Pending Plans for Payment Alignment

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It is clear that whatever happens to the Patient Protection and Affordable Care Act (PPACA), passed during the present administration, major changes will occur—very soon—in the financing of medical care delivery in the United States. Given that 21% of all health care expenditures and 43% of the Medicare budget are devoted to cardiovascular care, it will not be a surprise to any of us that some of the most intense effort toward reduction of expenses will be aimed directly at us and the hospitals we use. When anyone observes that 17.4% of our current gross domestic product—heading toward a projected 21% in 2020—is devoted to medical care, it should be clear that our costs are not sustainable, and that transformative solutions must be applied to this as-yet unsolved problem.

A decade ago, the American College of Cardiology (ACC) formed the Medical Directors Institute, a committee dedicated to interacting with insurance carriers and business interests to find pathways that would facilitate improved medical care, pari passu, while decreasing the unsustainable costs of the current system. Discovering pathways that are different from our historic fee-for-service models will be critical for our survival and prosperity in our constrained health care environment. The feedback we are receiving from the Medical Directors of insurance carriers indicates that by properly utilizing our guidelines for cardiovascular care, and our Appropriate Use Criteria (AUC), we can create a system that rewards us for excellent care and outcomes. In this effort, we in the ACC are far ahead of any other specialty organization, and we can significantly influence the pathways for medical care and reimbursement for our future and that of our patients.

The ACC now has a pilot project involving three very dissimilar states: Florida, California, and Oregon. This project is considering how models such as accountable care organizations (ACOs) could bundle payments, offer optimal care to patients for common cardiovascular diseases at reduced costs, and still fairly compensate cardiologists and hospitals for this care.

In July 2011, Richard Wright (Pacific Heart Institute), Dipti Itchhaporia, Lianna Collinge (California ACC), Raymond Yen, and I met in Los Angeles for a day-long meeting with the Medical Directors of Aetna, Wellpoint/Anthem Blue Cross Blue Shield, Blue Shield of California, Cigna, and United HealthCare to discuss how we might proceed.

These insurance companies are aware that the rates of coronary intervention in California are one-third of that of the US average.

They like our promulgation of practice guidelines and AUC. Nonetheless, they continue to focus on "the most appropriate test" (ie, least expensive) for patients—hence their reluctance to abandon preauthorization for nuclear scan and stress echocardiography. All the insurance plans are moving toward tiered networks of doctors and hospitals, with the goal of directing businesses and patients to higher quality and lower cost providers (the 1990s experience with that model suggested that only costs mattered). Both sides recognized that sometimes inappropriate tests are ordered on patients. We pushed strongly for a "gold carding" system in which cardiologists who follow appropriate guidelines for testing can avoid the hassles of preauthorization.

New payment models, especially those involving ACOs, were discussed at length. None of the carriers have developed plans that are ready for implementation. They are searching for ideas from us. In late September 2011, we had our first conference call regarding the details of bundled payments to be negotiated. In late October 2011, we will have a national meeting to discuss ideas of shared savings that are fair to all. Stay tuned for a late fall summary in *Reviews in Cardiovascular Medicine*. Any progression to bundled payments will be gradual and will initially apply to specific procedures (eg, percutaneous transluminal coronary intervention with 30 day follow-up) rather than total care. (For a good description of some caveats involved in starting an ACO, read the recent article by Singer and Shortell[1] regarding 10 potential mistakes in implementing ACOs.)

My sense of these Medical Directors (all but one of whom are physicians) is that they do recognize the errors of the past. They realize that good medical care will only occur if we cardiologists are decision-making members of the team, and are properly incentivized to offer the best care possible. What we know now is that our future and that of medical care will be changing radically. We must be part of a joint team with hospitals, businesses, insurance carriers, and patients to allow us to continue being the leaders in excellence in cardiovascular care throughout the world. ■

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The Changing Landscape of Cardiovascular Care

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The 2011 Environmental Scanning Report of the American College of Cardiology (ACC) is a fascinating read. It was put together under the leadership of one of our own California members: Past President and Northern California Governor, Lars Laslett, MD. This is a highlight of this report.

