

Rationing Care vs. Rational Care

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Objectives

- Describe what I do as an associate medical director
- Discuss the costs of healthcare
- Discuss where the problems may lie
- Show how we as physicians may be part of the problem
- Show differences in care between US and other industrialized nations
- Describe possible solutions

What do I do as a Medical Director?

- Review advanced imaging requests for medical necessity
 - CT scans
 - MRIs
 - Bone Density
 - PET scans
- Review Procedures for medical necessity
 - Surgeries
 - Sleep Studies
 - Injections

Medically necessary

"Medically Necessary" are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
- not primarily for the convenience of the covered individual, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Investigational

"Investigational" means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet the WellPoint Technology Evaluation Criteria because it does not meet one or more of the following criteria:

- have final approval from the appropriate government regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings.

In addition to the above criteria, the Medical Policy & Technology Assessment Committee (MPTAC) will consider recommendations of national physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, and in its sole discretion, may consider other relevant factors, including information from the practicing community.

A few examples

- Request for an MRI of the L-spine
 - 55 y/o male c/o 3 days of new onset back pain since doing yard work over the weekend
 - 8/10 pain, unable to bend over, unable to sleep, walks stooped over
 - Intermittent pain that goes to right hamstring, no fevers or chills, no hx. of cancer, no urinary incontinence
 - Past Medical History: HTN, Hyperlipidemia
 - Medications: Lisinopril, Simvastatin, Ibuprofen X 3 days
 - PE: vs. 150/88, 85, a febrile, Neurologic exam normal, SLR negative

Evaluation of Signs or Symptoms

Signs or symptoms of spinal cord or nerve root compression, with or without surgery (e.g., focal neurologic deficit or abnormal findings on neurologic exam [e.g., motor weakness, dermatomal sensory loss or significant reflex abnormality]); **or**

Pain or radiculopathy not improving despite 4 weeks of conservative therapy which may include appropriate pharmacologic interventions or physical therapy or exercises with the following exceptions:

Given the rarity of back pain in children the 4 week requirement for treatment need not be applied to the pediatric patient; **or**

•Individuals with rheumatoid arthritis are at increased risk for spinal misalignment and the requirement for 4 weeks of conservative treatment prior to imaging is not applicable to this group; **or**

Low back pain not meeting either of the above two criteria, but associated suggestive of multiple myeloma, history of drug abuse or tuberculosis; **or**

with "red flag" symptoms, such as unexplained weight loss, history of malignant disease, fever, abnormal serum electrophoresis Post lumbar spine surgery with persistent pain for evaluation of either of the following:

Differentiation of recurrent disc herniation from scarring; **or**

Evaluation of post surgical complications, such as epidural hematoma or abscess; **or**

Signs or symptoms of lumbar myelopathy or nerve root compression with new onset of extremity weakness, bladder or bowel symptoms, ataxia, spasticity, spinal level sensory loss, etc.; **or**

Signs or symptoms suggestive of spinal stenosis (e.g., weakness, spasticity, clonus, muscle wasting, generalized sensory loss, nerve root compression, hyperactive reflexes, suggestive x-ray findings).

- Request for a CT scan of the coronary arteries with calcium scoring
 - 44 y/o male with a family hx. of CAD
 - No cp/sob
 - Exercises aerobically 40 minutes 5 days per week
 - Recent ETT negative
 - Past Medical History: Hyperlipidemia
 - Medications: None
 - PE: vs. 120/80, 62, cardiopulmonary exam normal
 - Labs: LDL- 142, HDL-40

Investigational and Not Medically Necessary:

The use of electron beam computed tomography (EBCT), helical CT or multi-slice spiral (also known as multi-row detector) CT (MSCT) is considered **investigational and not medically necessary** for the detection of coronary artery calcium, including, but not limited to, the following indications:

as part of a cardiac risk assessment in asymptomatic or symptomatic patients;

as a diagnostic test in patients considered at intermediate risk for coronary artery disease, where other cardiac tests have been inconclusive;

as a diagnostic test in symptomatic patients;

In conjunction with a coronary CT angiography (CCTA).

Comments I hear from providers-

- How can you make a decision without seeing the patient
- You are all health insurance whores who get paid to deny care
- How can you be so short sighted at an academic institution
- Ok- I'll let the patient know who denied their test so they know who to sue

Third Level Appeal Panel

- Anthem's process of appeal starts with an Anthem medical director (uses Anthem medical policies and approved guidelines)
- If a service is denied an appeal to a like specialist can be made (outside Anthem)
- If denied again a third level appeal can be granted (3 docs not associated with anthem- do not have follow anthem medical policies)

Common Cases

- Artificial cervical disc replacement
- Surgical assist
- Bag of Peas
- Genetic testing

Genetic Testing Example

- 42 y/o male
- Metabolic syndrome- BMI-37
- Hyperglycemia- glucose 115 fasting
- LDL-148, HDL-34, TG-284
- Psa- normal
- Genetic testing requested for dm, mi, prostate cancer

Result Summary

Based on the 4 marker deCODE T2™ genetic risk profile this patient has 1.10 -fold the general population risk to develop type 2 diabetes (hereafter called T2D).

Note:

High risk results do not mean the patient is destined to develop T2D and low risk does not mean the patient is without risk for T2D. deCODE T2™ is not a determinative diagnostic test, but a risk test, much like LDL-cholesterol or PSA.

Prediabetes to Type 2 diabetes risk:

If this patient is overweight or obese and has prediabetes (impaired fasting glucose and impaired glucose tolerance) his/her genetic risk profile predicts a 30 to 35% absolute risk to convert to T2D over the next 3 to 4 years, i.e. similar to baseline risk of any recently diagnosed overweight or obese prediabetic. This is based on the DPP and DPS studies outlined below (2,3,14,15).

Drug responses to sulfonylureas and metformin:

If this patient has or develops T2D, his/her genetic profile predicts response to sulfonylurea that is comparable to that of the general diabetes population. The patient is likely to respond as well to sulfonylurea as to metformin. See below for details

The remaining lifetime risk:

Is the combined risk to develop T2D after a certain age, assuming the patient has not already been diagnosed with T2D. It is dependent on known risk factors, such as obesity, ethnicity, prediabetes and age.

The genetic risk identified by the deCODE T2™ test is largely independent of any other risk factors that the patient may have and therefore may be multiplied by the relative risks conferred by them.

The remaining lifetime risk for this patient (see table 2 below) can be multiplied by 1.10 to obtain his/her specific residual lifetime risk. For example, for an overweight white male who is 45 years of age, the remaining lifetime risk based on Table 2 is 23.7%. However, not all genetic risk factors are known or measured by deCODE T2™.

