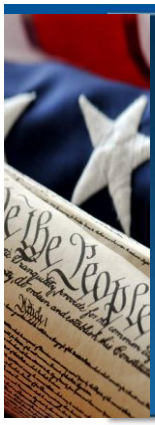


The NCDR in the Era of Healthcare Reform

NCDR.13
Annual Conference
San Francisco

Ralph Brindis, MD, MPH, MACC, FSCAI
Clinical Professor of Medicine , UCSF
Senior Medical Officer, External Affairs, NCDR
Past President, American College of Cardiology
March 8, 2013

Disclosures: None

The Case for Reform

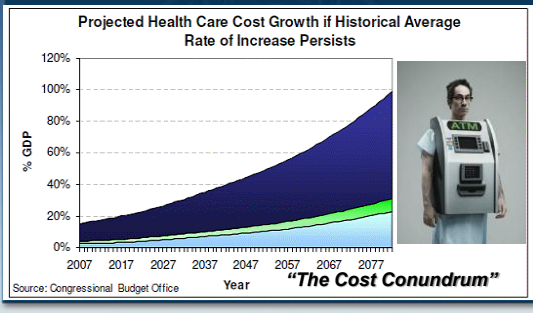
Health spending in the United States soared above $2 trillion for the first time in 2006 and has nearly doubled in the past decade, amounting to > $8,000 per person per year ($15,000 in McAllen Texas).

2012: $2.8 Trillion

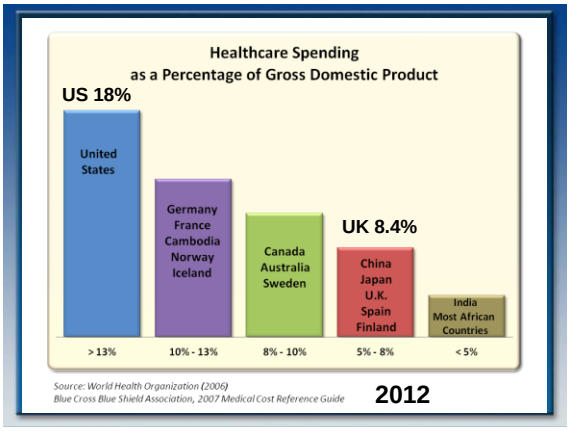
↓

2018: $4.4 Trillion

The Projected Health Care Cost Growth Rate is Unsustainable

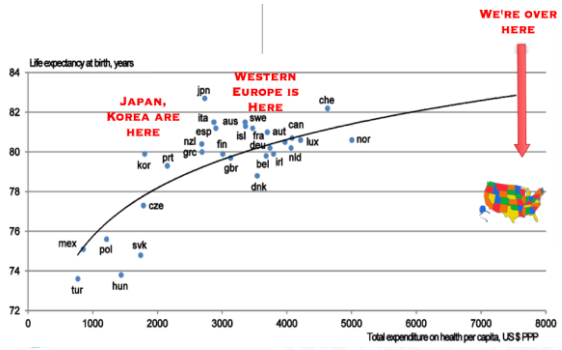


"The Cost Conundrum"



2012

The Problem for US Health Care

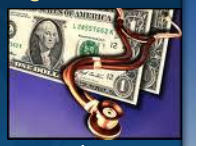


National Healthcare Expenditures, 2012

- NHE = $2.8 trillion
- 18% of GDP
- NHE per capita = $8,402 (2012)
- Average private health insurance premium in 2009 for a family = $13,375 (2010)
- Yearly take home pay of a minimum wage worker = $13,186 (2010)

Health Affairs 2010 29 (3)

The Cost of Health Care Reform The One Trillion Dollar Question



- Zeros matter
- A million seconds ago was last week.
- A billion seconds ago, Richard Nixon was in the White House.
- A trillion seconds ago was 30,000 BC

John Kitzhaber Keynote at IHI National Forum, Dec, 2008

The Medical Cost Environment

- $2.8 trillion spent on medical care in US in 2012, > $8,402 per person.
- In 2010 federal government became largest financer of health care (29% of spending), surpassing households (28%)
- Medicare/Medicaid is 23% of federal budget exceeding defense spending by 3%
- The government spent half of the revenues on health care, while health care costs only 6% of personal income.
- Public health insurance paid for 39% of medical care; private coverage paid for 33%. Out-of-pocket spending by consumers accounted for 12%

The Issues

Coverage

Choice

Cost

Quality

Groundhog Day –Health Care Reform

The Challenge for Health Reform

President Obama's Principles for Healthcare Reform

The Administration believes that comprehensive health reform should:

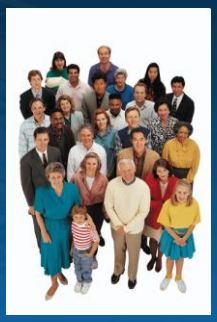
- Reduce long-term growth of health care costs for businesses and government
- Protect families from bankruptcy or debt because of health care costs
- Guarantee choice of doctors and health plans

White House Principles for Healthcare Reform

- Invest in prevention and wellness
- Improve patient safety and quality of care
- Assure affordable, quality health coverage for all Americans
- Maintain coverage when you change or lose your job
- End barriers to coverage for people with pre-existing medical conditions

What Do People Want?

- Peace of mind
- Choice and control
- Affordability
- Personal Physician
- They want personal access at an affordable cost
- Personal responsibility --------
  in others!!



The Challenge of the Uninsured

- ***Department of Health and Human Services- Secretary Kathleen Sebelius:*** *"The status quo is unsustainable and we cannot allow millions of Americans to continue to go without the care they need and deserve."* ***47 Million uninsured in US.***

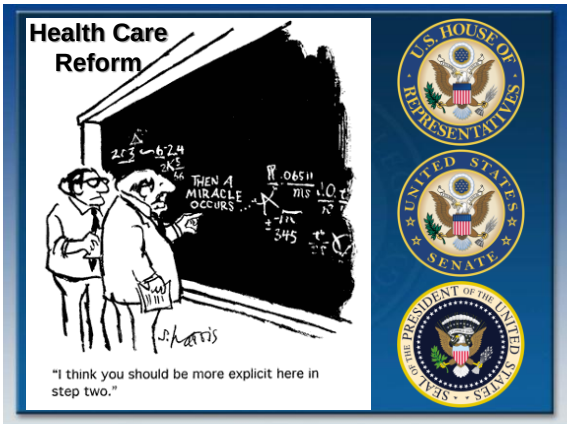
U.S. Health Care (2012)

- Recent HHS study found that the wealthiest 30% of population accounts for nearly 89% of health care expenditures
- Tens of millions of Americans — those whose employers don't provide health insurance, who are too poor to pay for it themselves and yet are too rich to use Medicaid — get the least health care of all

Pre-existing Conditions (2012)

- GAO estimates between 36 to 122 adults under 65 yo have "pre-existing conditions"
- 17 Million of these lack health insurance

"Health reform is unlikely to be adopted if it is not at or near the top of the national political agenda…"
President Barack Obama
March 5, 2009

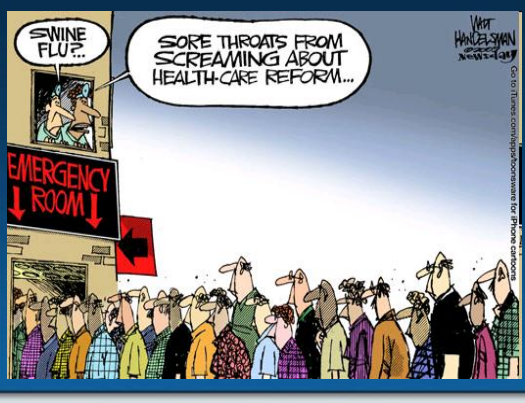


Legislation on Healthcare Reform & … Political Climate of the 112th

"You can lead a man to Congress, but you can't make him think."

