ACC Proposals Involve Testing New Payment and Delivery System Models

By Jack Lewin, M.D.

Health care reform is on the move, and the practice of medicine as we know it will change significantly in the coming years. As health care reform proceeds, the ACC stands ready to be accountable and to lead in improving quality and value through payment reform with tools such as the National Cardiovascular Data Registry (NCDR®), IC³ Program® and new clinical decision support programs and the development of new quality improvement clinical networks.

In fact, the College is already working in several areas to ensure improvement in imaging appropriateness, reductions in hospital re-admissions, reduction of geographic variations in care and resource allocation and improved adherence to guidelines. Among the pilots underway, the ACC's Hospital to Home (H2H) initiative is committed to improving transitions across sites and sources of care for patients with cardiovascular disease, and thereby reducing preventable 30-day re-admissions for patients with heart disease by at least 20 percent by 2012.

The College is focused also on improving the evidence-based accuracy of imaging — i.e., using the right test the first time — by at least 15 percent through the use of appropriate use criteria (AUC) at the point of care. The ACC believes that imaging quality and cost effectiveness can best be improved by the systematic application of AUC.

When it comes to addressing the large variations in Medicare spending for similar cardiovascular patients with no correlation between higher spending and better care or improved health outcomes, the ACC has developed a "revascularization" tool to help clinicians determine from well over 100 clinical presentations which therapeutic approach is most appropriate both scientifically and clinically. This kind of project, with the right resources and/or incentives, could improve quality and reduce variation by using Web-based and EHR-embedded decision support for all specialties and practices dealing with cardiovascular care, and it would do so in a way that does not undermine practices. If we do not do this ourselves, others will do it with a *blunt instrument* approach.

Physician Network Proposal

On other fronts, the ACC is working with lawmakers and key health care stakeholders to develop and test different incentives for providers to work together to deliver cost-effective, efficient, quality care. One new proposal, which is garnering interest from the Centers for Medicare and Medicaid Services (CMS) and Congress, would enable smaller practices that are not part of a larger integrated system to participate in new payment incentives for improved quality and more efficient care through what Congress is calling *Accountable Care Organizations* (ACO). Our proposal applies a registry-measured quality of care improvement model that would align payment incentives with improvements in quality.

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In brief, the ACC proposal would create a voluntary, multi-specialty, quality physician network, organized around participation in CMS-approved clinical registries, to improve the coordination of post-hospitalization cardiac care and prevent avoidable re-admissions. Physicians would be paid via a combination of budget neutral fee-for-service and a virtual bundled bonus (VBB) payment that would reward efficient practice and improved outcomes while reducing the cost to CMS over time.

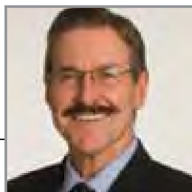
The proposal would enable private practice physicians to deliver meaningful and economically rewarding collaborative care as a first step toward more formal integration over time (as in the ACO concepts), while still maintaining the autonomy necessary to meet local market demands and protect the primacy of the doctor-patient relationship. Furthermore, the physicians in the quality network would ensure that Medicare costs are no greater than actuarially predicted for the targeted population.

In terms of payment methodology, this approach is novel because it would allow for the distribution of bundled bonus payments without requiring contractual relationships between participating physicians or hospitals, creating three specific benefits. First, because the bundle would be divided and paid according to the services rendered for each individual patient episode, physicians would be rewarded for providing the customized, patient-specific inputs required to produce optimal outcomes. Second, it would provide significant economic incentive for physicians to collaborate in patient care during the transition to a more integrated delivery structure. Third, it would provide a model for virtual integration in geographies where formal integration is unlikely or impossible.

Coordinating Efforts

Obviously this proposal would only be successful if developed in cooperation with other health care constituencies. In particular, parallel incentives would need to be developed for hospitals and patients. However, the proposal has the potential to improve significantly the delivery and coordination of care and also ensure that physician incentives and reimbursement are aligned to support these changes — a component that seems to be missing from many of the overarching health care reform proposals on the table.