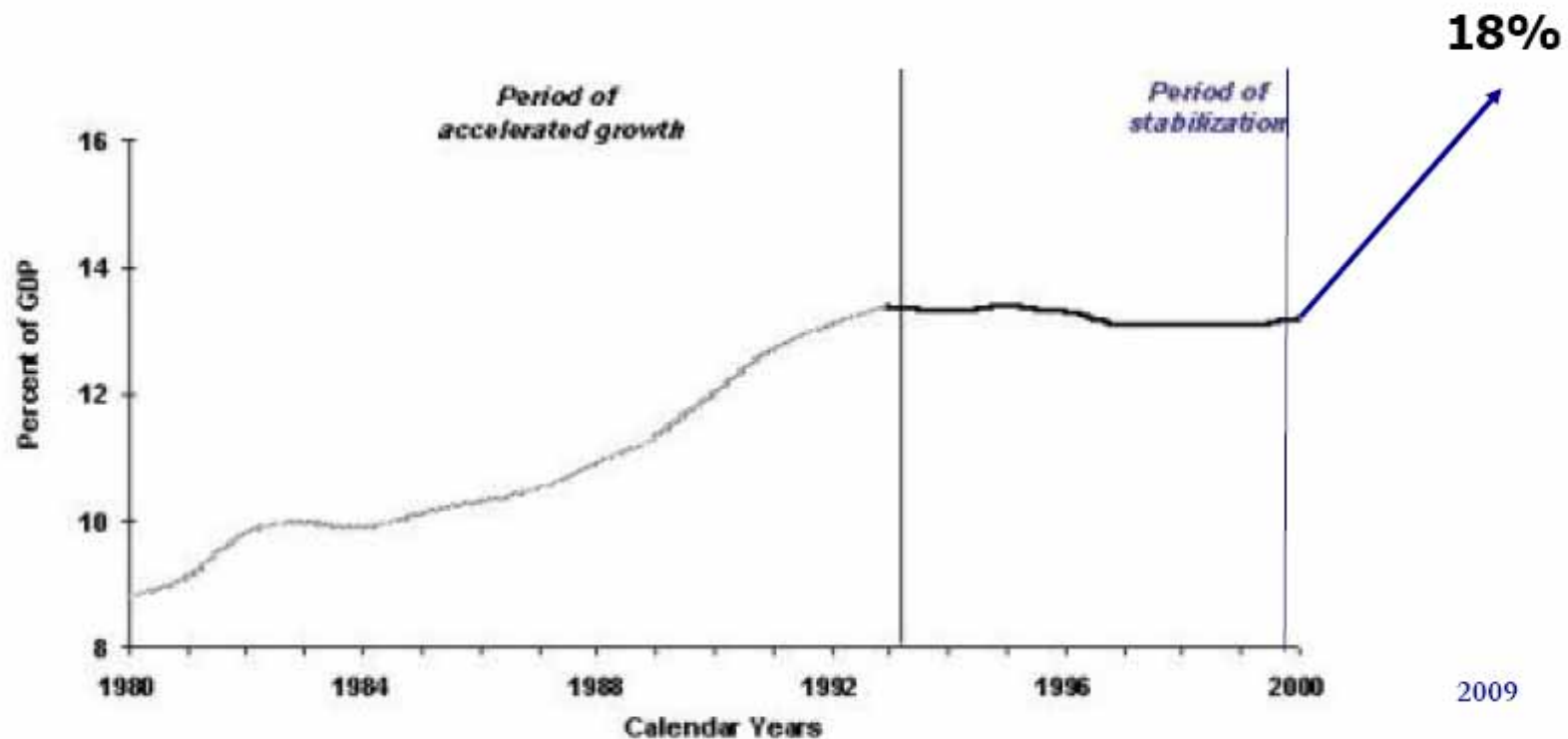
Comments I hear-

- I don't understand- It is not experimental, it's FDA approved
- I trust my doctor to know what is best for me
- I called and was told that it was covered
- This treatment will change my life!
- Also noted- few providers participate in appeals

The background of the slide is a solid dark brown color with a pattern of lighter brown, stylized autumn leaves scattered across it. The leaves have prominent veins and are in various orientations, creating a textured, organic feel.

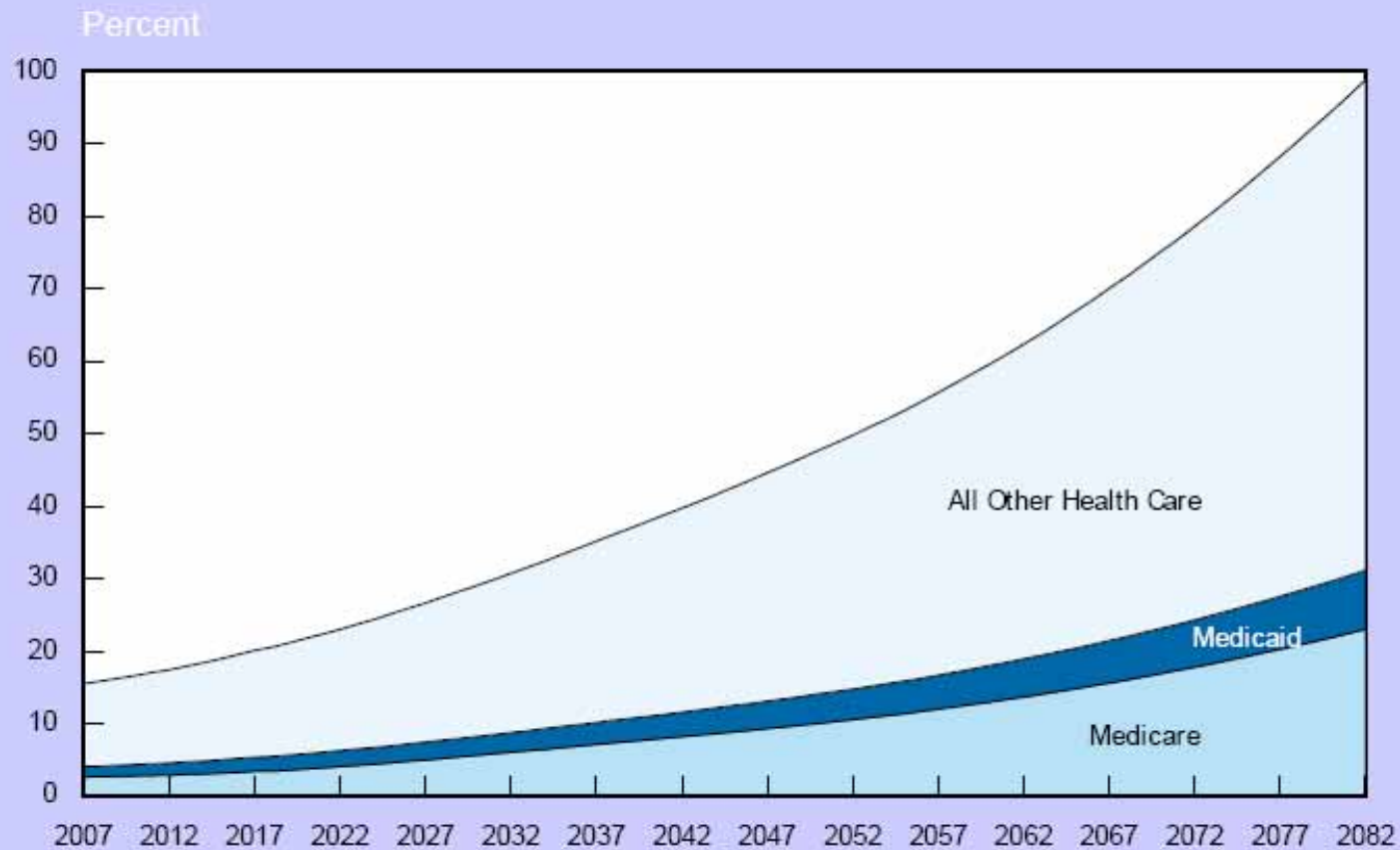
Why is Healthcare so Expensive?

