

Subject: Maryland Medicare Waiver

March 22, 2015

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As the glow of San Diego becomes a distant memory, and the snow again comes and melts in Baltimore, I bring to the attention of this group a challenge unique to the state of Maryland.

As I am not by any means an expert in this area, the description below is my understanding of what is happening. I worry that this may be a model of the future of health care in the country as it guarantees health care savings to the federal government and as far as I can tell, there is little interest in increasing Medicare expenditures (and the taxes needed to pay for them) any more than already exists. I will start with some background and then try to relay some of the implications of what these changes have meant for cardiologists in my state.

Maryland is the only state in the Union that has a waiver from Medicare that allows it to regulate hospital rates. This means that unlike the New York Times article which demonstrated the large variations in cost for the similar procedures, Maryland hospitals charge insurance companies within a relatively narrow band (with adjustments for residency training hospitals, indigent care, etc). You can see the N Engl J Med 2014; 370:493-495 for some background. Under the previous Medicare waiver system in which the State of Maryland operated, hospital payments for services were regulated by the Health Services Cost Review Commission (HSCRC), which essentially allowed hospitals to get their costs back plus a certain margin. This created an incentive for hospitals to increase volume—which resulted in high hospitalization and readmission rates. This system was acceptable to Medicare, as Maryland's overall health care costs were kept below the national average for a couple of decades. However, hospital and health care costs in Maryland increased more quickly in the mid 2000's. With the cost savings no longer present, Medicare told the state that its waiver would be eliminated. The state, its hospitals, payers, and others worked frantically to come up with a new system that would guarantee cost increases below the national average. The incentive for the state was the additional \$1.6 billion that Medicare provides the state in order to keep overall health care costs from increasing as fast as the national average.

The new system, started on January 1st, 2014, creates a new model. It caps hospital payments at a certain amount (based on 2013 revenue) with an allowed growth rate of 3.58%. This is the guarantee that health costs will not increase beyond that number. If the hospital finds ways to reduce their overall costs while providing similar services for the same population (that is, the hospital can't just close its OB suite, or stop doing cardiovascular care), they will be able to keep the difference. If they go over, they eat the extra. Some hospital systems have decided to focus on core areas of expertise and allow the other services to wither. Another hospital system has been increasing its outpatient footprint because that revenue is not yet capped and because it is more cost efficient to treat patients in the outpatient setting. However, in-patient cardiovascular care is uniquely expensive. Caths, CABGs, TAVRs, TMVRs, LVADs, transplants and ICDs are incredibly expensive treatments and technologies. Eliminating even 4-5 tavr, or one LVAD, allows for hiring several outpatient nurse practitioners or a couple of internists to see many more patients. All hospitals are looking to reduce costs every where they can find them. At our hospital (University of Maryland Medical Center), the discussion of limiting TAVRs, VAD, transplants hasn't come up yet, but the hospital is unwilling to support hiring additional cardiologists to replace the ones that are leaving/ retiring, and if that happens to limit the number of patients we see or expensive procedures we do, well, that's a positive effect. It becomes difficult then for trainees finishing to increase the workforce, unless they are replacing a retiring physician. (As this is happening now more frequently for our general cardiologists, the market for our general fellows has actually been more robust than it has been in almost 8 years). For a hospital to start a

new service line makes no sense, because every new expenditure comes out of the hard cap set the year before. (By the way, this system also creates a floor for weaker hospitals because they have a guaranteed income stream even if they are not performing well). Even if a hospital were to demonstrate a shift in volume, they would get no additional money in the index year, and only 50% of the amount the following years (with the idea that the fixed costs are already there, and the variable costs are much less...!).

This group is quite aware of the impact that MedPAC had on cardiology practices. When the Medicare Payment Advisory Commission (MedPAC) made recommendations that resulted in a reduction in the fees paid for nuclear stress tests and echos about 8 years ago, a large number of private practice cardiologists and groups were driven into the hands of hospital systems to cover costs. Under the old system, the hospital systems were interested in incorporating these physicians into their hospitals because the volume these cardiologists generated (echo, nucs, caths, CABG, etc), resulted in increased revenue and profit for the hospital. Cardiologists' income was therefore made not just of professional fees, but hospital support. Now, that has been turned on its head. Just as many of the original physician- hospital contracts are coming up for renegotiation, hospitals no longer want volume. Any volume is essentially a cost against their fixed budget. The current mal-alignment of incentives creates conflict between employed cardiologists and their hospital employers. As cardiologists and their groups go to the hospital to renegotiate contracts, they will find that the previous lure they had of offering volume to the hospitals no longer holds interest. The threat of "taking their patients" elsewhere is also empty, as their departure will reduce the hospital's overall costs! As we can readily see, the place where hospitals will be interested in rewarding cardiologists is for help in meeting readmission and quality metrics. Hospital executives are struggling with this issue as there will be a tremendous incentive to shift as much work as possible out of the hospital (we've seen the opposite cycle before...) as outpatient payments are not yet under the cap (but will be in 2017). But volume in and of itself is a negative, not a positive. And since quality metrics are nebulous at best and not necessarily under physician control (our hospital has spent a large sum of money cleaning nicks in the wall, and increasing how much they spend on cleaning the bathrooms so that patient satisfaction increases!), this will be limited in scope for cardiologists.

