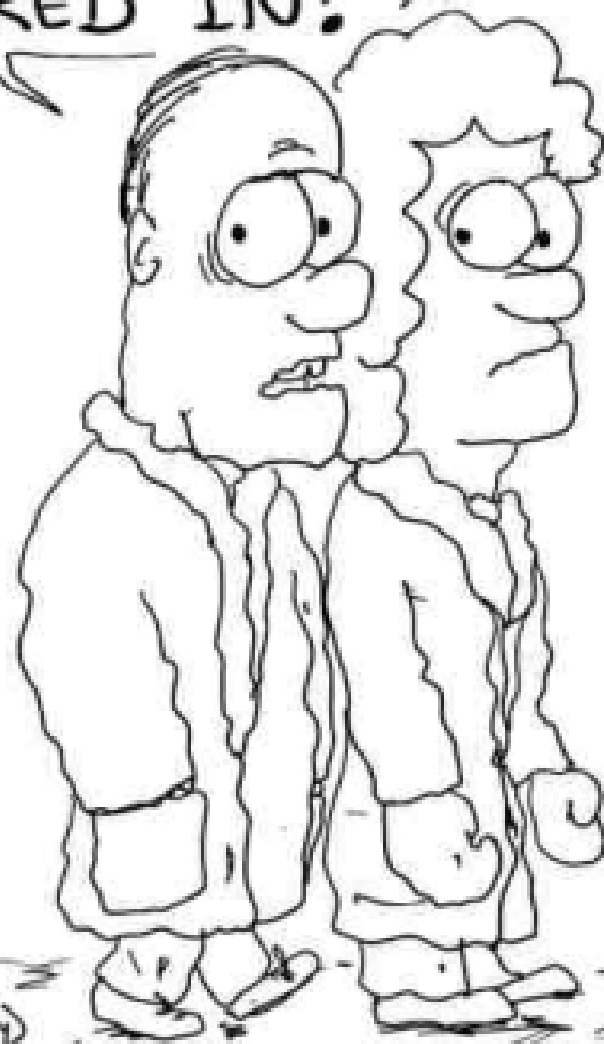


# How is CMS cutting costs?

- Motivated, smart senior and mid-level CMS staff who want value for the US healthcare \$
  - They aren't afraid to disrupt the system or break some eggs while trampling through the system
  - View the ends justify the means
- Plus the support of the political class
- Plus support from academia and business



UH, OH! THAT LOOKS LIKE OUR DOCTOR!  
THE NEW MEDICARE CUTS MUST  
HAVE KICKED IN!



missy (thanks to Phil Carey)

# Sustainable Growth Rate

- Passed in 1997 (BBA), SGR was intended to ensure that the yearly increase in the expense per Medicare beneficiary does not exceed the growth in GDP
- Current "baked in" reduction to current MPFS is  $\sim 24\%$
- Cost to eliminate is **\$140.2 B** (CBO)
- The current temp fix expires March 31, 2015

# Proposed SGR "Fix" Last Year

- Small annual increases in PFS
- Development of metrics for performance, outcomes, quality = **Value**
- Little chance of long term reform given the current legislative climate
- Hoping for yet another temp fix

KICKING THE CAN DOWN THE ROAD *with CIVILITY*

AFTER YOU.

NO, NO,  
AFTER YOU.



# AMA: CPT and RUC

- Determine procedure codes and physician reimbursement from CMS. Used as a basis of payment for other payers using the RVU system.
- Editorial panel members plus specialty society advisors
- Responsible for almost all procedure coding
  - New codes, modified codes, deleted codes
  - Category 1, 3 are most relevant to us.
- Meet 3X on an annual cycle
- CPT defines the codes. RUC assigns the values.

# RUC

- Breaks down a code into various services provided as part of that service by use of a clinical vignette for a 'typical' patient.
- Quantitates the services used by survey of practitioners across specialties
- Includes a calculation of practice expense for procedures performed in the non-facility setting
- Establishes RVU for a procedure

# Bundling as a means to control costs

- When CPT takes 2 or more codes typically billed together and creates a new single code to describe all
- CMS assumes that if 2 or more codes are used to describe an episode of care then there must be some overlap of services and therefore they are overpaying.
- RUC typically devalues the new code value by a substantial margin.