US Health care expenditures as percentage of GDP



Source: CMS. Office of the Actuary, National Health Statistics Group.

The Entire US Economy becomes Healthcare in 2082!



Source: CBO Long-Term Outlook for Health Care Spending, Dec 2007

Per capita health care spending of select OECD nations, 2003

Source: The Commonwealth Fund

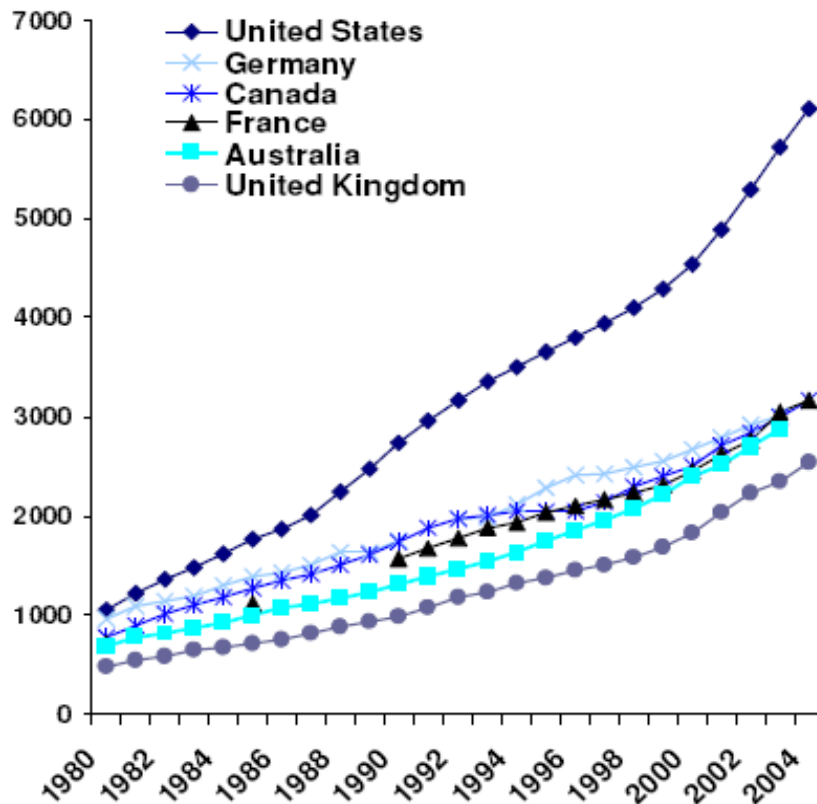


Costs of Health Care

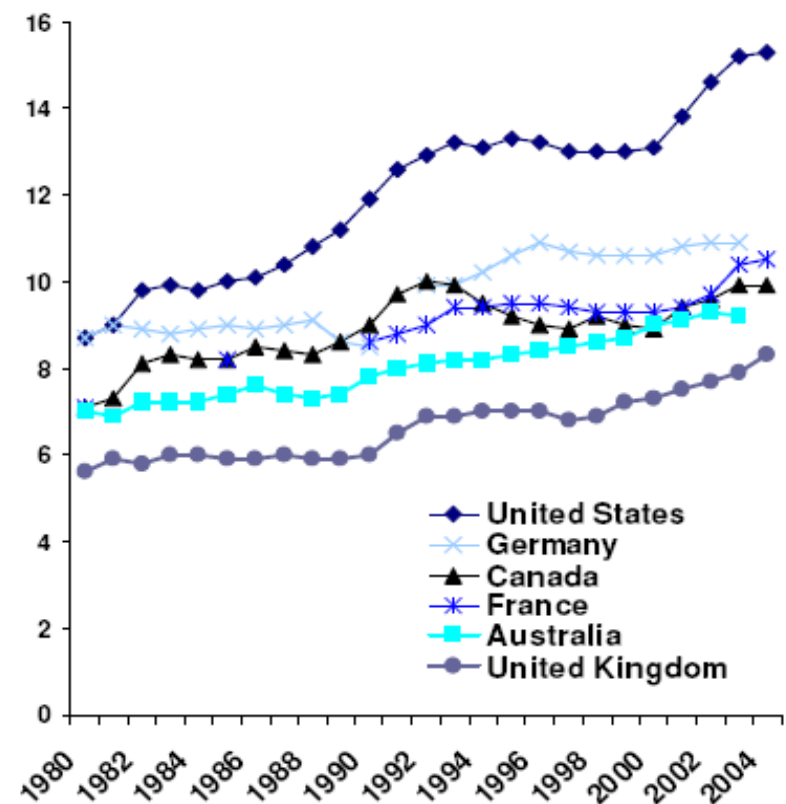
- Physician fees
- Hospital costs
- Insurance Industry
- Drugs
- Malpractice
- Technology
- Patient expectations (entitlement)

International Comparison of Spending on Health 1980–2004

Average spending on health per capita (\$US PPP)