Milton Berle

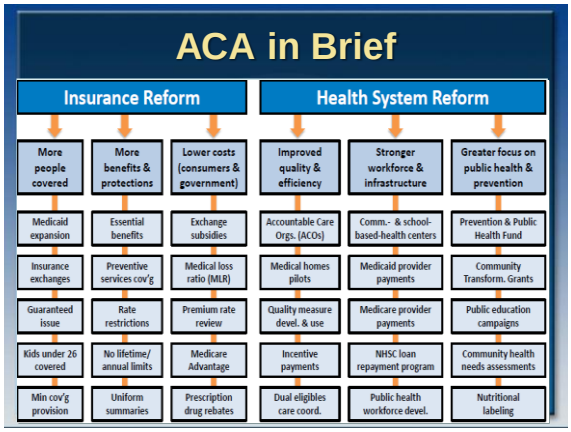
Legislation on Healthcare Reform



The State of the Union Address, January 27, 2010

Obama signing Healthcare Reform Bill March 23, 2010

ACA in Brief



ACA more Detailed

Insurance: More people covered	Insurance: More benefits & protections	Insurance: Lower costs for consumers, gov't	System: Improved quality & efficiency	System: Stronger workforce, infrastructure	System: greater focus on public health, prevention
Medicaid expansion: Nearly all Americans under 65 with incomes under 133% of the federal poverty line will now be eligible, in states that choose to expand. *(2014)*	Essential health benefits: In order for a plan to qualify to be sold through the exchanges, it will have to offer a minimum set of benefits. *(2014)*	Exchange subsidies: Many individuals and small businesses buying exchange plans will receive subsidies or tax credits to help them afford coverage. *(2014)*	Accountable Care Orgs. (ACOs): Medicare incentives to providers to work together to coordinate care, improve quality of care, and reduce costs. *(pilot 2012)*	Community- & school-based-health center funding: New funding for community health centers (CHCs) and school-based health centers (SBHCs). *(2010)*	Prevention & Public Health Fund (PPHF): New funding for state and local prevention efforts, bolstering public health capacity, & prevention research and tracking *(2010)*
Insurance exchanges: New virtual marketplaces will help consumers and small businesses comparison-shop for insurance. Also see "exchange subsidies." *(2014)*	Preventive service coverage: Insurers must cover certain preventive services at no cost to enrollees. *(2010 most services; 2012 additional women's services)*	Medical loss ratio (MLR): Insurers must spend at least 80-85% of premium dollars on health care (instead of profits, marketing costs, etc), or refund enrollees. *(2011)*	Medical homes: New options under Medicaid to test and implement medical home models of coordinating care and integrating community-based services *(2010, 2011)*	Medicaid provider payments: Medicaid primary care provider payments are increased so they are equal to Medicare provider payments. *(2013-2014)*	Community Transformation Grants (CTG): PPHF funding (see above) focused on community-level efforts to address preventable chronic conditions. *(2010)*
Guaranteed issue: Insurers can no longer deny coverage due to pre-existing conditions. Until it's effective for adults in 2014, there is a temporary Pre-Existing Condition Plan for adults. *(kids 2010; adults 2014)*	Rate restrictions: Insurers can't charge higher premiums based on gender or health status; other limitations also apply. *(2014)*	Premium rate review: Insurers must justify proposed premium increases of 10% or more; states or the federal government will review and publish the info for the public. *(2011)*	Quality measure devel. & use: New quality measures for M'care/M'caid providers, incl patient-centeredness, health disparities, meaningful use of electronic records, and more. *(2011)*	Medicare provider payments: 10% bonus payments for Medicare primary care services, and for general surgeons serving communities in need. *(2011-2013)*	Public education campaigns: New funding for large-scale outreach activities focused on nutrition and exercise, tobacco cessation, oral health, and more. *(2010)*
Kids under 26 covered: Young adults can stay on their parents' plans until age 26. *(2010)*	No lifetime/annual limits: Insurers are banned or restricted from imposing lifetime or annual coverage limits on essential benefits. *(2010; 2014)*	Medicare Advantage reform: Excessive payments to insurers via this program will be curbed, to lower government and consumer costs. *(2012)*	Incentive payments: M'care payments will be based on quality measures, not number of patients served. Payments reduced for hosp.-acquired infections or excessive readmissions. *(2012, 2014)*	Loan repayments: The National Health Service Corps program (loan repayments while serving communities in need) is permanently authorized, and funding is increased. *(2010)*	Community health needs assessments (CHNAs): Tax-exempt hospitals must assess and address community needs, and include public health stakeholders in the process. *(2012)*
Minimum coverage provision ("individual mandate"): Most Americans will have to obtain coverage or pay a small penalty, in order to keep the system balanced. *(2014)*	Uniform summaries: Insurers must provide standardized summaries of benefits and coverage so consumers can easily understand and compare plans. *(2012)*	Prescription drug rebates: Medicare enrollees who reach the drug coverage "donut hole" get rebates while the hole is slowly closed. *(2011)*	Dual eligibles care: New efforts to coordinate care for Medicare/Medicaid dual eligibles, often the sickest and most costly enrollees. *(2010)*	Public health workforce development: PPHF funding (see above) for graduate and post-graduate training in public health and preventive medicine. *(2010)*	Nutritional labeling: Chain restaurants & vending machines must display nutritional info. *(2011, but implementation delayed)*

ACA

Patient Protection & Affordable Care Act

On Passage in 2010

- Health insurance reform implementation fund of $1 billion available in HHS for insurance reform regulations
- Preservation of the right to maintain existing coverage is protected
- National efforts to combat health care fraud (not focused on physicians) funded and launched
-

ACA
Health Care Quality Improvements

- **Physician Quality Reporting Initiative (PQRI)**
  - Extended through 2014
  - Incentive payment increased by .5 percent [2011 to 2014]
  - Improvements include appeals process and more timely feedback
  - Maintenance of Certification program participation option (.5 percent payment incentive)
  - Penalties for not participating [2015]
- **Innovation Funding**
  - Funding set aside for state projects to help identify innovative care models that can be replicated throughout the country

