Stormy Times: A Change of Season—Embrace the Opportunity and Make a Difference

Dipti Itchhaporia, MD, FACC

Chair-Elect, Board of Governors, American College of Cardiology (ACC); Southern California Governor, California Chapter of the ACC; Immediate Past-President, California Chapter of the ACC; Robert and Georgia Roth Chair for Excellence in Cardiac Care; Director of Disease Management, Hoag Memorial Hospital Presbyterian, Newport Beach, CA

[Rev Cardiovasc Med. *2011;12(4):227-229 doi: 10.3909/ricm0628a*]

We have heard that these are stormy times for the field of cardiology. The current environment is one of a weakened economy with sparse budgets and a push to reduce the national deficit, and the implementation of health care reform and the Sustainable Growth Rate (SGR).

In late 2008 and early 2009, we experienced the biggest contraction of the US economy in the past 25 years; however, health care costs have risen. These rising costs have been the challenge and the impetus for health care reform. It is clear that health care is being shifted from volume-driven care to value-driven care. With the passing of the Affordable Care Act, there are proposals for payment innovation. These include Accountable Care Organizations (ACOs), a "Medicare Shared Savings Program," as well as bundled-payment pilot programs for episodes of care.

ACOs are composed of a group of physicians, physicians and clinics, or hospitals that come together to pool their resources to provide higher-quality care at lower cost. If they lower the cost of care, they receive a portion of the savings. Recently, the federal government released the ACO final rule. Two different tracks were proposed, in addition to several concessions. The two tracks include an "Upside Only" track and the "Upside and Downside" track, as initially proposed. The Upside Only track allows ACOs to participate in their first 3-year contract without a downside risk, meaning they will receive bonuses of shared savings but not be liable if their patients are more expensive than expected. ACOs can keep 50% of the shared savings in the one-sided risk model as compared with 60% for the two-sided risk model.

The final rule allows for beneficiaries to be assigned to an ACO on a prospective basis (rather than on the proposed retrospective basis), allowing physicians to know which patients will be part of their panel. However, there will be ongoing retrospective adjustments. The final rule allows a patient to be assigned to a cardiologist even if he or she has not seen a primary care physician in the previous year. This is a concession from the initial proposed rule which did not allow patients to be assigned to a cardiologist in an ACO.

In California, there is a multipayer, multihospital demonstration of episode (or "bundled") payment for total knee and total hip replacement. There has been discussion about a bundled payment project for cardiac catheterization and percutaneous coronary intervention as well, although financial incentives have yet to be determined. There is great skepticism as to whether they can in fact bundle something as complex as

percutaneous interventions or heart failure treatment.

In addition to health care reform, there are many vagaries in physician payment, including the SGR. This is the formula for Medicare physician payment rates that were put in place as a cost control measure in 1997. It sets a target for Medicare expenditure on physician services based on Gross Domestic Product rather than actual costs. If the expenditure exceeds the target, Medicare recoups the money by cutting physician reimbursement. The SGR has triggered such cuts since 2002, but Congress has postponed these cuts each year, so that their cumulative effect currently mandates a 30% reduction in all Medicare payments, were they to be adopted.

Physician groups have been seeking an SGR fix for years from Congress. The Congressional Joint Select Committee on Deficit Reduction, also known as the Committee of Twelve (Gang of 12), was charged with issuing recommendations by November 23, 2011, for at least $1.2 trillion in additional deficit reduction steps to be undertaken over a 10-year period. The hope is that they will include an SGR fix in their plan.

The Medicare Payment Advisory Commission is an independent government commission of 17 members who recently approved an SGR reform plan that is not supported by most physician groups. In this plan, Congress would repeal the SGR (thus blocking a 29.5% pay cut scheduled for 2012) and replace it with a 10-year path of statuary updates. Proposed are two fee schedules, one for primary care services, in which payment rates would remain flat for 10 years, and another for non-primary care services, in which payments would decline 5.9% per year for 3 years and then remain flat for 7 years. In addition to the proposal for cuts to non-primary care doctors, they recommend data collection about service volume and work time to establish more accurate work and practice expense values. They want to use these data to identify overpriced fee schedule services and reduce the Resource-Based Relative Value Scale (RBRVS) accordingly.

With regard to health care costs, there is a movement to tie reimbursement to quality metrics. The Affordable Care Act endorses the creation of larger health care entities, such as ACOs, by providing financial incentives. However, in an ACO, providers will have to assume more risk. As a response, health care providers are trying to pool the new risks by integrating—providers are integrating, hospitals are integrating, and hospitals and physicians are integrating. The American College of Cardiology (ACC) reports that, since 2009, more than 50% of all practices have taken some form of cost-cutting action as a direct result of cuts in reimbursement for cardiovascular services. Nearly 40% of private group practices are currently integrating with hospitals or merging with other practices. They recognize that the trend is a move from fee-for-service to fixed incomes with performance bonuses based on balanced score cards. To achieve these quality metrics, they have begun to coordinate care with the formation of ACOs, to make plans for hospital and physician gain sharing so that they can more effectively participate in bundled and global payments.