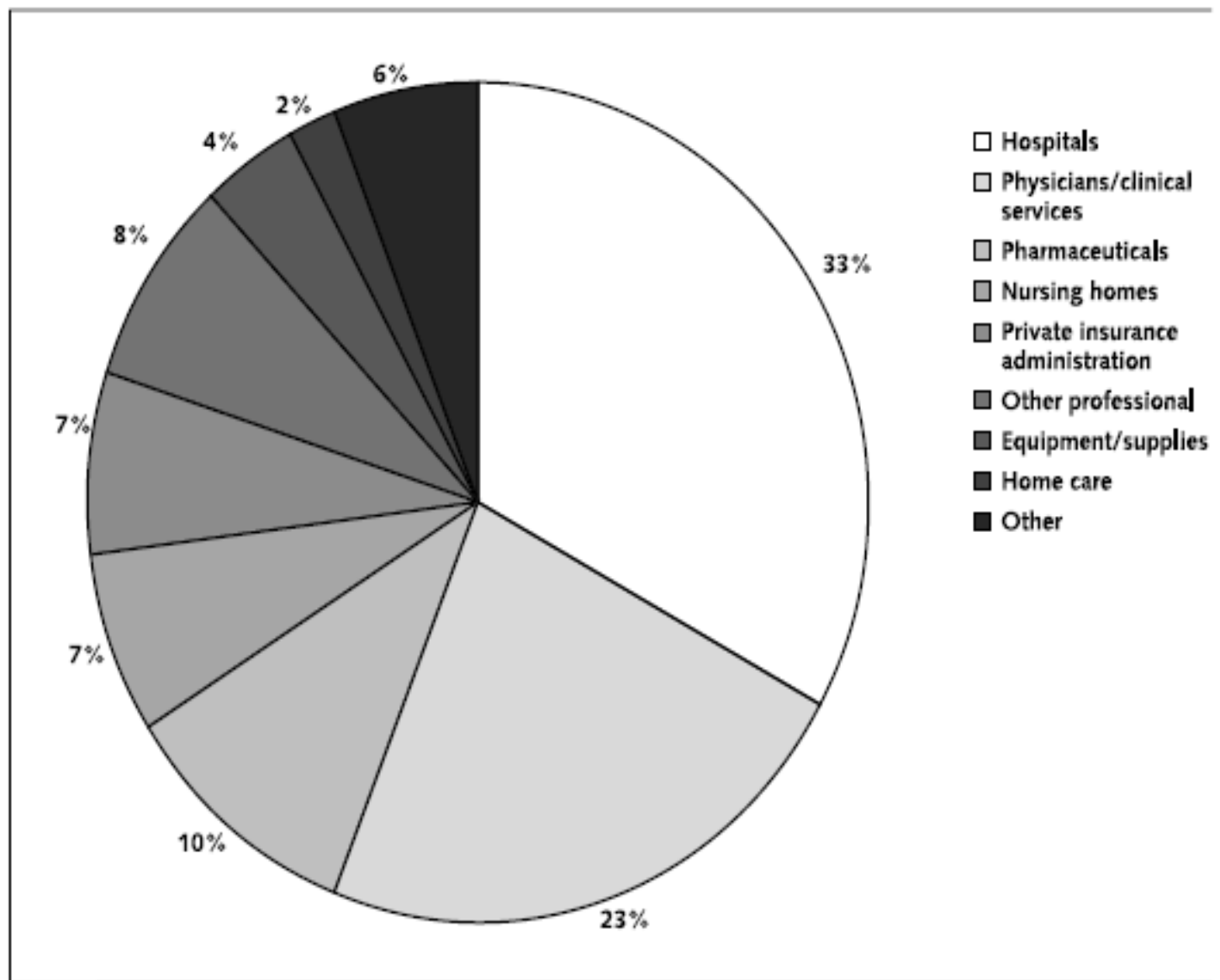
Total expenditures on health as percent of GDP



Data: OECD Health Data 2005 and 2006.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 2. Where the health care dollar goes, 2002.



Adapted with permission from Levit et al. (2). Copyright 2004, Project HOPE—The People-to-People Health Foundation, Inc.

Health care costs

- Physician fees-
 - Fee for service- the more services you give the more you get paid
 - Relative value units – since 1992
 - Adjusted for geographic area
 - RUC recommends updates yearly to CMS
 - 29 members (26 voting members)
 - 14 do E and M billing (only two primary care providers)
 - SGR instituted in 1997 to help control costs
 - Tied volume of service per MC beneficiary to growth in gdp
 - No reimbursement for improved quality of care

Relative Value Units for Selected Services, 2008

Service (HCPCS code)	Total	Physician Work	Practice Expense	Professional Liability Insurance
Intermediate Office Visit (99214)	2.53	1.42	1.06	0.05
Diagnostic Colonoscopy (45378)	5.64	3.69	1.65	0.30
Total Hip Replacement (27130)	37.66	21.61	12.54	3.51

Source: CMS Web site. www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10.

Hospital Costs

- Routine expenses of business
 - Building
 - Staff
 - Advertising
 - Equipment (MRI, CT, PET, NM, etc.....)
- Compliance
 - JHCO
 - Credentialing

(UCH approximate cost is \$1.2 million/yr)

Insurance industry costs

- Claims
- Administrative costs
- Advertising
- Appeals
- Credentialing
- Provider contracting
- NCQA quality standards
- State Mandates
- Lobbying to Washington

Table 1: Total Mandates by State

State	Total Mandates	State	Total Mandates
AK	32	MT	40
AL	21	NC	50
AR	43	ND	34
AZ	47	NE	32
CA	56	NH	44
CO	51	NJ	45
CT	54	NM	57
DC	27	NV	52
DE	28	NY	51
FL	52	OH	29
GA	45	OK	38
HI	24	OR	40
IA	26	PA	52
ID	13	RI	70
IL	47	SC	29
IN	34	SD	30
KS	39	TN	41
KY	41	TX	57
LA	50	UT	23
MA	52	VA	60
MD	66	VT	30
ME	55	WA	57
MI	25	WI	34
MN	68	WV	38
MO	41	WY	34
MS	29		
TOTAL			2133

How do we get state mandates?

- Service denied by insurance company
- Advocacy groups lobby to state legislature
- Legislature reviews mandates and expected cost
- Bill created
- State Legislature votes to approve
- Unintended consequences – huge price increases (<1% per mandate)

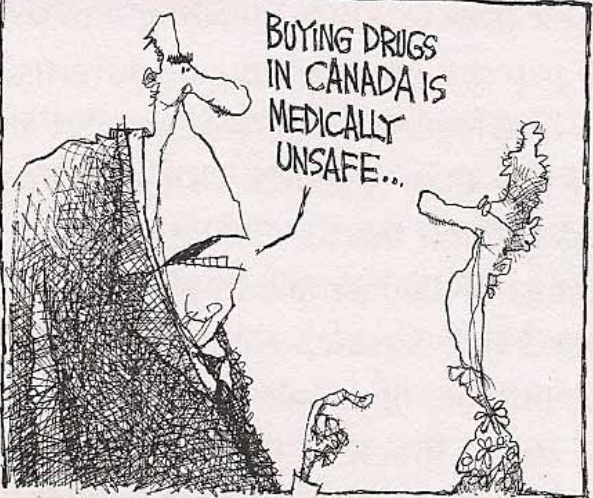
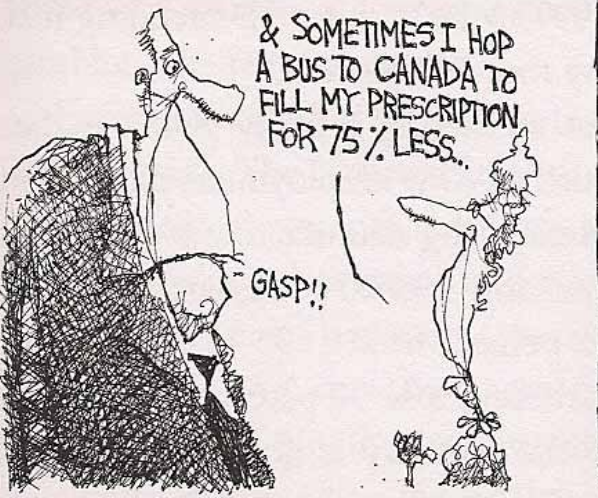
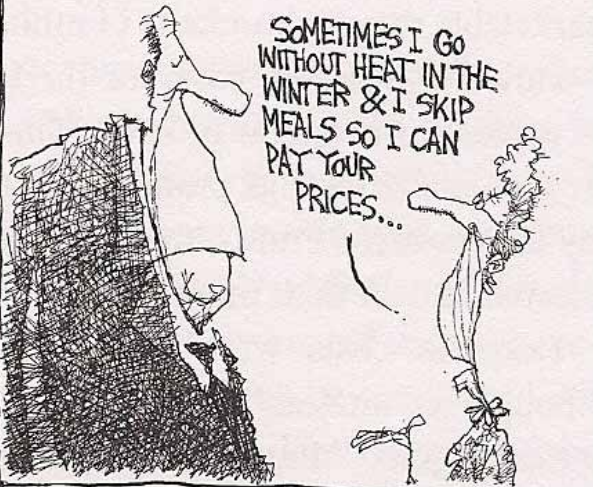
An Example