ACA Payment Innovation

- **Accountable Care Organizations (ACOs)**
  - HHS to establish a "Medicare Shared Savings Program" that allows groups of providers who meet certain statutory criteria to be recognized as ACOs [2012]
  - HHS to develop a five-year national, voluntary bundled payment pilot program to provide incentives to hospitals, physicians, and other providers to improve patient care and achieve Medicare savings [2013]

ACA Payment Innovation

Independent Payment Advisory Board (IPAB)

- A 15-member board tasked with developing and presenting proposals to the President and Congress [2014], to:
  - Extend the solvency of Medicare
  - Slow cost growth
  - Improve quality of care
  - Reduce national health expenditures
- Proposals will be automatically implemented unless Congress approves alternatives that achieve the same level of savings
- Members appointed by the President and approved by the Senate for 6-year terms
- Hospitals exempt from payment modification proposals until 2019

Transparency & Program Integrity

Physician Feedback Program:

- HHS to provide reports to physicians comparing their resource use with other physicians caring for patients with similar conditions [2012]

Physician Compare:

- HHS to establish a "Physician Compare" website with information on physicians enrolled in Medicare [2011]. Note: HHS must implement a plan for including information on physician performance [2013]

Self Referral Violation:

- CMS will create a protocol for physicians who violate the physician self-referral (Stark) law and wish to disclose those violations to the Agency

ACA 2010

- Prohibitions on lifetime or annual insurance limits for essential health benefits implemented for all private health insurance
- Coverage of new preventive services required by all insurers
- Extension of dependent coverage to unmarried adult children through age 26 through their parents insurance is implemented
- Prohibitions of insurance discrimination based on salary implemented

ACA 2010

- Required medical loss ratios (80 percent or more of the premium dollar must be spent on medical care) implemented
- New insurance appeals processes implemented
- Full coverage for pre-existing health conditions for enrollees under 19 implemented
- Patient protections including choice of provider and medical reimbursement data implemented
- Establishment of PCORI (Patient-Centered Outcomes Research Institute)

ACA 2011

- Grants for wellness programs available
- States- Medical malpractice demonstration grants
- Primary care scholarship and loan repayments
- Medicare Innovation Center established with $10 billion to fund payment reform and quality improvement pilots
- Restrictions on physician ownership of specialty hospitals tightened

ACA 2012

- Ensuring quality of care improvements implemented
- New systems for linking payment to quality outcomes will be established
- Hospital penalties for higher-than-expected readmission rates will be implemented

ACA 2013

- Insurance exchanges implemented by the states or by HHS if they choose not to do so
- Uninsured individuals, small business employees and other citizens without coverage will be guaranteed affordable choices of insurance options
- Increased 10% Medicaid payment for primary care
- Primary care MDs will be paid full Medicare reimbursement rates

ACA 2014

- Coverage for pre-existing health conditions guaranteed for all citizens
- Guaranteed issue of insurance to all who apply
- Guaranteed renewability of insurance
- Prohibition on excessive insurance waiting periods
- Adjusted community rating rules for all insurers implemented (charges must be consistent for all insured persons, regardless of medical conditions, based on age groups)
- Nondiscrimination on health status related factors
- Wellness program requirements

ACA 2014

- Small business tax credit fully available
- **Individual Mandate**
  - Penalty $95 per person for 2014. Increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016. After 2016, dollar amounts indexed. Families pay a cap of $2,250 per family .
- New employer responsibilities for coverage - fines imposed ($2000 per employee; first 30 employees exempted)

ACA Impact on Physicians and role of the NCDR!!!!!

Quality and Value Based Purchasing (VBP)

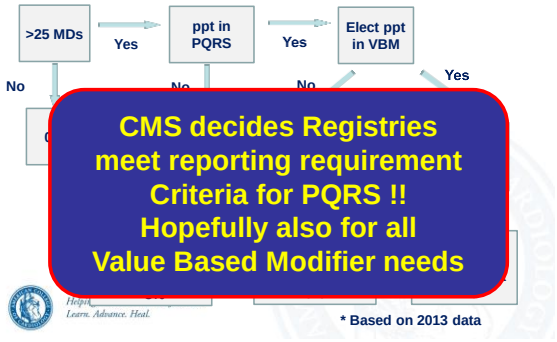
- **Quality Modifier 2015**
- **PQRS; extended bonus 4 years, then added penalties**

Public Reporting

- **MD specific feedback**
- **CMS Physician Compare**

Sunshine Act, CMMI, PCORI, IPAB

Quality Modifier Starts 2015*



ACA Left Out: Substantial Payment Reform

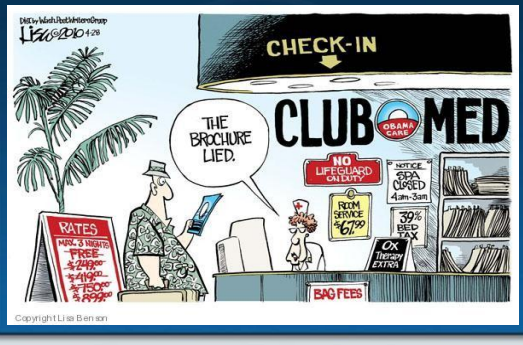
Without Radical Reform:

1. Price controls
   - will have us doing more and more for less and less
2. Capitation
   - Accountable Care Organizations

Real Payment Reform may be preferred:

- Reorganizing how payers pay providers
- Realigning incentives

ACA "Cost Control" April 2010



ACA Left Out: Real Malpractice Reform

- No proposal for caps on non-economic damages
- Needed:
  - Alternative mechanisms for resolving disputes
    - Health courts
    - Administrative panels
    - No fault
  - Screening panels, safe harbors for guidelines – based care
  - Limit attorney fees, damages, collateral source offsets, etc.

