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**AMERICAN
COLLEGE of
CARDIOLOGY**

American College of Cardiology Proposal to Improve Continuous Cardiac Care:

A scalable and patient-centric model to reduce preventable emergency room visits and hospital readmissions through the meaningful realignment of physician economic incentives

Proposal-in-Brief

The American College of Cardiology (ACC) proposes the creation of voluntary, multi-specialty, virtual physician networks, organized around participation in CMS approved clinical registries, to improve the coordination of post hospitalization cardiac care and prevent avoidable readmissions. Physicians would be paid via a budget neutral payment bundle that rewards efficient practice and improved outcomes while reducing the cost to CMS over time. While hospitals and health systems could easily be integrated into this approach, the current proposal enables private practice physicians to achieve antitrust compliant virtual integration and still maintain the organizational and operational autonomy necessary to adapt care delivery to their respective micro markets. Likewise, patients would continue to exercise complete choice in selecting their physician.

Introduction

The ACC and its 37,000 members are committed to actively creating value in American healthcare through the provision of high quality, cost-effective care. At the microeconomic level—the individual physician treating the individual patient—the ACC believes that healthcare value can be greatly enhanced through the application of evidence-based medicine, clinical guidelines, appropriate use criteria, and bedside decision support, all capabilities in which the College has invested heavily over the last two decades. At the macroeconomic level, however, it is unlikely that any centrally dictated model for ambulatory patient care will be optimal. The state-of-the-art in American medicine is simply too complex and too dynamic for a one-size-fits-all approach.

The ACC therefore believes that healthcare reform must include a fundamental revision of the economic incentives currently faced by physicians. Appropriate incentives would reward physicians for managing

patient health, thereby delivering better outcomes for significantly less cost. At the same time, physicians would be empowered to do what every other sector of the economy does in response to economic incentives—innovate within a specific market context to produce a higher quality, lower cost product. Thus, delivering effective cardiac care to indigent populations in South Central Los Angeles will look very different than delivering care in rural Appalachia or suburban Washington, DC. It is not the specifics of ambulatory care organization that matters, but whether patients are living to their fullest potential.

The ACC believes that an important first step in incentive realignment could be accomplished by bundling physician payments for post hospitalization ambulatory care for percutaneous interventions (PCI), heart failure (HF), and acute myocardial infarction (AMI) with the goal of minimizing hospital readmission. The bundle period would likely need to be 60 to 90 days to create sufficient incentives for all parties to meaningfully modify behavior. For the sake of simplicity, this proposal will assume a 90 day bundle. When combined with meaningful incentive reform for hospitals and patients, this model will significantly advance patient outcomes through improved coordination of care without resorting to a forced restructuring of American medicine into vertically integrated health systems.

Bundled Payment Calculation and Distribution

Total Medicare payment liabilities to all physicians involved in caring for a patient, or the value of the total bundle, would be comprised of two parts. The first part is based on the condition-specific, 90-day *outcome controlled utilization mean* (OCUM). The OCUM is the mean number of RVUs Medicare historically reimburses all physicians for the care of a patient with average mortality risk and no readmission for 90 days following hospitalization. If the OCUM is too low to create a reasonable bundle value, a best practice value of RVUs could be substituted. Dollar costs to Medicare could then be determined by multiplying the OCUM by the conversion factor. The OCUM defines the pool of money that Medicare is already paying to physicians that could be more efficiently allocated to drive better outcomes and lower long-term costs. The OCUM can be roughly expressed as¹:

$$(1) \text{ OCUM} = (\sum \text{RVU}_i^{\text{ALL}}) / n$$

¹ $\text{RVU}_i^{\text{ALL}}$ is all the RVUs required to care for patient i 90 days post hospitalization; n is the total number of patients within a specified time with the specified condition; in calculating this expression, the mortality risk for patient i should be equal to the average condition-specific population mortality.