# Other CMS methods to decrease payment independent of legislation

- Multiple Procedure Payment Reduction (MPPR)
  - Applies to all proceduralists
  - For imaging, this was originally for the technical charge only, now expanded to include professional fees for physicians and physician groups.
  - multiple services to the same patient, in the same session, on the same day.
- 100%, 75%, 50%



# Assumed Utilization Rate

- Defined as the amount of time during which an imaging center is open to patients and "expensive equipment (priced above \$1 million)" is actually in use during a 50 hour work week, the equipment utilization rate is one figure in a larger formula that helps calculate practice expenses reimbursed under Medicare.
- 50%, 75%, 90% for CT, MRI, PET
- Surveys show the correct UR is ~50%

# Private (commercial) Payers

- May take their cue from CMS
- May impose additional restrictions on procedures
  - Typically there are controls for high end imaging
  - Pre-certification, guide lines
- May deny payment for seemingly arbitrary reasons
  - Who, where, why, what

# Site of Service

- CMS and payers may control where certain procedures are performed and by whom.
- Typically affects freestanding centers in particular.
  - An accreditation challenge



# Hospitals – Bundled Payments

- Inpatient DRG's (bundled hospital payment, not docs)
- Outpatient HOPPS, depending on APCs
- CMS would love to pay everyone the same for outpatient services, but the methodology for determining procedure expense is dramatically different in the different sites of care. CMS came close to mandating this year though.



# HOPPS and APCs

- Hospitals keep track of expenses each year
- Annual updates to HOPPS and APCs

# Alternate Payment projects

- Commercial payers experimenting with bundled payments for specified procedures. E.g. joint replacement
- CMS pilots with “gainsharing”, CCO’s and others.
- ACO’s, Clinically-Integrated Networks
- More to come