- Applied Behavioral Analysis (ABA), Intensive Behavioral Intervention (IBI)
 - one on one therapy (40 hrs/week)
 - No scientific evidence that it is any better than standard therapy
- Denied by Anthem
- Law suit by patients' parents- jury sided with family
- Advocacy group brought to the legislature
- Now a mandated benefit for in Colorado

Drugs

- FDA approves new drugs when found to be safe and pass the “non-inferiority test”
- Huge marketing campaigns by drug manufacturers
- Lobbying to Washington
- Cost of Research and Development
- Lawsuits when drugs are found to be harmful

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Malpractice

- Insurance coverage
 - Average cost per claim went from \$95,000 to \$320,000 per claim from 1986-2002
 - Malpractice rates increased 15% between 2000 and 2002
 - Malpractice claims account for less than 2% of healthcare costs
- Defensive medicine
 - CBO states that it is unclear whether this actually increases cost
 - Really?

(CBO brief January 8, 2004)



"I'll want to run a few tests on you, just to cover my ass."

Technology-

”if we have it we must use it”

- MRI
- CT scans
- PET scans
- Cardiac CT scan
- Virtual Colonoscopy
- Chemotherapy drugs
- Genetic testing
- Advanced surgical procedures

CT scans and MRIs

- From 2000- 2006 Medicare spending for imaging more than doubled to about \$14 billion
- Lumbar spine imaging increased by 307% from 1994-2005
- Spine imaging in patients with no indication of systemic disease or major neurologic compromise appears not to improve patient outcomes

Cardiac CT scanning

- May 2006 MedCAC (Medicare Evidence Development and Coverage Advisory Committee) met and despite a lack of evidence with regard to outcomes declined to issue a national coverage decision
- Regional insurers were lobbied for coverage and within months MC was covering cardiac CT angiography in all 50 states
- A year later, alarmed at the costs of exploding use of cardiac CT angiography- CMS limited coverage
- Overwhelming opposition by Cardiologists, Radiologists and representatives or professional societies caused CMS again to turn it over to regional decision makers
- The use of cardiac imaging increases 26% per year despite the lack of evidence that it improves long term outcomes
- It possibly leads to additional unnecessary procedures

Cancer treatments

- Chemotherapy drugs that improve median survival by 10 days but increase costs by thousands of dollars per treatment
- IMRT radiation therapy to patients with stage 4 pancreatic cancer

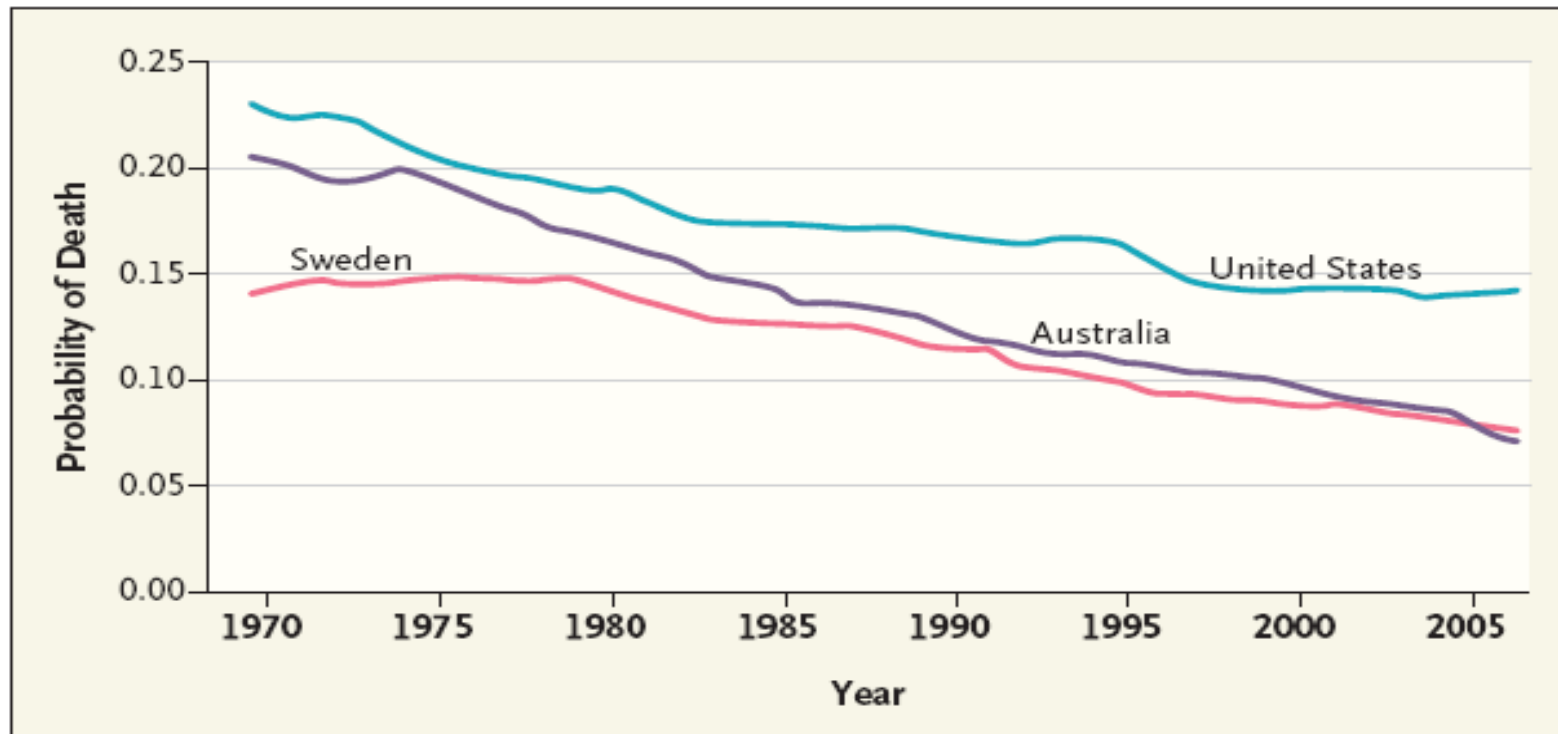
Genetic testing

- New genetic tests are available on a weekly basis
- Very few affect the treatment of the patient or long term survival
- Test ordered to have an answer to the patient's disease

How are we doing?

- RAND: Americans get evidenced based care only 55% of the time
- IOM: Up to 98,000 Americans die each year due to avoidable medical errors
- CDC: 2 million acquire nosocomial infections each year and 90,000 die
- WHO: US rates 37th in the world, 2000

Getting worse?



Probability of Death for Boys and Men 15 to 60 Years of Age in Sweden, Australia, and the United States, 1970–2007.

Data are from the Australian Bureau of Statistics, the U.S. National Center for Health Statistics, and the World Health Organization.

Where do the problems lie?