The second part of the Medicare liability in the bundle would be the *business case bonus*, or BCB. The BCB is a proportion of the expected cost to Medicare for the average condition specific readmission. The expected cost is calculated by multiplying the average cost of readmission by the average rate of readmission. The BCB defines the pool of money that Medicare could split with the physicians if the physicians prevented readmission in the 90 days following hospitalization. While the division of the saved dollars between Medicare and the physicians can be negotiated, it can be roughly expressed as:

$$(2) \text{ BCB} = \frac{1}{2} E(\text{RC}) \text{ where } E(\text{RC}) = (\text{readmission rate}) \times (\text{average cost of readmission})$$

The *maximum physician payment* (MPP) for an individual physician (MPP_{Pi}) participating in the care of a patient and successfully avoiding readmission could then be derived using traditional RVUs, the conversion factor (CF), and expressions (1) and (2) as follows²:

$$(3) \text{ MPP}_{Pi} = \alpha [\sum \text{RVU}_{Pi} (\text{CF})] + \frac{1}{2} E(\text{RC}) (\sum \text{RVU}_{Pi} / \sum \text{RVU}_{\Sigma Pi})$$

$$(4) \text{ Where } \alpha = \text{OCUM} / \sum \text{RVU}_{\Sigma Pi}$$

The first half of the expression represents the payment each individual physician receives for their individual work performed in the patient's care in the 90 days following hospitalization. The RVUs would presumably include practice and malpractice expense RVUs and the Geographic Practice Cost Indices. An additional term (or terms) could be added to the expression to provide a *severity adjustment multiplier* (SAM) and a *regional realignment schedule* (RRS) if desired. While not defined mathematically here, the RRS would gradually reduce unjustifiable variation in payment across regions over a multiyear period.

It is important to note that the weighting term α is what enables the first half of the expression to create a more dynamic incentive. Under no circumstances can the payments to the physicians participating in the bundle exceed the previously defined *outcome controlled utilization mean* (OCUM). If the physicians use more RVUs than the OCUM allows, the payment per RVU would decline in a proportional amount. If,

² $\sum \text{RVU}_{Pi}$ is the total number of RVUs used by physician Pi to treat patient i ; CF is the conversion factor; $\sum \text{RVU}_{\Sigma Pi}$ is the total number of RVUs provided by all physicians to treat patient i .

however, the physicians needed less utilization to keep the patient healthy and out of the hospital, the payment per RVU would actually increase. This would incent physicians to look for the most efficient strategies to maintain patient health and prevent readmission. If the patient was readmitted, no physician participating in the bundle could receive more per RVU than the standard conversion factor.

The second half of the expression, or the *business case bonus* (BCB), simply allocates a pre-established percentage of the avoided expected readmission costs amongst the physicians participating in the bundle in proportion to the number of RVUs they contributed to the total number of RVUs required to keep the patient healthy and out of the hospital.³ This would constitute a significant financial incentive to prevent avoidable readmission. To avoid an adverse selection problem where only high performing physicians would join the program and be rewarded for their already low readmission rates without saving incremental dollars CMS may need to customize the expected readmission rate, and hence the total value of the potential bonus, by geography.

While this is the simplest expression of the bundle, the ACC would also strongly encourage Medicare to include payment for currently unreimbursed RVUs that are integral to ideal, chronic condition management, including but not limited to phone and email exchanges, remote monitoring technology, care coordination, and social services. These additional payments could be included through a variety of straightforward mathematical additions to the above defined expressions.

Bundled Payment Administration

The basic bundled payment methodology detailed above could easily be expanded to other medical specialties and to cover more extended periods of time. It could be implemented for single- or multi-specialty practices and IPAs that currently manage full or partial patient risk. Integrated health systems, hospitals with substantial physician employment, and DOJ-approved Clinically Integrated Physician Hospital Organizations could manage such contracts with or without additional bundling of the associated inpatient services.

³ For simplicity's sake in expression (3) the physicians would evenly split the avoided readmission cost with Medicare. In reality, the portion of the prospective avoided readmission cost is a more complicated function if the program guarantees that Medicare will not pay more in bonuses than it saves. The dynamic division of the avoided expense can be generalized as follows: $SOS = \frac{(RA_0 - RA_1)}{(RA_0 - RA_0 RA_1)} (1 - MS)$ where *SOS* is the share of savings paid to the physicians, RA_0 is the original readmission rate, RA_1 is the new readmission rate, and *MS* is Medicare's share of the savings. The ACC believes that a mutually acceptable division of expected savings could be achieved through actuarial analysis in advance of launching the program.

