My original intention with this column was to comment on how this is a year of health care reform. Below this brief commentary, which became necessary with recent events, you will find my original column.

While we had hoped for significant reform to promote quality care, we now find ourselves in the midst of major activity by Congress and the Obama Administration that is centered predominantly on coverage and funding issues, possibly resulting in no delivery of real reform or significant changes in the sustained growth revenue formula. To make matters worse, on July 1, the Centers for Medicare and Medicaid Services (CMS) released proposed Medicare payment rules that, if finalized, will include severe reductions for cardiology reimbursement. So here we are—hoping that Congress has the will to create a new health care system that solves delivery problems, but once again gearing up to fight physician reimbursement issues, the sustained growth revenue-mandated cuts, and attacks on Stark exemptions.

Congress’s chance to create a system that improves health care delivery, quality, and outcomes and lowers costs took a significant blow last week with the release of the CMS proposed Medicare payment rules. Instead of working to improve quality and outcomes and long-term continuity of care, the American College of Cardiology (ACC) and other similar organizations will have to direct their efforts at fighting the CMS proposals. By reducing cardiology reimbursement in general by 10% with cuts as great as 50% for echocardiography and single-photon emission cardiac tomography, the proposed rule effectively removes any chance that cardiovascular professionals and other subspecialists would work with Congress on physician offsets as “pay-fors” for reform. Congress and the Obama Administration also should consider the degree to which CMS has alienated the physician community and should probably re-gauge the willingness of physicians to work toward reform in light of these proposed rules. This new turn also threatens to split medicine into factions competing for dollars, rather than working in unity to improve the quality and delivery of health care for all Americans.

Suffice it to say that the ACC will do all in its power to protect our ability to provide individualized state-of-the-science quality care to our patients and to protect the viability of cardiology practices.

Still, this is a year of health care reform, and I bear some obligation to comment on the topic at least once in this column even though our attention needs to focus on the recently announced payment cuts for cardiology. Over the years, we have heard continuous chatter about problems with the health care system, but little has been offered in the way of solutions. While the chatter continued, the costs of health care continued rising, headlines appeared about significant differences in regional utilization unrelated to demographics (1), the number of uninsured increased, and obesity, with its associated cardiovascular risk, became rampant.

As a medical community, we offered little in the way of meaningful solutions to either curtail health care costs or promote preventive care, and so now Congress is trying to...
create a new health care system that solves all of these problems while they “improve” physician reimbursement and find the methods for funding the added health care.

Based on recent clinical trial and registry data, cardiovascular professionals have evidence suggesting that many of the heart disease treatments we offer are not always needed to ensure longevity and quality of life, but they do increase costs. Recent observations have generated discussion about the appropriate use of elective percutaneous intervention (2,3), cardiac surgery (4), and implantable cardioverter-defibrillators (5,6), and inappropriate use of imaging continues to be a topic of discussion. These studies suggest that if we used therapies and imaging more appropriately, costs would decrease and we would have added funds to cover the increased number of uninsured citizens. There is also a perception that improving efficiency and care delivery would improve the national outcomes statistics, which presently put us behind most other advanced countries in health care outcomes and put us well ahead of these countries in per capita cost for health care (7). That perception may not be correct, but it holds sway in the current health care debate.

**Breaking Out of a Self-Perpetuating System**

So, the task remains to create a system that improves health care delivery, improves quality and outcomes, and lowers cost. Improving quality and outcomes involves greater attention to long-term continuity of care of patients with chronic heart disease. For example, management of heart failure (HF) is best done with a team approach that includes frequent communication and surveillance, attention to small changes in health status, and patients’ participation in their care. This approach has been shown to reduce hospitalizations and emergency room visits (8–10) and improve quality of life, but our present system offers no recognition of this model of care and provides limited reimbursement. With our perverse payment system, the incentive is to ignore the long-term care of an HF patient and to manage their recurrent exacerbations with hospitalizations and the associated procedures to treat acute decompensated HF. Insurers limit hospital days and deny coverage for a newly insured patient with HF, so patients with HF who change employers are likely to lose their coverage. Under this system, everybody gains except the patient. Similar care issues apply to chronic lung disease, diabetes, hypertension, and even preventive cardiology. With the current reimbursement system, prevention and chronic disease management—although good for the patient—are not good economically for hospitals and physicians.