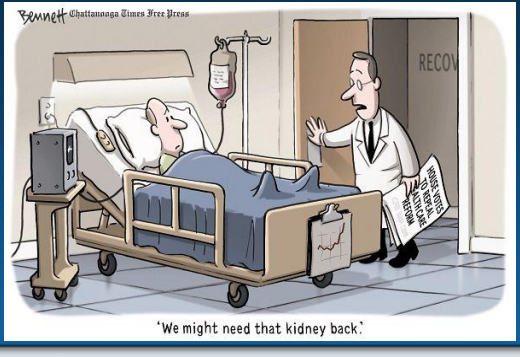
ACA Left Out: SGRrrrrr

Sustainable Growth Rate Formula

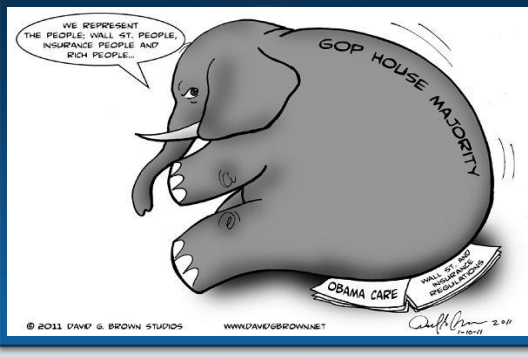
- A yearly spending target to control aggregate costs of physician services.
- Based on utilization of physician services and a 10 year GDP average
- Medicare physician payments at risk to be cut by 30%
- Fix would cost > $300 B over 10 years

Vladeck, NEJM 2010;362:1955-1957

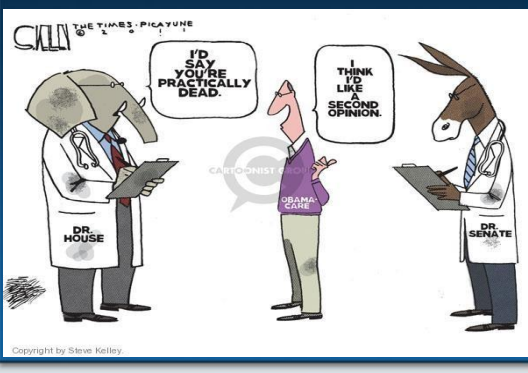
House Repeals ACA Jan 2011



House ACA Repeal Votes Jan 2011



House/Senate ACA Discordance Jan 2011



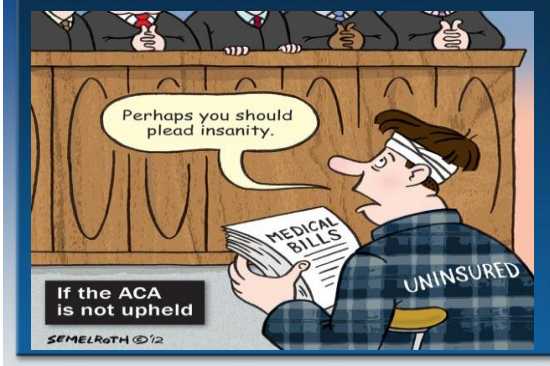
ACA March 2011

SCOTUS ACA Hearings March 2012

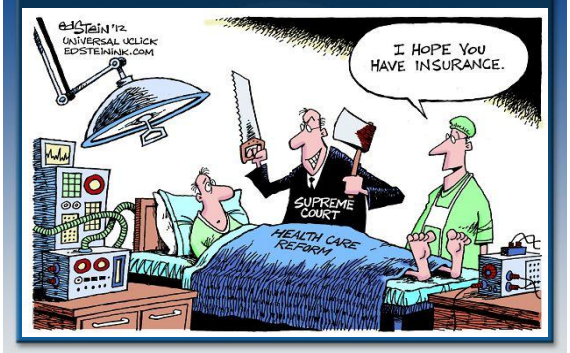
National Federation of Independent Business v Sebelius

Eve of SCOTUS Decision

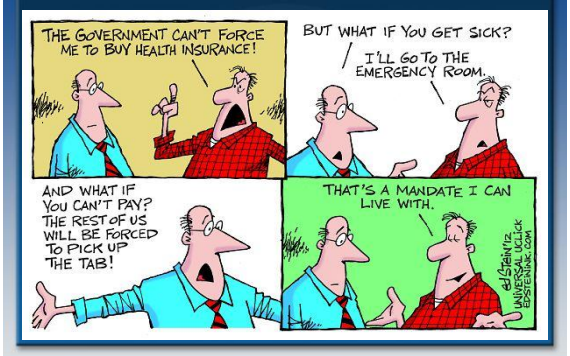
Eve SCOTUS Decision June 2012



Eve SCOTUS Decision June 2012



Eve SCOTUS Decision



SCOTUS Decision

National Federation of Independent Business v Sebelius

June 28, 2012

Helping Cardiovascular Professionals Learn. Advance. Heal.

Supreme Court Decision

Individual Mandate 5-4

- Violates Commerce Clause 5-4
- Allowed under Congress' Taxing Authority 5-4

Medicaid Expansion 5-4

- Unconstitutionally coercive 7-2
- Remedy: no penalizing states by withholding existing Medicaid $$ 5-4

Helping Cardiovascular Professionals Learn. Advance. Heal.

Post SCOTUS Individual Mandate

Post SCOTUS Decision

Immediate Outcome of SCOTUS Ruling

- 6 million young adults enrolled in parents' insurance plans
- 5.2 million Medicare enrollees saved on prescription-drug costs because of the shrinking Part D "doughnut hole"
- 600,000 new adult Medicaid enrollees in seven states that have already expanded Medicaid eligibility
- 12.8 million consumers who will receive more than $1 billion in insurance-premium rebates

"The Road Ahead for the Affordable Care Act"

McDonough, NEJM 2012:367;199-201

Uninsured Numbers Since ACA

"Fewer Uninsured People" Sept. 13, 2012 NY Times

- The # of Americans without health insurance declined in 2011, first drop since 2007
- Uninsured fell to 48.6 million (15.7%) in 2011 down from 49.9 million (16.3%) in 2010
- 3 million of children under 26 y.o. now covered

ACA saved $2.1 B for Consumers

- HHS report of Sept 11, 2012
  - New rate review rules instituted 9/2011 in ACA prevent insurance companies from raising rates with no accountability or transparency saving $1 billion (average rebate of $151 per household)
  - ACA Medical Loss Ratio (or 80/20) rule delivering rebates of $1.1 billion to 13 million

The Future of Health Care Reform: Impact of the US Supreme Court Decision

- Bars HHS from denying all Medicaid funding to states that opt out of ACA's Medicaid expansion, but allows states to obtain additional funding in exchange for opting in and complying with ACA's standards.
- Implementation of health insurance exchanges and other provisions will continue, with delays as many states "clueless".
- If states opt out of Medicaid expansions, millions of low income Americans who would have obtained coverage would remain uninsured, and providers will continue to face significant uncompensated care burdens.

Republican Reaction Post SCOTUS

Post SCOTUS Decision

JAMA

Lawrence O. Gostin August 2012:308;571-572

The Supreme Court's Historic Ruling on the Affordable Care Act

Economic Sustainability and Universal Coverage

"ACA's economic viability hinges on whether individuals actually purchase insurance, while universal coverage hinges on states expanding Medicaid"

The Individual Purchase Mandate
The Commerce Power
The ACA's Economic Viability
Medicaid Expansion
The Spending Power
The Promise of Universal Coverage

The Supreme Court and the Future of Medicaid

Stoltzfus and Rosenbaum NEJM Sept 2012:367;983-985.