# The Rise of Consumer-driven Healthcare

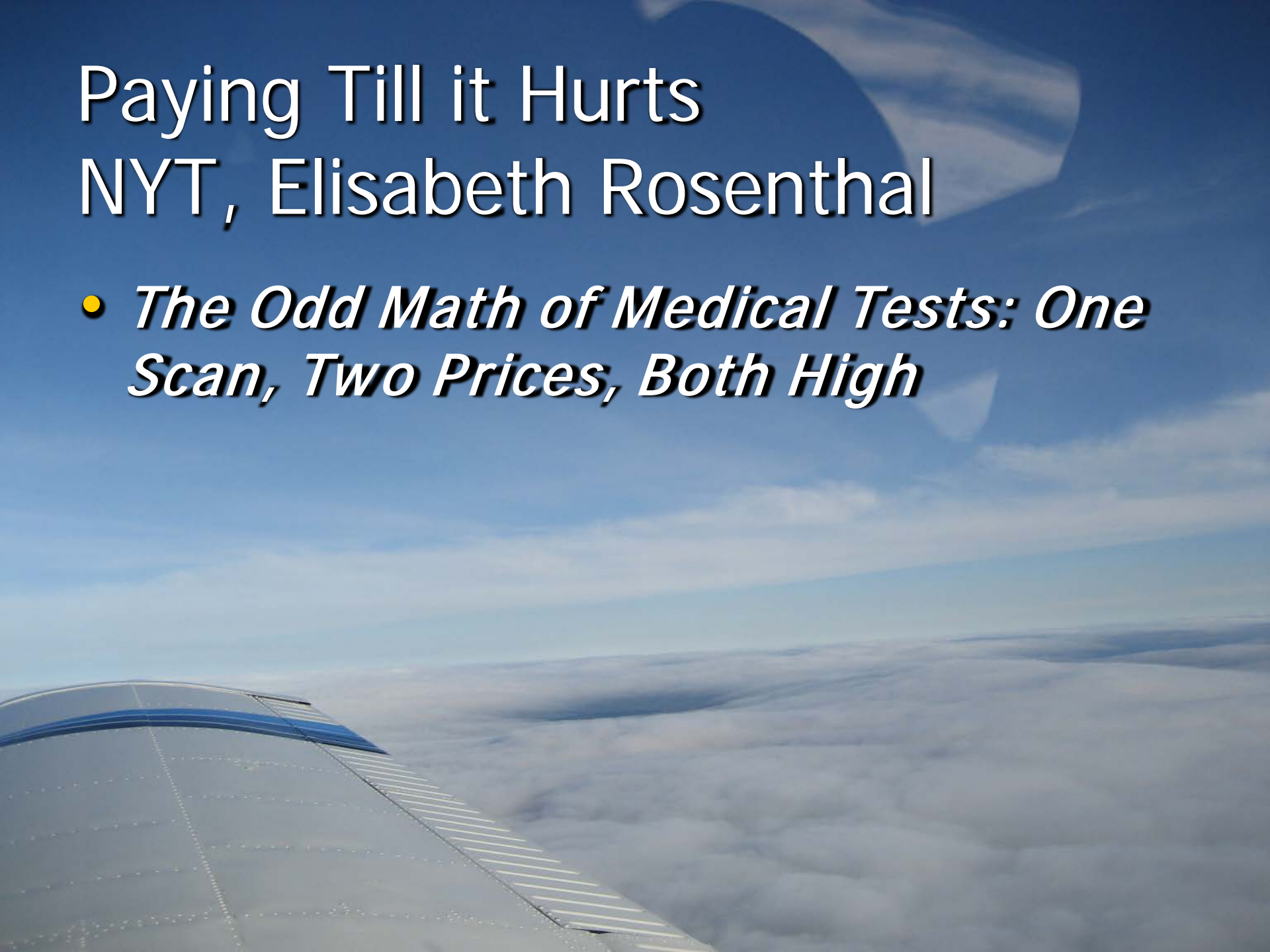
- Hospitals are expensive and have a very hard time charging less
- High deductibles + high co-pays => consumers go shopping
- Payers are "steering" patients to lower cost sites of service