This is just one of several payment reform models that the ACC would like to see tested as reform efforts kick into high gear. Ultimately, the ACC's chief goal is to enable cardiovascular specialists to thrive in this changing and dynamic health care environment. The College is continuing to work with Congress, CMS and other stakeholders to develop a health care system that puts patients first and rewards physicians and other medical professionals for their commitment to quality, evidence-based care. Our ideas may not be perfect, but at least we have some ideas on the table. For more on the ACC's efforts, including a more detailed overview of the payment reform proposals outlined here, go to *qualityfirst.acc.org*. You can also share your thoughts on health care reform and related issues at *lewinreport.acc.org*.



Lewin is CEO of the American College of Cardiology.

Advocacy Briefs

House Committees Release Discussion Draft on Health Reform

Three House committees — Energy and Commerce, Ways and Means, and Education and Labor — on June 19 released a discussion draft that aims to provide high-quality, affordable health care to all Americans while containing cost growth. The discussion draft rebases the current sustainable growth rate thereby wiping out all deficits for the last nine years, provides a positive Medicare Economic Index (MEI) update in 2010 (approximately 1 percent) and removes Medicare Part B drugs and labs from the calculation of physician services spending. The draft establishes two spending targets under the SGR formula, one for primary care and preventive services and one for all other services. The draft also supports the Physician Quality Reporting Initiative by continuing funding, setting up an appeals process and providing more timely feedback. However, the draft bill includes a provision to change the assumption for the time imaging equipment that is in use from 50 percent to 75 percent, which will result in lower payments for imaging services. The ACC opposes this provision.

Senate Panel Releases Health Reform Proposal

The Senate Committee on Health, Education, Labor and Pensions (HELP) on June 17 began to mark up its health care reform legislation, the Affordable Health Choices Act. The bill encourages adoption and use of health IT; promotes evidence-based medicine; facilitates health literacy; and includes strategies for tackling preventable medical errors and hospital re-admissions, as well as better managing chronic conditions through care coordination, medical homes and community health teams. The ACC submitted a letter to the committee commending it for "tak[ing] the necessary steps towards improving the coordination and quality of care," which is available on *qualityfirst.acc.org.*

There's Not Always Robust Evidence, Mr. President: The Lewin Report

Robert Hendel, M.D., F.A.C.C., featured on ACC's online forum, The Lewin Report, discussed the value of appropriate use criteria in filling the void in robust scientific evidence. Commenting on President Obama's speech to the American Medical Association: "President Obama cited the recent JAMA publication that found only half of all cardiac guidelines are based on scientific evidence," Hendel wrote, "However, this conclusion is misleading with regards to the value of practice guidelines and the overall aim of providing the best care. Not every clinical scenario has robust literature support and in its absence, expert consensus opinion must fill the void to assist cardiologists in decision-making." Read the post in full at: *LewinReport.acc.org.*

Conference Addresses Payment Reform, Cardiovascular Disease

The ACC on June 12 partnered with Avalere Health on a day-long symposium that used cardiovascular disease as a prism to explore the challenges and opportunities associated with payment reform. The event featured discussions and presentations by key health care reform leaders on innovative payment models that reward quality and more efficient care delivery; infrastructure needs to support health care providers; and new funding streams for health IT adoption. Special guest Rep. Lois Capps (D-Calif.) provided an overview of House efforts to pass overarching health care reform legislation. ACC CEO **Jack Lewin, M.D.**, spoke about cardiovascular care as a model for examining systemic payment reform, while ACC Senior Vice President for Science and Quality **Janet Wright, M.D., F.A.C.C.**, moderated a panel that looked at point-of-care information and its influence on care delivery. During the meeting, Avalere Health released a report —"Exploring Opportunities for Efficient Care"— focusing on the "potential for better use of risk stratification to advance the goal of greater efficiency."