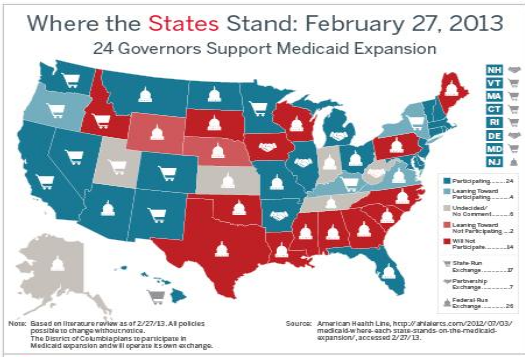
"Medicaid expansion in New York, Maine and Arizona was associated not only with improved health care coverage but also with reduced mortality."

"The question of whether the states will expand Medicaid, therefore, is not just a question of politics; it is a question of life, health, and death."

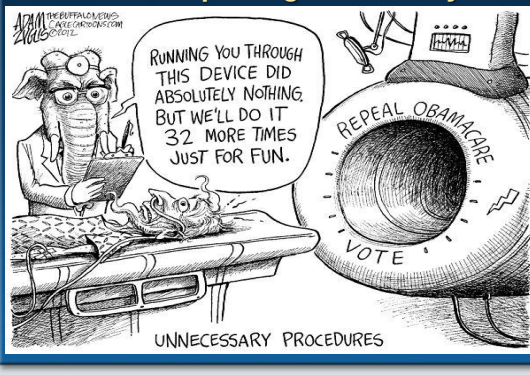
Medicaid: The Stakes for States

- 15.1 million newly Medicaid eligible under ACA
  - US government will pay 100% of Medicaid cost to the states but by 2020 US government will pay only 90%
- 3.6 million of these Medicaid eligible also eligible for Insurance exchanges
  - States motivated for patients to choose insurance exchanges as no cost to the states
  - Medicaid accounts for >20% of total state budgets and represents the largest single source of federal funding to the states.

Medicaid Expansion



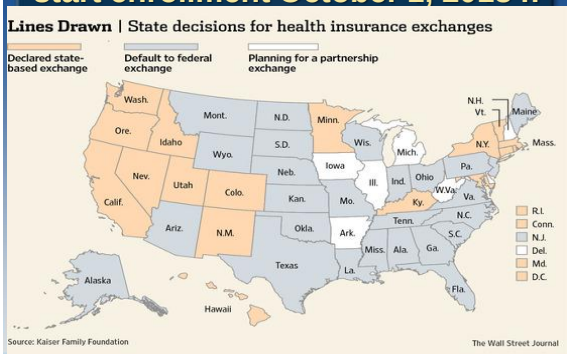
House ACA Repealing Efforts July 2012



2012 Election: Mass. = ACA

Scrambling to Implement Health Insurance Exchanges

Health Insurance Exchanges start enrollment October 1, 2013 !!



Individual Mandate Jan 2014

- Only 17 states & D.C. will set up their own state insurance exchanges marketplace to buy health care coverage
- Federal government will run exchanges solely or in a state partnership in the remainder of the 50 states

California Health Benefit Exchange

- California: 7 million uninsured people, > any state
  - Singular challenges: size, diversity and geographic spread of uninsured population & vast budget problems.
  - Web portal 10/2013
    - Three million people expected to buy insurance by 2019
    - Many others will likely enroll in Medicaid via the web portal
  - State's contribution could exceed $2 billion a year

"California Tries to Guide the Way on Health Law" *NY Times 9/15/2012*

"We are the example. If it can be done here, it can be done anywhere." *Anthony Wright, Health Access California*

Renaming the California Health Benefit Exchange:
CoveredCalifornia
www.coveredca.com/

Peter Lee,
Exec. Dir. Insurance Exchange

CoveredCalifornia

Guidelines for Selection of Qualified Health Plans

I. **Promote affordability** for the consumer and small employer- both in terms of premium and at point of care

II. **Assure access to quality care** for consumers presenting with a range of health statuses and conditions

III. **Facilitate informed choice for health plans and providers** by consumers and small employers

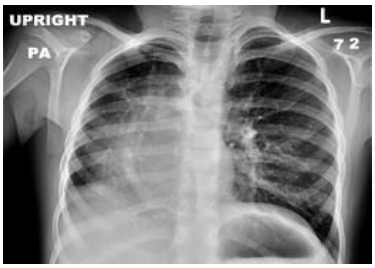
IV. **Promote wellness** and prevention

V. **Reduce health disparities** and foster health equity

VI. **Be a catalyst for delivery system reform** while being mindful of the Exchange's impact on and role in the broader health care delivery system

VII. **Operate with speed and agility** and use resources efficiently in the most focused possible way

Sequestration

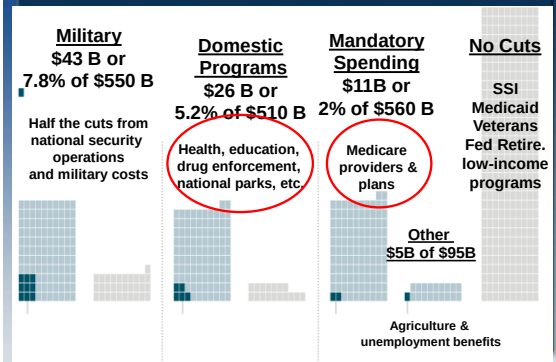


Rearrange the letters of "**sequestration**" around, and you get "**quiet senators**."

Sequestration March 1, 2013

- Sequestration Poses Significant Threat to Patients, Physicians, and Medical Innovation
- Budget Control Act of 2011 and budget sequester targets, Medicare reimbursement reduced annually by 2 % beginning in 2013.
- GME funding threatened risking the number of new physicians being trained as we face physician shortages and increasing population demands – 2% cut
- Dramatic impact on research and public health, cutting 8.4 % of federal programs such as NIH in 2013

Where the $85B/Yr. Cuts Fall



Sequestration National Health Related Cuts

- **NIH** faces a $1.6 billion cut
- **FDA** will absorb $210 million in cuts
  - cut funding: contracts, collaborations & travel
- **Medicare** provider payments cut 2% April 1st
- **NSF** expects a $35 million cut
  - 1,000 fewer grants, 1601 fewer graduate students &177 fewer postdocs in 2013
- **CDC**- Center for Disease Control (5-7%)
- **Indian Health Service** (5-7%)

Sequestration Cuts to States

- **Community Health Centers** (900,000 less patients served)
- **Child Care**
- **Vaccines for Children**
- **Public Health**
- **Nutritional Assistance for Seniors**
- **STOP Violence Against Women Program**
- **Clean Air and Water**
- **Teachers and Schools**
- **Work-study Jobs**
- **Head Start**
- **Job Search Assistance**
- **Military Readiness**
- **Law Enforcement**

IOM Report

Best Care at Lower Cost:
The Path to Continuously Learning Health Care in America

The National Academies Press
Fall 2012

http://www.nap.edu/catalog.php?record_id=13444

IOM Estimated Sources of Excess Costs in Health Care (2009)

Category	Sources	Estimate of Excess Costs
Unnecessary Services	• Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks	$210 billion
Inefficiently Delivered Services		$130 billion
Excess Administrative Costs		$190 billion
Prices That Are Too High		$105 billion
Missed Prevention Opportunities		$55 billion
Fraud	• All sources—payers, clinicians, patients	$75 billion

$800 Billion of waste each year

Vs

$85 Billion of Sequestration Cuts!!

