

The Election's Health Care Impact

BY DAVID W. PARKE II, MD

Most people watching the 2012 US elections were focused on the presidential race, but, for those of us in medicine, the legislative results held equal if not greater interest. As we all know, Congress loves to kick physician-reimbursement issues down the road instead of permanently solving problems such as the sustainable growth rate formula (SGR). So, what kind of Congress did we get out of the election?

The good news is that physicians are a small but growing minority: the 113th Congress includes 20. Previously, 2 of these members were Democrats, and now there are 4. We have both an ophthalmologist and an optometrist in the Senate. Unfortunately, we did lose some friends in the election, including ophthalmologist Nan Hayworth. In the House, an emerging power base called the GOP Doctors Caucus comprises 13 physicians, 10 of whom are specialists, as well as some non-physician members. These representatives are starting to gain seniority and are actually becoming a very effective group for us to work with in several areas.

Physicians need all the friends we can make because our industry is undergoing some of the biggest changes we have seen in decades. While some may attribute that to the passage of the Affordable Care Act, the biggest driver of change was and is cost. Health care expenditures are now about 18% of the GDP and are closing in on one-fifth of the economy. At the same time, the average retiree in America has less than \$60 000 in retirement funds, while the cost for their retirement-years care not covered by Medicare is already close to almost half a million dollars.

SEQUESTRATION IN HEALTH CARE

With Congress and President Obama trying to reign in overall spending and tackle the deficit—never mind the ongoing and growing Medicare spending deficit tied to the SGR—health care funding becomes even more complicated. As we all know, sequestration went into effect on March 1, and it is supposed to save \$85.4 billion this year. Most of the cuts are from defense pro-

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grams, with about \$10 billion expected to come from Medicare provider payments.

There are a couple of things to remember. First, the cuts to Medicare reimbursement are effective April 1. Second, the Centers for Medicare & Medicaid Services (CMS) has not yet announced whether it is absolutely going to involve the patient. Initially, CMS indicated that it would not, but it is rethinking this. We still have time for this to be fixed. The big challenge will be the “pay for,” or funding mechanisms. The choice might be primary care vs specialties or specialty A issues vs specialty B issues. There is also the question of service and payment setting: office or ambulatory surgery center (ASC) vs hospital.

On the one hand, physician influence pales in comparison to hospitals, if you lump all of the physician groups together and look at the comparative size of our impact and the lobbyist support working with us. If you think of your congressional district and its top 5 employers, I pretty much guarantee that at least 1 is a hospital system. But on the other hand, the hospital lobby is far from uniform. In Los Angeles, the average operational margin for hospitals is -1.5%; a rate dragged down by LA County and by other facilities. But at the same time, an academic center like UCLA has a 14.3% margin on a multibillion-dollar system. Bottom line: although there is a lot of power in hospital systems, there is also an awful lot of heterogeneity.

How does ophthalmology fit into all of this? Some people may say, “You folks are a rounding error. You don’t have the big drivers—congestive heart failure,

diabetes, or asthma.” But that is dead wrong. If you look at the top 20 diseases within Medicare on a total cost basis, ophthalmology has 2 of them: cataract and glaucoma. When you include patient in-office drug cost, we have 4 diseases with the addition of age-related macular degeneration (AMD) and diabetic retinopathy. According to data from CMS, the 2-year cost for neovascular AMD is between \$7000 and \$67 000 per patient, and every 10% change in prescribing patterns yields \$200 million annually. So, when we ophthalmologists go to talk to the people at CMS, they pay attention because we are not an economic rounding error.

PHYSICIAN PAYMENT REFORM

In just a few years, we have gone from facing an SGR-driven cut of 10% in 2008 to the 27% cut that would have taken effect January 1, had Congress not passed another short-term solution. Everyone wants to repeal the SGR, but the cost of a permanent fix has proved daunting thus far. Right now, the SGR fix is “on sale,” with the Congressional Budget Office having temporarily reduced the cost of a permanent fix by more than \$100 billion due to a decrease in the rate at which health care costs are rising.

As Congress considers how to eliminate the SGR, there is also the question of what replaces it. Do you move to accountable care organizations (ACOs) or value-based purchasing, or do you bundle care into longitudinal care bundles, such as by paying for 1 year’s worth of AMD care? What will happen to fee-for-service? Some believe it should go away completely—and most believe that if you fast-forward 20 years, that will certainly be the case.