- Broken reimbursement system?
- No Payment based on quality of care and outcomes?
- Cost of Care?
- Safety net is not adequate for uninsured?
- It is estimated that 30% of care is unnecessary
- Harm caused by unnecessary care?

Are physicians part of the problem?

- Variability in Care

- Dartmouth Atlas

- Over 20 years of work studying variability in costs and care in MC patients across the country
 - Higher cost per capita cities gave more care when corrected for variables (illness, poverty etc.)
 - Higher cost cities had more doctors, more hospital beds and more advanced imaging facilities
 - Higher cost did not lead to better outcomes

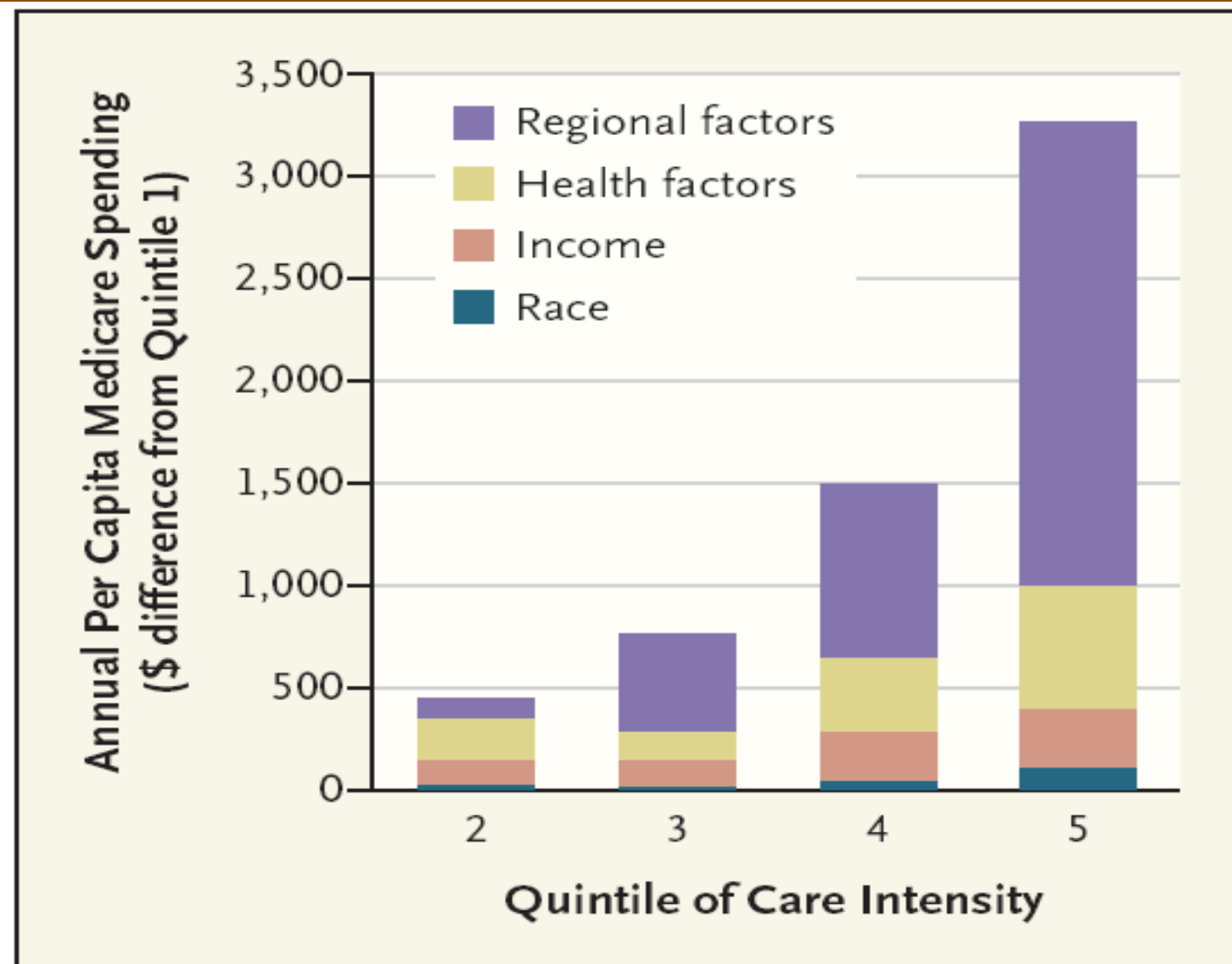


Figure 2. Proportion of Higher Regional Medicare Spending Attributable to Differences in Race, Income, Health Factors, and Regional Factors.

Annual Utilization Rates and Spending on Hospital Services and Selected Physician Services in Regions with Various Levels of Intensity of Care.*

Type of Care	Level of Medicare Spending per Medicare Beneficiary				
	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5
Inpatient days per beneficiary	1.4	1.6	1.8	2.1	2.1
Physician visits per beneficiary	10.7	12.1	13.0	13.6	14.5
MRIs per 100 beneficiaries	16.6	17.6	19.3	19.7	21.9
CT scans per 100 beneficiaries	46.9	54.0	58.7	61.2	61.4

* Utilization data are from authors' analyses of the 2004 and 2005 Medicare physician (Part B) claims and Medicare Provider Analysis and Review data and represent annual rates of selected services and per-beneficiary spending on physician services (adjusted for regional differences in age, sex, and race). The data on computed tomographic (CT) and magnetic resonance imaging (MRI) scans are numbers per 100 beneficiaries, not numbers of beneficiaries undergoing these procedures; many beneficiaries undergo multiple scans in a single year.

Direct harm

- CT scans have 50 times the radiation dosage of a standard X-ray
- 1.5-2% of cancers are thought to be secondary to excessive radiation exposure
- Between 1997 and 2001 14 drugs were withdrawn from the market due to serious side effects
- Complications from prescription drugs cost over \$177 billion dollars per year
- Treatment complications led to 914,000 hospitalizations in 2000 at a cost of \$19 billion

TABLE 2. REPRESENTATIVE RESULTS OF MAGNETIC RESONANCE IMAGING STUDIES IN ASYMPTOMATIC ADULTS.*

STUDY	SUBJECTS	ANATOMICAL FINDINGS				
		HERNIATED DISK	BULGING DISK	DEGENERATIVE DISK	ANNULAR STENOSIS	ANNULAR TEAR
		prevalence (%)				
Boden et al. ²⁶	Volunteers <60 yr old	22	54	46	1	NR
	Volunteers ≥60 yr old	36	79	93	21	NR
Jensen et al. ²⁷	Volunteers (mean age, 42 yr)	28	52	NR	7	14
Weishaupt et al. ²⁸	Volunteers (mean age, 35 yr)	40	24	72	NR	33
Stadnik et al. ²⁹	Patients referred for head or neck imaging (median age, 42 yr)	33	81	72	NR	56

*NR denotes not reported.