# Paying Till it Hurts

## NYT, Elisabeth Rosenthal

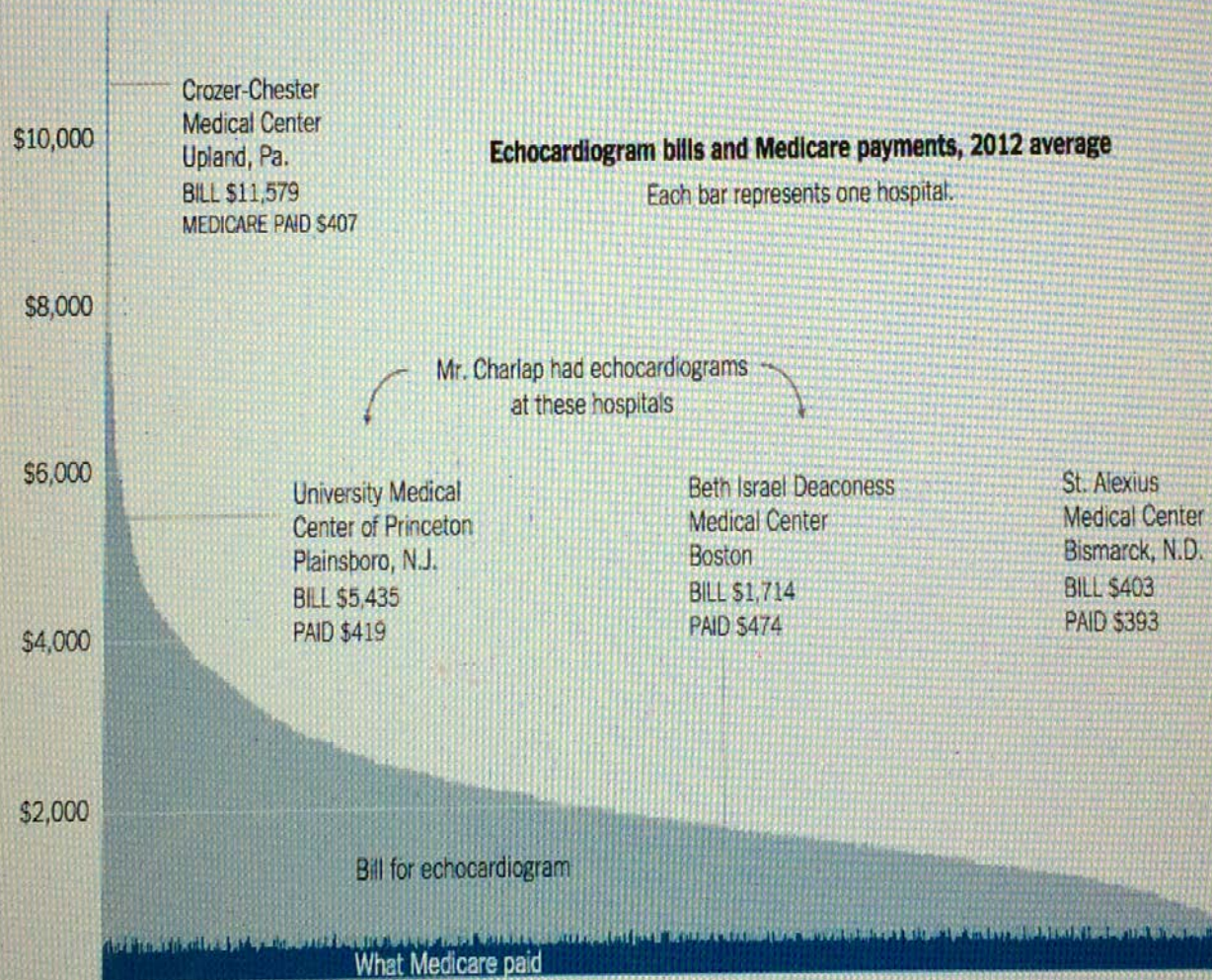
- ***The Odd Math of Medical Tests: One Scan, Two Prices, Both High***





## High Price for Simple Technology

The price tag for an echocardiogram in the United States can be several thousand dollars, but the actual value, according to Medicare, is several hundred.