However, given that so much of healthcare is currently delivered in small and medium sized practice settings, this proposal creates an opportunity for independent physicians to participate in incentive realignment through bundled payments. The bundling methodology proposed above, along with the administrative and operational methodology that follows, are designed to create virtual accountable care organizations in both urban and rural geographies without the need for practice realignment and new antitrust exemptions. When presented with the right behavioral and infrastructure investment incentives, private practice physicians are capable of collaborating to provide flexible, innovative, and market-specific patient care management solutions without participating in formally defined accountable care organizations, such as the Medical Home. Ultimately, then, the market-mimicking incentives created through payment bundles and patient choice will adjudicate the effectiveness of various models in meeting the challenges of highly dissimilar practice environments. The ACC also believes that the revised incentives should be accompanied by mandated participation in a CMS approved clinical registry, affording physicians and Medicare the tools to reliably monitor and improve clinical care. The administrative and operational methodology to create virtual accountable care organizations would function as follows:

Registering and Infrastructure

- (1) Physicians would, at least at first, opt into a program to receive bundled payments around the designated conditions. The bundled payment program for PCI, HF, and AMI would be open to cardiologists, primary care physicians, and potentially other specialists, including ED physicians, hospitalists, radiologists, nephrologists, pulmonologists, gerontologists, etc., necessary for comprehensive coordination of care.
- (2) All physicians would be required to have a certified electronic health record capable of reporting standardized clinical data on key cardiac care performance measures to a CMS-approved, centralized clinical registry.
- (3) Current fee-for-service administrative systems would be maintained for claim submission. Unique patient and physician identifiers would be essential for constructing and allocating bundle payments on the back end.

Patient Management and Payment

- (4) Hospital discharge after admission for PCI, HF, or AMI would constitute the triggering event. Hospitals would be incented, perhaps through an enhanced DRG, to cleanly transition the patient across care settings through an initial home visit followed by a formal, contractual handoff to a primary or specialty care physician in the bundling program.
- (5) The receiving physician could then refer the patient to any other physician participating in the program as needed to optimally manage the patient's care. For example, a patient may require a specialized imaging study and nephrology consult to preemptively manage emerging complications or comorbidities.
- (6) Clinical data would be continuously submitted to the CMS-approved data registry.
- (7) After 90 days all physicians who participated in the care of the patient would be compensated according to the bundled payment methodology outlined above. Each bundle is likely to be paid out differently according to case-specific referrals and utilization intensity.
- (8) Exceptions and exemptions would need to be defined for unrelated readmissions, exceptionally complicated cases requiring sub-sub-specialists not participating in the program, hospice transitions, and other legitimate alternate outcomes.
- (9) Claims would be reconciled and payment would be calculated and distributed by existing Medicare intermediaries.
- (10) It is fully expected that physicians would, over time, create teams with various degrees of formality (virtual accountable care organizations) within the program to coordinate care plans and handoffs to maximize the efficiency of optimal care. Because Medicare will continue to make all payments, the resulting virtual integration is not expected to violate existing antitrust regulations.

Continuous Quality Improvement

- (11) All physicians would receive quarterly reports from the registry with benchmark comparisons to local, regional, and national performance on NQF-endorsed measures.
- (12) Performance reports would be supplemented by targeted quality improvement tools that have pre-established interfaces with CME and maintenance of certification requirements.

Caveats

The ACC would like to forthrightly acknowledge the host of potential technical, political, and administrative challenges associated with this proposal. Nonetheless, the ACC believes this is a

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framework around which viable next-generation physician payment could be constructed. We believe the proposed model is an embodiment of payment for value and would look forward to implementing such a model in conjunction with a wide range of traditional and non-traditional partners. However, any payment reform in this direction would rightly be viewed by physicians as complicated and financially risky. Substantial resources would need to be dedicated to modeling projected incomes for physicians and educating them on the benefits of the revised system.

Conclusions

The ACC believes that bundled payment reform must deliver the following:

- (1) Provide a reasonable business case to incent physician behavior change (upside of at least 10%)
- (2) Pay physicians for previously unreimbursed services essential to 21st century coordination of care
- (3) Save CMS money now and bend the cost growth curve over the long term
- (4) Mandate participation in CMS recognized clinical registries to ensure access to validated clinical performance data and the tools necessary for continuous quality improvement
- (5) Incent patients to select physicians participating in bundled payment programs.
- (6) Provide concomitant incentives for hospitals to make effective patient handoffs through optimal discharge education, medication adherence, and home visits in the immediate post-discharge period
- (7) Effectively pay for ambulatory care in both urban and rural geographies
- (8) Create the technical and programmatic infrastructure necessary for the accelerated adoption of current best practice—evidence-based guidelines, appropriate use criteria, clinical decision support, registry participation, etc.—as well as future innovation.

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