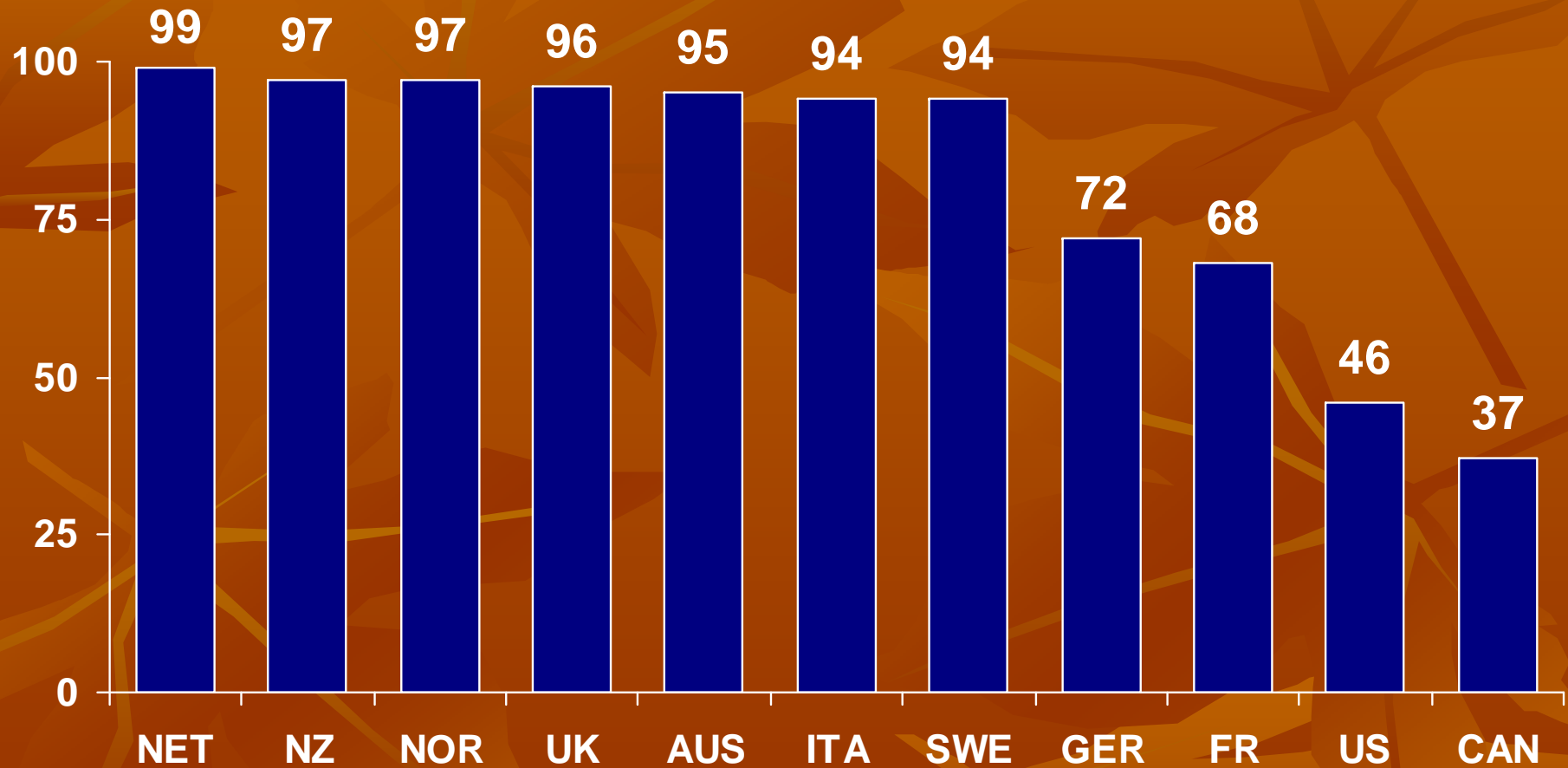
Indirect Harm

- Providing an expensive intervention of marginal value to one patient may deprive many others of less expensive care that is more effective
- Health Care may cause indirect harm from other determinants of health such as education, environmental quality, jobs and income
 - The average American family spends more of its disposable income on health care than on housing, food, or clothing
 - 62% of personal bankruptcies were do to health care costs

What are other industrialized nations doing that we aren't?

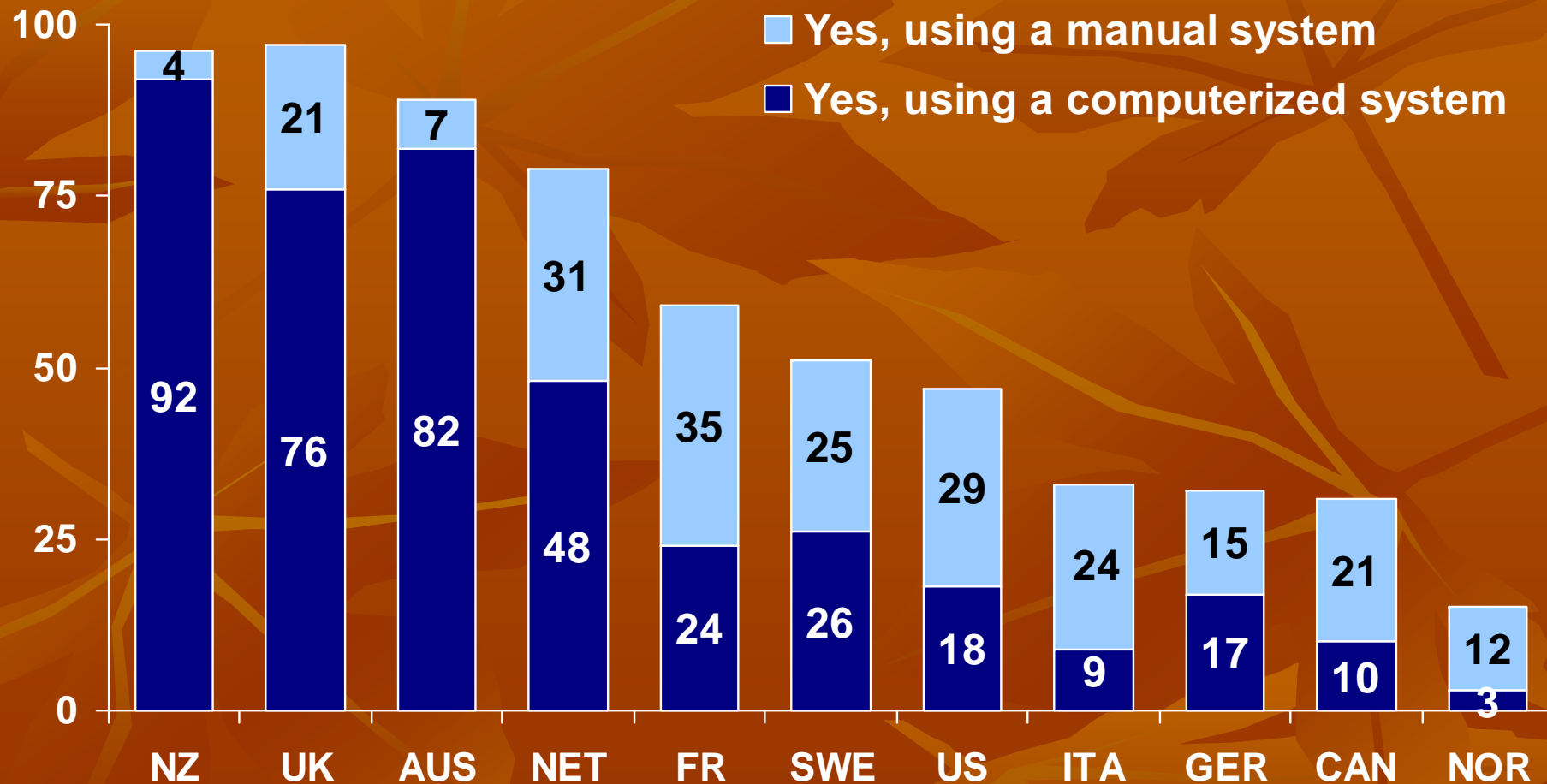
- 90% or more of primary care physicians are on an EMR
- Comparative cost-effectiveness of drugs, devices, diagnostic tests and treatment procedures done on a national level
- NHS covers new technologies whose cost per unit of health is below a certain threshold, such as \$50,000 per quality-adjusted life-year
- Requirement to enroll with a primary care provider
- Bonuses given to providers who meet quality targets
- Patient centered medical home model
- Prices for pharmaceuticals negotiated
- Specialists employed by hospital and payments are bundled