Bitter Pill: Why Medical Bills are Killing Us

Feb. 20, 2013

Causes and Cures (1)

Aaron HJ and Ginsburg PB

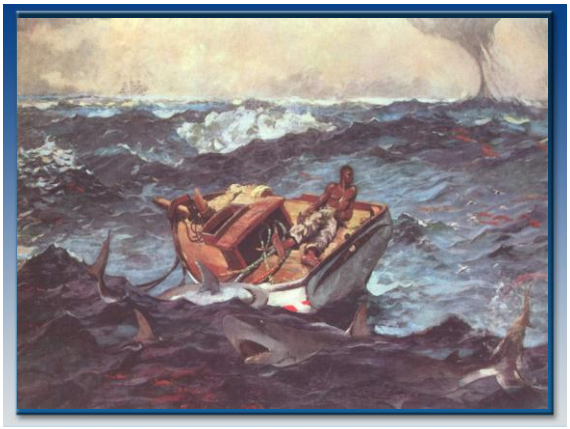
Is Health Spending Excessive? If So, What Can We Do About It?,

Health Affairs, 2010:28; 1260-1275

Moral hazard and disincentives of insurance system	**More co-pays**
Tax advantage	**Tax on Cadillac plans**
High income/expectations	**Education/ change in societal expectations**
Fee-for-service	**Bundling, capitation, blended with FFS**
Forced demand by providers	**Clinical Practice Guidelines, Appropriate Use Criteria, RBMs**
Specialty Mix	**Increased payment to primary care Increased use of non-MDs**

Causes and Cures (2)

Fragmentation	EMR, bundled payments, ACOs
Malpractice	True reform? Non-adversarial systems
Pay levels of providers, pricing of services	Rate setting
Patent system	Regulate patent expiration deals
Technology, Drugs	Generics, rate setting
Lack of transparency about cost and comparative effectiveness	Cost transparency and more comparative effectiveness research and education



Stormy Waters – Hospitals & MDs

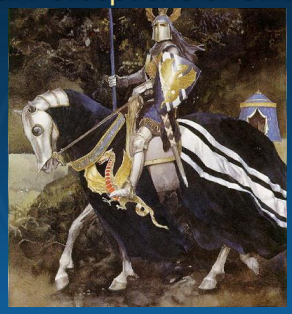
- Affordable Care Act and Medicaid Expansion
- Continued Reimbursement Cuts – CMS/Payers
  - SGR Continuing Saga
  - Imaging "Substitution" & Pre-authorization Payer Strategies
- Migration to Hospital Practice Integration Models
- Competency- MOCs, Accreditations
- Demand for Quality Reporting
- Demand for Public Reporting & Transparency
- EHR and Meaningful Use Adoption
- Demand for Appropriateness Evaluations
  - Maryland State, HCA and DOJ Alleged Fraud investigations

- EHRs; meaningful use
- Value based purchasing
- Public Reporting
- Accountable Care Organizations
- Payment cuts
- Claims data profiling
- Physician Quality Reporting System (PQRS)
- Preauthorization
- Payer Programs
- Episode groupers
- Efficiency metrics (= cut costs)
- Hospital employment
- Bundled payments (capitation)
- Coverage determinations
- Utilization review
- MOC / MOL
- Appropriateness auditing
- Certification exams

The 2012 CV Specialist:
Quality, Accountability, Transparency & Cost

Sir Luke Fildes, 1887, The Tate Museum, London

Societal Perceptions of Clinicians



Knights ???

Societal Perceptions of Clinicians

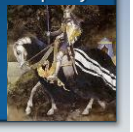
Knaves???

Societal Perceptions of Clinicians

Pawns???

If Clinicians are Knights

- "Knighthood" the definition of Professionalism
  - Stewardship for Healthcare system in our hands
  - Trusted to practice Appropriate Use of resources
  - Champion of patients and policies to support our work
  - Save and improve lives, financial gain is secondary
  - Continuing education and clinical and basic research
  - Respected advisor for policy and payment when policy affects health of public



Jain & Cassel JAMA 2010;304:1009-1110

If Clinicians are Knaves

- Policy, management and educational efforts designed to combat and work against clinicians and not for them
- Self-interest/financial gain first; patients secondary
- Need rewards and incentives to motivate
  - Monitoring for abuse, fraud and waste required
- Learn new techniques/procedures for personal gain
- Research for self-glorification and narcissism
- Health care system functions in spite of … not due to them
- Regulations guard against malfeasance and need for public protection

Jain & Cassel JAMA 2010;304:1009-1110

Clinicians viewed as Knaves & Pawns NOT Knights - Implications

- Views of unwarranted variations in care, evidence of waste and occasionally fraud
- The modern clinician in the United States now regarded at times as a Knave or a Pawn - rather than a Knight !!

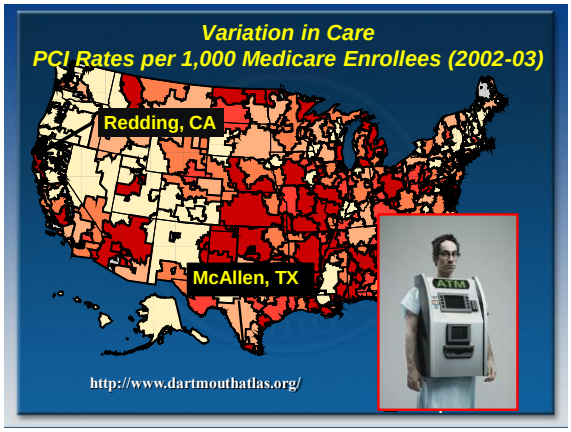
Donald Berwick, MD

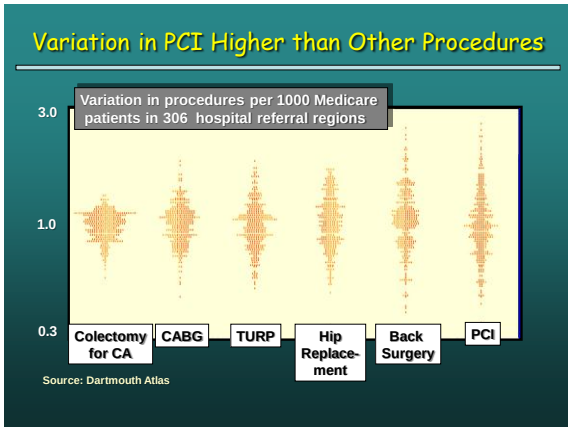
Past President and CEO, Institute for Healthcare Improvement

Administrator, CMS: 7/10 – 12/11

"Unintended variation is stealing healthcare blind"