It is clear that the field of cardiology continues to experience monumental changes. The dramatic cuts to cardiology that were included in the 2010 Medicare Physician Fee Schedule resulted in declining reimbursement; that, along with increasing overhead costs in private practices, added increased financial pressure that resulted in physician hospital integration. The ACC 2010 Practice Census found that up to 40% of private practice cardiologists have integrated into hospital employment and joint practice models, and an additional 13% of practices are considering integration or merger. In addition, over the past year, more than

half of all practices have made at least one change to cut costs.[1]

Given this new reality, the ACC is working with health care organizations and state and federal government to find solutions to temper costs while balancing the need to provide access to safe and quality care. Since 1950, mortality has fallen steadily, more in whites than in blacks,[2] but despite the strides made in management of heart disease, cardiovascular disease (CVD) and diabetes are still major contributors to the overall disease burden and thus overall health care costs. Currently, approximately one in three Americans has some form of heart disease; by 2030 some form of CVD will appear in approximately 40.5% of the population.[2]

Currently, CVD accounts for 17% of the national health expenditure and 43% of the Medicare budget, reflecting the much older Medicare population than the population at large.[3] Between 2010 and 2030, the cost of total direct medical care due to CVD is projected to triple, from $273 billion to $818 billion.[4] Total health care spending accounted for 16% of the gross domestic product (GDP) in the United States in 2008, the highest share amongst the Organization for Economic Cooperation and Development (OECD) countries. The average amongst the OECD countries is 9%. France, Switzerland, and Germany which allocated 11.2%, 10.7%, and 10.5% of their GDP, respectively, to health care followed the United States. The public share of health care expenditure in the United States (46.5%) was lower than in any other OECD country except Mexico.[5] Private insurance accounts for 34.1% of total health care spending in the United States—by far the largest share among OECD countries. Aside from the United States, Canada, and France are the only other OECD countries in which private insurance represents more than 10% of total health care spending. Interestingly, the centers for Medicare and Medicaid Services reported that US health care spending grew only 4% in 2009, reaching its slowest rate in nearly 50 years. This equates to $2.5 trillion on health care spending in 2009, or $8086 per US resident. Despite the 15% decrease in growth of spending from 2008 (the second slowest rate of growth since 1960), the share of GDP devoted to health care grew from 16% in 2008 to 17.6% in 2009. A partial breakdown of costs shows that 31% of health care spending is for hospitals, whereas 20% is for physician and clinical services, and 13% is for retail drugs and medical products.[6,7] Of interest is that the United States is not alone in its efforts to harness health care costs—all other OECD countries are under huge financial pressures to curtail their health care spending.

In the setting of health care reform, escalating costs, and increasing disease burden, the cardiology workforce becomes an issue of concern. The ACC Workforce Workgroup, along with the Association of American Medical Colleges and the Lewin Group, published a study that concluded there will continue to be a significant shortage of cardiologists, and this shortage will worsen over the next two decades. Currently, there is a deficit of more than 1500 general cardiologists as well as a 2000-physician deficit in interventional cardiology that is projected to continue until 2025.[8]

A critical factor in the supply of cardiologists in the near future will be retirement rates. Currently, 43% of general cardiologists, 315 of pediatric cardiologists, and 21% of interventional cardiologists are over the age of 55.[8] Increased regulation, insufficient reimbursement, on-call responsibilities, personal health issues, lack of professional satisfaction, and requirements for recertification may play a major role in the timing of retirement.

As more women are entering medical school than ever before, the number of women choosing cardiology as a subspecialty will add to the determination of the cardiology workforce. The number of female cardiologists and fellows has nearly doubled in the past decade. Although women currently comprise a very small proportion of all cardiologists, there is currently a large pool of potential female candidates for a career in cardiovascular medicine. We have held receptions both in Northern and Southern California to target this pool of potential candidates to encourage a career in cardiology.

An added burden for the workforce is the many changes in certification and recertification requirements. In 1990, the American Board of Internal Medicine (ABIM) mandated a 10-year limit on all cardiology board certifications, thus mandating recertification starting in 2001.[9,10] The Maintenance of Certification (MOC) process continues to evolve. The ACC has been working with ABIM to facilitate the MOC process and, in fact, the ACC Scientific Sessions have many MOC sessions. This has met with positive reviews from members. In April 2010, the ACC met with representatives from ABIM, the Certification Board of Computed Tomography, the Certification Board of Nuclear Cardiology, and the National Board of Echocardiography to find a collaborative approach to test imaging in a more clinically relevant way on the ABIM CVD certification and MOC examinations. The goal is to reduce the financial and time burden for the candidates taking multiple examinations.

The new player in the assessment of the competence of physicians is the Federation of State Medical Boards (FSMB). The FSMB is proposing

starting pilot projects in some states in the fall of 2011 that will mandate a licensee to provide evidence of participation in a program of continuous professional development as a prerequisite to license renewal.[11]

This is a small synopsis of the Environmental Scan Report. It reminds us that given the magnitude of the disease burden associated with CVD and the fact that this translates into a large financial burden particularly in a time of monetary constraints and rising medical costs, the field of cardiology will always play an important role in the health care arena. It helps us to understand our environment from all aspects so we may be best prepared for what the future holds. ■

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