We have lived with this episodic care or sick patient reimbursement system long enough to consider it the norm, so the reform needed to break out of this habit will take some time. The process this year in Washington is likely to be, at best, a start, but it will not provide a complete solution. There are many logical solutions to reforming our system; however, none of them will be easy to implement, and all will be resisted by those who stand to lose from the reforms. If we design reform to preserve income for the current participants—insurers, hospitals, providers, lawyers, drug and device manufacturers—reform will be difficult to achieve. This collective group of participants did promise President Obama that they would reduce health care costs over the next few years, but I do not think this translates into a plan to reduce their incomes. So from the start, the math does not work. Let us set aside income and special interests for a moment and look at what reform could be.

**Realistic View of Universal Coverage**

A large part of the current debate on restructuring health care revolves around providing coverage and access for the 47 million uninsured. Current proposals include creating insurance exchanges with payment subsidies for those in poverty and creating a government-subsidized, public insurance plan that would compete with private payers. Opposition to these plans is loud from many quarters. Insurers fear that either option will be more competitive than private insurance and that people will move away from private insurance. They foresee that we would inevitably drift to a totally government-run plan, which many proclaim as “socialized medicine.” In other countries, such systems have severely limited care and have driven patients to seek care abroad or in coexisting private plans.

The official position of the ACC on this issue leaves room for public and private insurance in a pluralistic coverage structure. All of the advanced countries in the world have a public plan, and most also have private plans that operate in parallel. Having a public option provides a safety net for those in poverty, and the competition forces private plans to be better social stewards. If the new system was properly constructed, Americans would have choices while physicians and hospitals would benefit from an influx of fully-covered patients. Raising Medicaid payments to Medicare levels would also improve patient access and physician reimbursement.

Clearly, a public plan has limitations and is not the sole answer to health care reform. However, some form of public option has a place in the overall picture, possibly through insurance cooperatives supported by government grants or loans that would minimize government involvement in the new health plans.

With all of the rhetorical objections to a public plan, few alternatives have been offered to resolve the problem of the uninsured. I believe this has become apparent to many of the legislators, and the argument for a public option has become compelling. We should soon know the outcome of this debate. Our society has always solved problems brought on by change, and the addition of a public plan would likely generate a number of innovative systems that will allow private and public insurance to
coexist on a long-term basis while dramatically reducing the number of uninsured Americans.

Paying for Health Instead of Sickness

The other important change that is needed is the recognition that reimbursement should be aimed at reducing sickness, not encouraging it. To create a system that rewards better quality care and improves longevity is a daunting task. We certainly do not want to wait 40 years until a patient is 85 years old to show that our care extended and improved his or her quality of life. Such a reimbursement system would require practices to exist for several generations to collect their proper quality reward.

What are the alternatives? The ACC proposes the use of process measures (following guidelines, appropriate use criteria, and performance measures), the use of electronic health records, connectivity with other practices, and e-prescribing as measures of quality that should be rewarded. Although the data are limited, studies support that following guidelines and performance measures improves outcome and reduces mortality (11). Connectivity through electronic medical records reduces redundancy in testing and allows more timely data sharing for patient care. Quality measures can be documented through registries, such as the National Cardiovascular Data Registry, an area in which the ACC has been a leader in development and implementation. With the IC3 Program, we can report the quality of a practice based on documented process measures and provide immediate feedback to practitioners about their practice’s performance.

The new health care system must commit to reimbursing for quality performance, and it must be more than the token 1% to 2% offered by the Physician Quality Reimbursement Initiative program. The new health care system needs to develop formulas for integrated care of chronic disease. These “episode of care” models are being developed, and the ACC has provided a model regarding post-hospitalization for congestive HF to CMS for consideration. Any new reimbursement systems should reward practices for reducing hospitalizations and stabilizing health status through team care for chronic cardiac diseases, such as HF, chronic stable angina, atrial fibrillation, and other chronic arrhythmias. Many noncardiac chronic diseases would also benefit from this type of care. A system for rewarding practices that provide intense programs of cardiovascular disease prevention through surveillance of risk factors, education, early intervention with medications, and lifestyle programs should also be part of a reformed reimbursement system.

Medicine Has Changed

For centuries, physicians have been trained to treat diseases, but this tradition comes from times when the earliest stages of disease and risks for disease were unknown. Today, we have the knowledge and the tools to intervene early in the disease process before overt symptoms of an irreversible disorder are manifest. Our systems for care and reimbursement need to be focused on the treatment of “pre-disease” and maintenance of health. This change, which represents a significant departure from the past, will provide for a healthier society and ultimately reduce the overall cost of care. Changing the health care system from one that focuses on disease to one that focuses on health and longevity will take time; my guess is 20 years. This is all the more reason for us to start today to advocate for a different reimbursement system, to educate the next generation of physicians in aiming for prevention and long-term engagement with their patients, and to shift our own practice behavior toward more prevention and long-term care.

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