Regardless of what ultimately becomes the new payment system, there must be a transition. There must also be a way to accommodate physicians in small towns who simply cannot take advantage of things such as ACOs, meaningful use, bundling of services, etc. So, fee-for-service is probably going to remain for a long period of time. One thing that everyone does agree with is that the quality concept is going to be thoroughly embedded in what comes down the road.

In the near term, any changes this Congress implements will likely be incremental, but a few bills have already been put forward. H.R. 574, introduced by Rep. Allyson Schwartz (D-PA) and Rep. Joe Heck, DO (R-NV), would permanently repeal the SGR and gets positive updates for 4 years. However, reimbursements would only increase 0.5% for specialists and 2.5% for primary care physicians. After year 4, payment increases would be tied to quality and efficiency. If you are in fee-for-service, the floor starts to go down.

The American Medical Association says that it has an optimistic view of the general structure of this proposal. At the American Academy of Ophthalmology, we are not as sanguine about it. We love that it is an alternative to the SGR, but where do you think that money for primary care is going to come from?

The Republicans also have some very interesting SGR-repeal proposals not yet drafted in specific bill language. They call for a period of stable payment rates (likely around 0% to 2%), followed by updates based on quality metrics. The key thing here is that the measures will not come from the Physician Quality Reporting System (PQRS) but will be determined by the physician community. This proposal would be the first opportunity we have had to, in essence, design the stick with which we will be beaten or rewarded by CMS. However, this is the House Republicans talking; it does not mean the Senate feels the same way.

The good news is that medical societies’ engagement in developing our own quality measures does not depend on the success of the House plans I just mentioned. We at the Academy are doing that right now, through development of our ophthalmic clinical data registry. Beta testing started in March, with enrollment set to go live by the beginning of 2014. While the biggest benefit of the registry is the ability to benchmark your performance and identify areas for improvement, it may eventually play a role in qualifying users for Maintenance of Certification, state licensure maintenance, and a host of other initiatives. And what a leap forward from all those paper records we used to deal with!

Just imagine: while you are in the OR, your information goes into an electronic medical record which, as you sleep, gets uploaded into the registry. You own the data, and the data are secure; they cannot be accessed by anyone else without your permission. However, you can get permission to share the data for value-based payments, PQRS, and demonstration of meaningful use.

INTEGRATION IN HEALTH CARE

Although EMR systems and registries provide an opportunity for efficiency at the individual level, there is also a significant push for systemic efficiencies through integration in health care, both vertically and horizontally. If you look at the typical ACO *theory*, it combines not just doctors and facilities, but doctors, facilities, and payers, leading to huge cost savings. However, the Pioneer ACO Model, the best of the best, did not perform very well. In fact, I would say that most health care economists who were predisposed to an optimistic

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view of integration now do not know if ACOs will yield a miniscule or substantive change.

Whatever the bottom-line impact of ACOs, integration has other implications. One is competition for physicians by hospital systems, which we have all seen. Look at your own community and consider how many primary care physicians are in solo or small-group practices; it is probably pretty close to zero. Three years ago, 12% of cardiologists were employed by hospitals, but according to the American College of Cardiology, nearly 70% are now. If you are a hospital CEO and you have \$100 million to spend on physicians, who do you want? With the exception of some retina specialists, ophthalmologists do not have any substantive economic effect. Overall, according to CMS data, 80% of ophthalmic procedures are done in ASCs. We are just not on the Christmas list for the typical hospital CEO.

However, ophthalmologists and retina specialists in particular have a host of options for relating to integrated systems, which includes independent physician associations. These are seeing a resurgence in some markets because they give power to physicians in a complex contracting environment. Beware if a hospital comes to you and says, "We would love to have you with our ACO, but if you agree, you cannot be with the other ACO in town." Even if they do not do that, they may say you have to use their EMR system. However, if you are used to 1 system and its EMR, are you really going to want to run 2 separate EMR systems in your office at the same time?

The other thing that is very interesting for retina in particular is the concept of subspecialty-specific physician organizations. We in retina probably have more power than most other subspecialties in ophthalmology. Why? We do trauma, which hospitals need for their trauma system designation. We are involved with babies in the NICU. For a lot of hospital systems, the single most profitable area of the hospital is the NICU and if you threaten the ability of that NICU to function, you really attract the hospital's attention.

CONCLUSION

Clearly, the future of health care in the United States is evolving. However, physicians have the opportunity to participate in the course it will take. Be knowledgeable about the changing health care environment, and, if possible, get engaged. ■

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