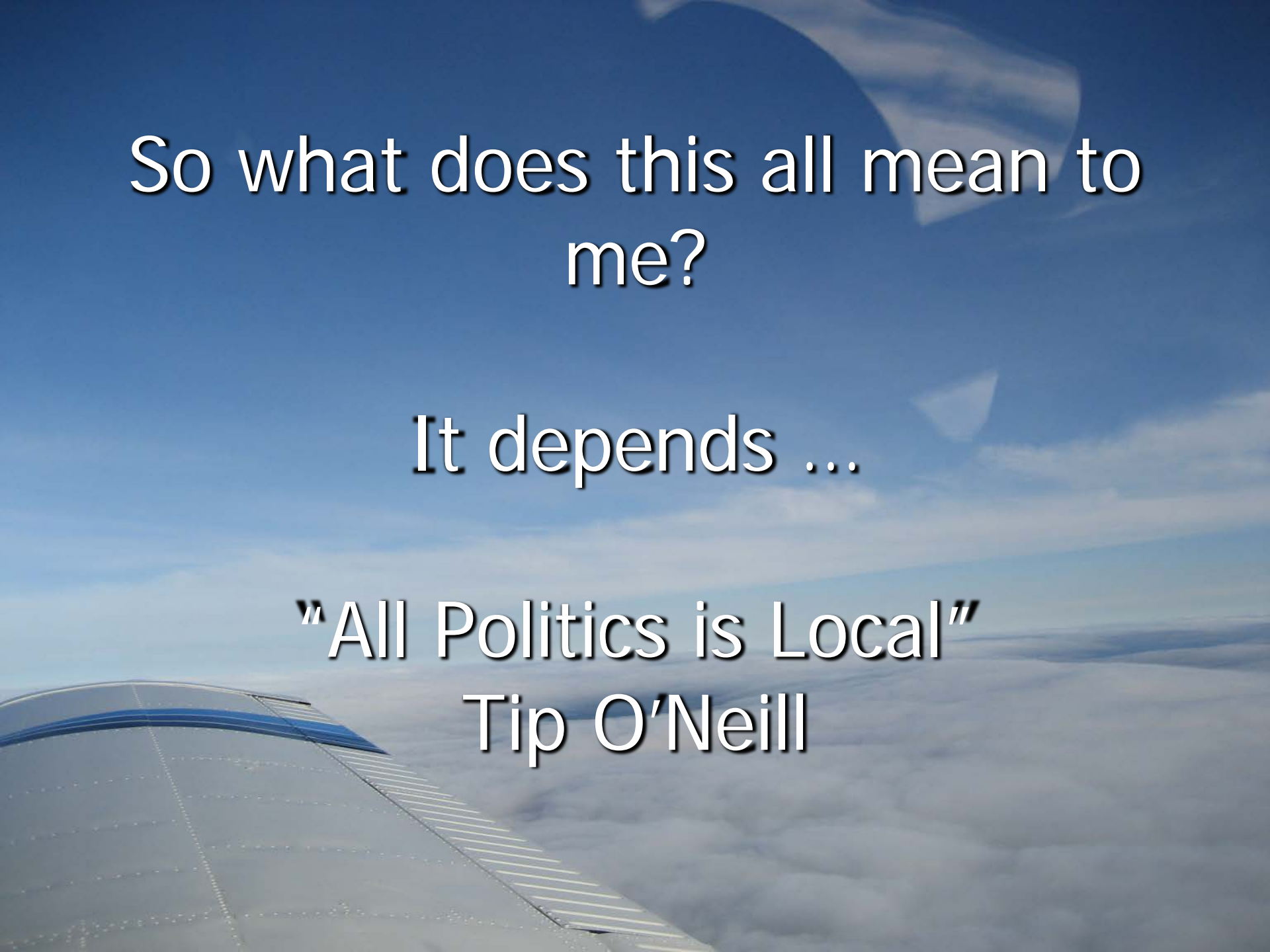
Source: Centers for Medicare and Medicaid Services