There are many, profound implications regarding this change for cardiovascular medicine. If Maryland is able to show a reduction in health care costs below the national average, there will be suggestions to expand this experiment. Perhaps increasing the amount of dollars spent on high quality outpatient care is better for population health than expensive heart transplant care. But even though the mid-LAD stent that I put in my patient last night for ongoing chest discomfort and a troponin of 16 was expensive, I worry that my skill set is not easily translatable to the outpatient setting.

Anuj Gupta, MD
Governor, Maryland ACC

March 22, 2015
Charles Brown, MD, FACC (Charles.brown@piedmont.org)

Very frightening. Thanks for a well written "heads up"!

March 22, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

Very frightening and the biggest effect is on our unsuspecting patients. Yet patients have no idea of what is coming down the pike and implications on their care. Heck, I'm scared about implications on my own care in the future. Don't you think its about time for the ACC to pour resources and educate the public on

how perverse the incentives will for those who provide health care and the negative impact this will have on being able to provide appropriate, high quality and state of the art health care?

March 22, 2015

John Harold, MD, FACC (john.harold@cshs.org)

Any time!

John

March 22, 2015

Smadar Kort, MD, FACC (Smadar.kort@stonybrookmedicine.edu)

I agree, Norman, we need to be proactive at the national level, since we know it would not remain confined to Maryland.

Since this will affect other hospital based procedures, we should collaborate with other medical, surgical and subspecialty societies and organizations as well as patients advocacy groups.

Thank you Anuj for the very thorough note!

Smadar

March 22, 2015

Kellyann Light-McGroary, MD, FACC (Kellyann-light-mcgroary@uiowa.edu)

Thanks Anuj for the frightening "enlightenment". I agree that we need to get this out on a national level. We need to be the voice that patients hear. We need to educate others about the concept of high value care: quality and cost effective. This is something we also need to champion on a state level, partnering with our state medical societies as well.

Given that the ACC is seen as a leader in the house of medicine it is important that we take advantage of this to get patient advocacy groups on board, united with providers, to make it clear that we need other alternatives. That said, even as an advanced heart failure physician who loves a good VAD procedure, it is imperative that we also recognize that there are finite resources and we need to use these technologies responsibly. This is why we have championed AUC as a society. Continuing this tradition and educating others is our strength.

KellyAnn

March 22, 2015

Edward Fry, MD, FACC (fry5@comcast.net)

Anuj,

Thanks for your clear and detailed explanation of a complex issue facing Maryland, one that may become a precedent for other states' Medicare coverage. We are all sympathetic to the difficulties that this must pose for you and your colleagues. Maryland has disproportionately borne the brunt of being the testing ground of regulation and legislation related to CV care. The problems you outline highlight the balance between the three goals of transforming health care: Increasing access to care, reducing overall costs, and

improving outcomes. This has to be accomplished, however, in an environment that is more predictable, sustainable, and rational. Focusing solely on one of the three legs of the stool (here cost) threatens to collapse the whole thing. As the ACC and the BOG we need to learn more about the process in MD and look to your leadership in better understanding these threats and how to respond to them as a professional society at the state and national level.

With all due respect to Paulette and George, good luck to the Terps (currently down by 7, 8:00 left). With Notre Dame the only IN team left in the field, we need to also support the Big 10, even if the name no longer applies.

Ed

March 23, 2015

Andrew Miller, MD, FACC (amiller@cvapc.com)

There are four major principles of medical ethics:

1. Autonomy: the patient has the right to choose/refuse medical treatment
2. Beneficence: the practitioner should act in the best interest of the patient
3. Non-maleficence: "first do not harm"
4. Social justice: scarce resources should be distributed justly and, therefore can impact medical decision making.

In most instances, this is the order of importance. In discussions on a national platform, this is the order of importance. This is the "patient first platform" we discussed in San Diego.

In Maryland, this capitation decision is squashing the first 3 principles with the 4th. This should not meet the smell test when placed in proper context in public. This is the making of a social movement Anuj!

I suspect there would be support with the state medical society and the ACC should partner to release a statement of concern. This would be a place where the patient-first platform could be better defined in public.

Good luck and let us know how we can lead/help/support,
Andy

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