There is a public reporting expectation and there are discussions about claims versus clinical data sets for this reporting. Physicians want to know who measures quality. Are we going to leave it up to the payors or are we going to be active participants? Can our registries help show our quality data?

Appropriateness of care is also an issue. In 2009, a cardiologist in Maryland was alleged to have implanted inappropriate stents. As a result of this procedure, the Maryland Chapter of the ACC worked closely with the Society for Cardiovascular Angiography and Interventions in supporting the Maryland Cardiovascular Safety Act. With a focus on quality and safety, the bill underscores the need for accreditation or some outside audits of catheterization laboratories, the use of clinical data in combination with claims data, and the use of appropriate use criteria to ensure patients receive the most appropriate treatments available.

These are indeed stormy times for cardiology. Now more than ever, we need ACC members to get involved and become educated about evolving practice models, quality metrics, and our robust registries and how these data can help us and our patients. We need to take all opportunities to educate hospitals, lawmakers, and payors regarding the important role data registries such as the National Cardiovascular Data Registry play in identifying gaps in care and improving outcomes. Please consider attending the Cardiovascular Care Summit in Las Vegas, Nevada, in January 2012.

In addition to education, there is a need for physician advocacy. The ACC has been advocating for medical liability reform and/or reduction of liability risks. ACC resources such as the Formation of Optimal Cardiovascular Utilization Strategies (FOCUS) tool are being leveraged to avoid additional cuts to cardiovascular services in imaging. FOCUS allows the cardiologist to enter clinical data to decide appropriateness of an imaging test so as to avoid the process of preauthorization with a Radiology Benefit Manager. A recent Cornell University study showed that US doctors spend $61,000 more per year in administrative expenses than our Canadian counterparts.[1]

Promoting quality programs such as Hospital to Home, which help reduce heart failure hospital readmission rates, helps spread the news that quality cardiology has reduced deaths from coronary artery disease by 30% over the past decade.

These feel like stormy times but this can be a change of season for cardiologists. Health care reform and the changing practice landscape bring opportunities. We need not only to adapt to change but also to embrace this change and be innovative. We need to be involved, not paralyzed, hesitant, overanalytical, or indifferent. This is the time to be engaged—with our hospitals, our local medical community, and with the ACC. Act as if what you do makes a difference. It does. ■

Reference

1. Morra D, Nicholson S, Levinson W, et al. US physician practices versus Canadians: spending nearly four times as much money interacting with payers. *Health Aff*. 2011;30:1443-1450.

Cardiology Training in the United Kingdom

Jim Hall, MD

British Cardiovascular Society, London, United Kingdom

[Rev Cardiovasc Med. *2011;12(4):229-230 doi: 10.3909/ricm0628b*]

In the United Kingdom, doctors who wish to follow a specialist career in cardiology (formally known as cardiovascular medicine) must fulfill the requirements of the Specialty Training Curriculum in Cardiology (available at www.bcs.com). The curriculum outlines how trainees should acquire the necessary knowledge and skills and how they should demonstrate their competence. The curriculum is regularly updated and the current version was published in 2010.

Delivery of Training

Specialty training follows broader medical training. Competitive entry into a recognized training program through a nationally coordinated recruitment process (applicant to post ratio of 15:1) is followed by a rotation through training posts that will lead to a Certificate of Completion of Training (CCT) and entry to the General Medical Council's specialist register. Only those on the specialist register are eligible to apply for a consultant cardiologist post in the UK National Health System.

Cardiology training takes place in clinical cardiac departments within hospitals across the United Kingdom, grouped together to provide rotations within regions (postgraduate deaneries). Cardiologists work with trainees as clinical supervisors to coach them in specific cardiological skills but also as educational supervisors to mentor their career development. The training usually consists of a 5-year program with the opportunity (which is strongly encouraged) to take time "out of program" to undertake a period of research leading to a higher degree (PhD or MD). In addition, trainees can take time out of program to gain extra clinical experience, often outside the United Kingdom.

Assessment of Training

The main methods for assessing competence of trainees are a series of workplace-based assessments, such as directly observed procedural skills, case-based discussions, and mini-clinical examinations. In addition, there is a multiple-choice question examination, the Knowledge-Based Assessment (KBA), for trainees in the third year of specialty training.

Quality Management of Training

Training is overseen by a Specialty Advisory Committee (SAC), which works in conjunction with the British

Cardiovascular Society's (BCS) Training Committee to maintain and improve the high standards of training in the United Kingdom. The training standards in cardiology are set by writing the curriculum, developing the assessment strategy, and providing external advice for quality management.

Role of Trainees

The BCS has over 300 trainee members with joint membership with the British Junior Cardiologists' Association. From this membership there are trainee representatives who serve as key members of the SAC, the training committee, the curriculum-writing groups, and the standard setting group of the KBA. Feedback from the wider body of trainees is actively sought on the opening training day at the BCS annual conference, and also informally at many educational events. ■