"20-30% of health spending is *waste* with no benefit to patients, because of overtreatment, failure to coordinate care, administrative complexity and fraud"


Variation in Care
PCI Rates per 1,000 Medicare Enrollees (2002-03)
Redding, CA
McAllen, TX
ATM
http://www.dartmouthatlas.org/


Variation in PCI Higher than Other Procedures
Variation in procedures per 1000 Medicare patients in 306 hospital referral regions
3.0
1.0
0.3
Colectomy for CA
CABG
TURP
Hip Replace-ment
Back Surgery
PCI
Source: Dartmouth Atlas


Unprotected
Left Main PCI

Potential Impact of Inappropriate PCI

- *700,000 PCI/year in US*
- *5% inappropriate and 12% uncertain (NCDR)*
- *25% of uncertain PCI are ? inappropriate*

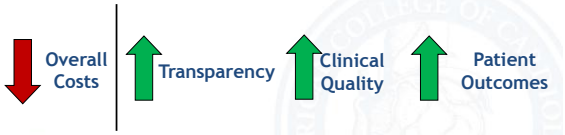
>200 deaths avoidable by eliminating inappropriate PCI

A New Conventional Wisdom for HCR

1. Societal consensus emerges that costs must stabilize through a combination of market forces, public policy, regulation, and delivery innovation

2. Discovery, innovation, profitability, high salaries and wages, advanced technology all still possible—but in a near zero sum environment where there are winners and losers

3. Solutions, and their associated trade offs, vary by region, payer, provider, and patient



Helping Cardiovascular Professionals Learn. Advance. Heal.

HCR and High Quality Cardiovascular Procedures

Patient Preferences

Quality Metrics
Public Reporting
NCDR Cath PCI Registry

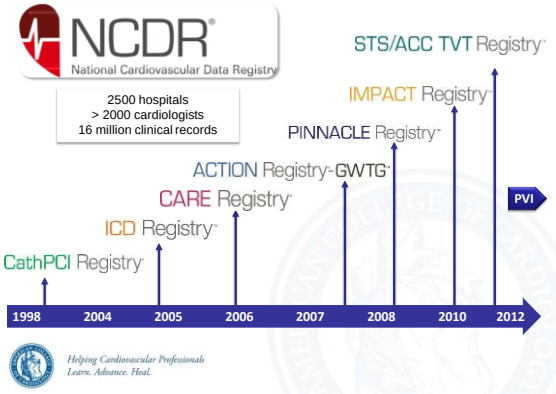
Right Patient ⇄ **Right Procedure Decision** → **Right Procedure Execution** → **Right Outcome**

Appropriate Use Criteria
Clinical Guidelines

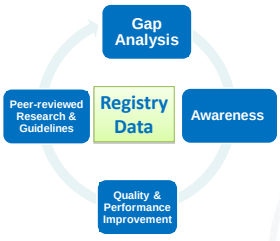
Ongoing trials and evidence

Performance Measures

Value equation for cardiovascular procedures – was the right procedure done in the right way with the right outcome in a timely fashion? *Measures: AUC, Process, & Outcomes*



Core of ACC's Strategy



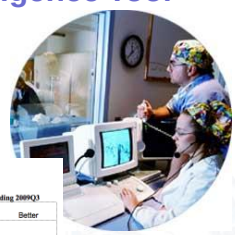
Why We Invest

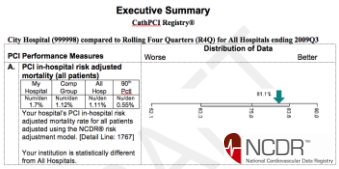
- ✓Unique clinical information
- ✓**Enable performance measurement by physicians for physicians**
- ✓Support for novel scientific research production
- ✓**Scaled delivery of registry-driven quality improvement programs**

Helping Cardiovascular Professionals Learn. Advance. Heal.

NCDR in the Era of HCR: Business Intelligence Tool

Point of care reports….





Executive Summary

CathPCI Registry®

City Hospital (999998) compared to Rolling Four Quarters (R4Q) for All Hospitals ending 2009Q3

PCI Performance Measures

A. PCI in-hospital risk adjusted mortality (all patients)

My Hospital Number	My Comp Group Number	All Hosp Number	90th Pctl Number
1.7%	1.12%	1.11%	0.55%

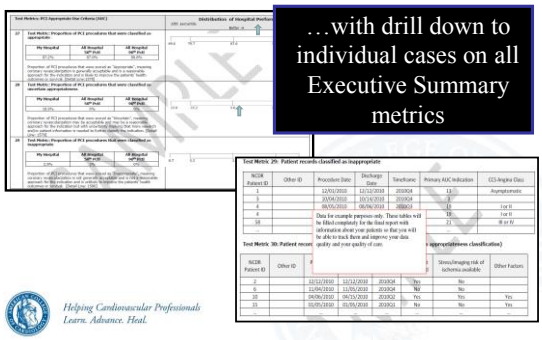
Your hospital's PCI in-hospital risk adjusted mortality rate for all patients adjusted using the NCDR® risk adjustment model. [Detail Line: 1767]

Your institution is statistically different from All Hospitals.

Distribution of Data — Worse / Better

NCDR® National Cardiovascular Data Registry

NCDR in the Era of HCR: Business Intelligence Tool



…with drill down to individual cases on all Executive Summary metrics

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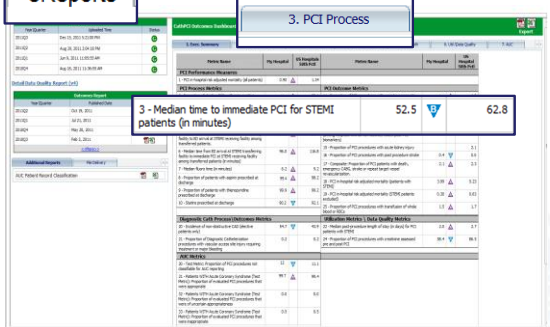
eReports

3. PCI Process



3 - Median time to immediate PCI for STEMI patients (in minutes) 52.5 62.8

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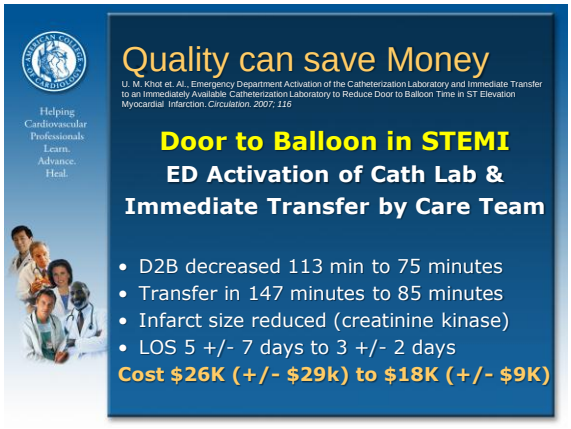