Doctors Use Electronic Patient Medical Records*



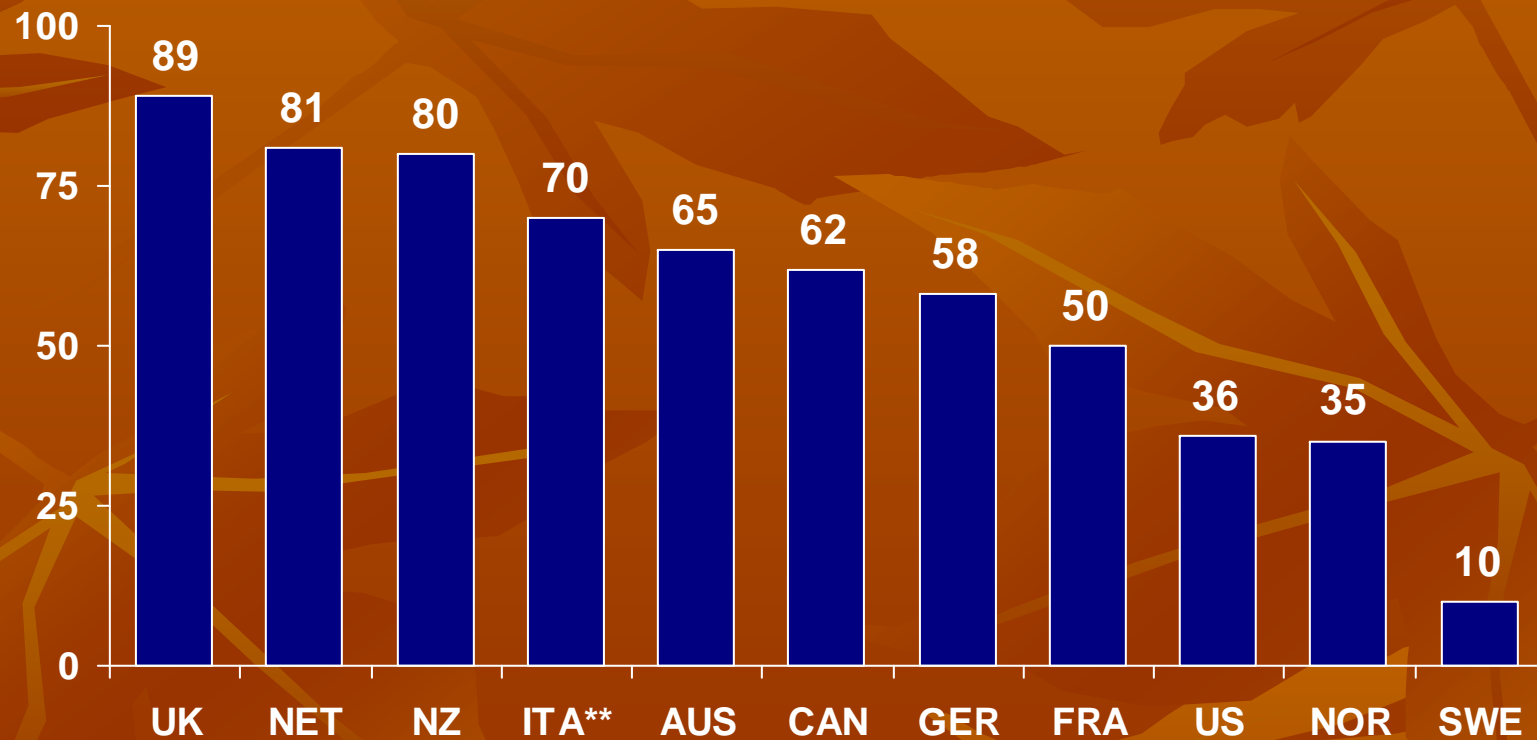
Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Practice Routinely Sends Patients Reminders for Preventive or Follow-Up Care



Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Doctors Can Receive Any Financial Incentives For Improved Quality Of Care



Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

What is the solution?

If the government can't get behind a program with all of the time, money and energy they have put into searching for a solution, how are we supposed to know?

A few possible solutions

- Clinical Effectiveness Research/ patient pays more for less effective treatments
 - Tried several times in the past- National Center for Health Care Technology and the Office of Technology Assessment
 - Both shut down due to political pressures
 - Most other developed countries have medical technology assessment agencies which were modeled after our defunct Office of Technology Assessment
 - Procedures rated by quality-adjusted life-year gained (QALY)
 - Must be well funded and free from conflicts of interest
 - 1.1 billion dollars towards Comparative Effective Research in the stimulus bill of 2009
 - Findings of this committee will not make coverage or reimbursement decisions

Solutions, Continued

- High-quality shared decision making
 - There is very good evidence that shared medical decision making decreases less beneficial procedures and treatments
 - Primary care is where this generally happens best
- Strengthening Primary Care
 - Areas with higher levels of primary care and less specialty care have lower expenditure rates and equal to better quality outcomes
- Get rid of fee for service model and pay for bundled care
 - Fee for service encourages more procedures, visits, tests
- EMR for all
 - Decreases duplication of tests, procedures
 - Improve ability to follow quality standards
 - Decreases medical errors

Solutions, continued

- Incentives based on quality of care
- Negotiate drug costs
 - Canada and France pay 60% of what the U.S. pays for drugs
 - Germany and UK pay 85% of what the U.S. pays for drugs
- Co-Insurance instead of Co-Pay
 - If there is a significant cost to the patient they will want to make sure it is necessary before they do it
- Physicians salaried
- Physicians should not be allowed to own health care facilities such as CT scanners, or outpatient surgery centers

Medical Technology is here to stay, and it's a good thing. But it's the primary reason for rising health care costs, which threaten to leave more and more people uninsured. Rapid medical advances, coupled with a financing system that pays most of the costs and few mechanisms to evaluate the clinical effectiveness of new advances, create a recipe for inefficient care. Relative low out-of-pocket costs to patients make price seem irrelevant. Payment systems generally encourage doctors and hospitals to do ever more, and concentrate on specific lucrative services.