Hannah Fairfield/The New York Times



# Costs, charges and payments

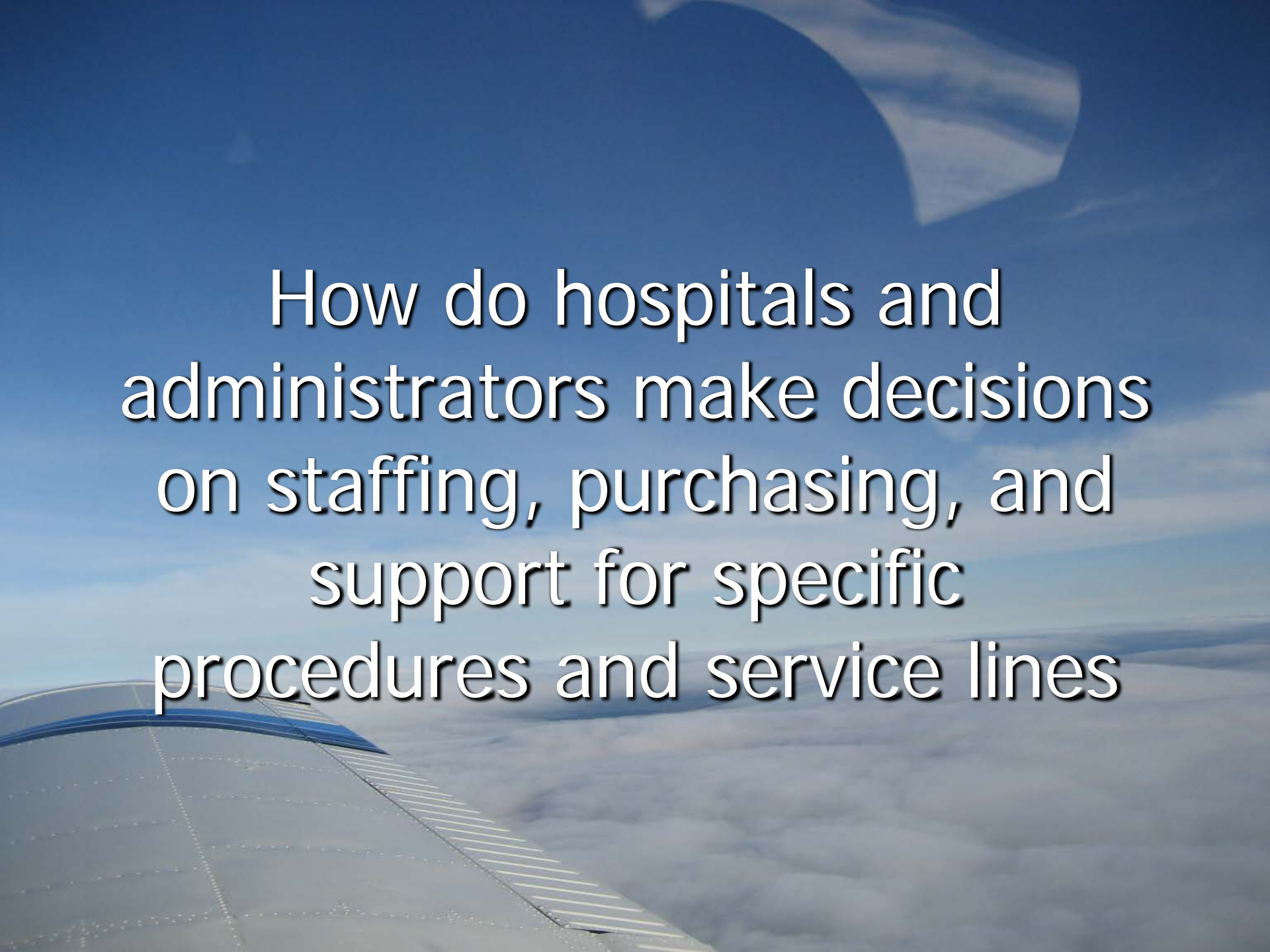
- Cost – how much it costs to provide a service
- Charge – what the provider bills the patient
- Payment – what the provider is paid by the patient or other payer



So what does this all mean to  
me?

It depends ...

**"All Politics is Local"**  
Tip O'Neill



How do hospitals and administrators make decisions on staffing, purchasing, and support for specific procedures and service lines



# Hospitals

- Where does your job or service fit in the organization?
  - Radiology
  - OR
  - Nursing
  - Other
- Who has influence?

# Finances

- Hospitals are employers like any other corporation now.
  - Ruthless in controlling costs
  - With a 3% profit margin, there is little room to maintain programs that lose money unless they are clinically essential.
  - Tiered bureaucracy. It isn't personal (to the other guy): CEO, VPs, Directors, Managers
  - Common to target the 25% percentile in staffing levels
- "Flexing" & Lay offs are becoming common

# Find a Way

- Nothing trumps finances
  - Critical look at processes and costs
  - Doctors don't know the costs in the hospital setting but hospitals are incentivized to educate them
- Patient satisfaction is a component of hospital value based purchasing
- Pt satisfaction is a part of executive incentives for hospital directors
- Be sure you are part of patient satisfaction metrics



# Find a way

- Expand your responsibilities in your organization
- Learn something new
  - Security and marketability
- Be professionally active outside of work to grow your specialty and to network with peers



# Is IR cheaper?

- Than what?
- Depends on how one calculates and may be specific to the condition being treated.
- Think about using the least resources possible. Even if a service is profitable it is critical that it be provided at the lowest possible cost.
- We need to prove our value. Until we look we don't know.

# The Nature of Revolution

- Winners - The winners write the story.
- Losers
- Survivors
- Once started, revolutions may spin beyond what their creators had planned or intended.
  - Maximillien de Robespierre.

# Slides

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