PRISM Models – Bleeding

Peri-Procedural Bleeding Complications Model

- Based upon NCDR Cath/PCI Registry
  - Uses pre-procedural data
  - Built upon 302,152 procedures from 440 sites
  - C-statistic = 0.73
- Stratifies patients into 3 risk groups
  - Low risk: <1%
  - Moderate: 1-3%
  - High risk: >3%

Mehta SK et al. *Circ Cardiovasc Intervent* 2009;2:222-229

Potential Interventions for High Bleeding Risk

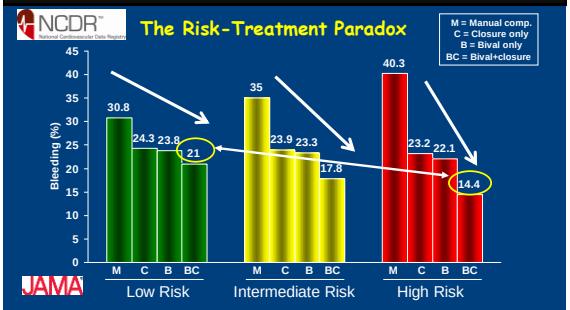
Interventions to Consider:

- Use of Bivalirudin
- Use of Closure Device
- Radial Approach
- Admission as an Inpatient for Observation

Recommendations:

- Low Risk – No Recommendation
- Moderate Risk – At least 1 Intervention
- High Risk – 2 or More Interventions

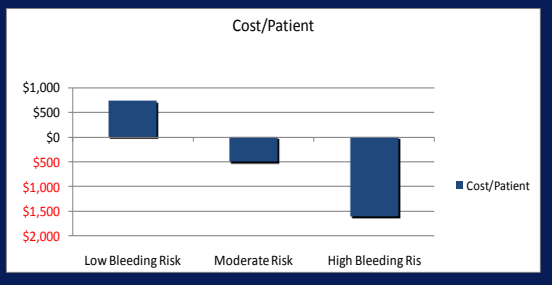
Use of bleeding avoidance strategies among patients undergoing PCI



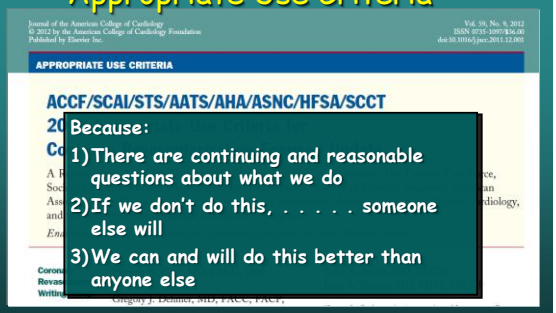
Marso et al. JAMA 2010;303(21):2156-2164
Amin et al. Circ Cardiovasc Qual Outcomes 2010;3:358-365

Costs per Patient of Bivalirudin Use

Detailed cost study of bivalirudin use by bleeding risk Mid America Heart Institute



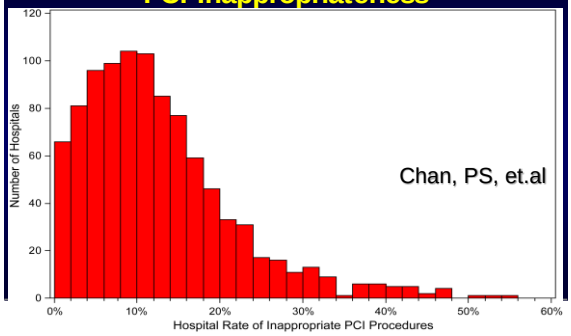
Appropriate Use Criteria



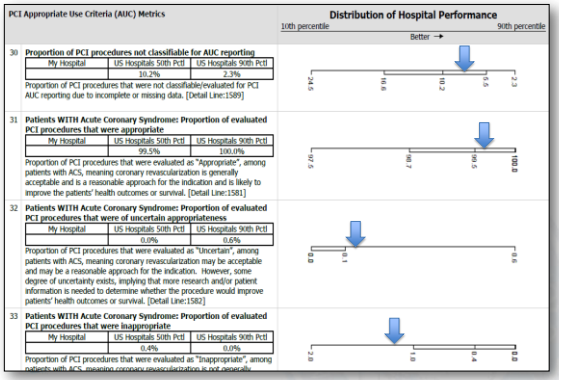
J Am Coll Cardiol 2012
Available at http://www.acc.org

NCDR CathPCI Registry

Hospital Variation in Non-Acute PCI Inappropriateness



NCDR CathPCI AUC Metrics



NCDR CathPCI Registry

Potential AUC Revasc. QI Efforts

1. Prompts for ordering physicians for Caths
2. Real-time Decision Tools after angiography and before PCI
3. "Time Out" vs. Ad-Hoc PCI

NCDR CathPCI Registry

AUC Calculator

The Society for Cardiovascular Angiography and Interventions
SCAI

www.SCAI.org/QIT

ACE
Accreditation for Cardiovascular Excellence

ACE in Era of Health Care Reform

ACE improves quality/efficiency/costs:

- Facilitates implementation of appropriate use criteria (AUC).
- Engages MDs in the quality outcomes process with highly effective peer review.
- Validates compliance with current published guidelines and consensus documents.
- Provides cost-effective programs - mitigate financial risk.

NCDR CathPCI Registry

The Joint Commission

AMA-convened
PCPI™ Physician Consortium for Performance Improvement®

National Summit on Overuse: Overuse of Elective PCI

Advisory Panel - Sept 2012

Proposed Interventions

1. Use of prope cations of Elective PCI
2. Encourage sta rpretation of non-invasive t ı ischemia
3. Focus on infor ing for patient knowledge/un fits/risks of PCI
4. Public/profess

The Joint Commission

PCPI

Proposal #1:

Promote Standardized Cath/Interventional Reports

- **Development of standardized template utilizing the AUC Criteria**
  - **Clinical presentation**
  - **Symptom severity**
  - **Ischemia severity**
  - **Extent of medical therapy**
  - **Extent of coronary anatomical findings on angiography**
- **Utilize a second "time-out" during the procedure to ensure that appropriate documentation of indications for the Elective PCI.**
- **Formal random external or internal case and film review on periodic basis.**

The Joint Commission

PCPI

Proposal #2

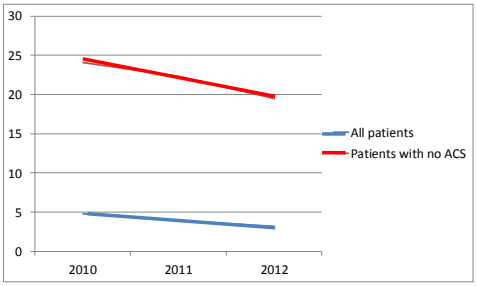
Promote standardized analysis/interpretation of non-invasive testing and ischemia

- **Development of standardized report for non-invasive testing including the following:**
  - **Radiation safety**
  - **Mandatory appropriate use criteria**
  - **Mandatory standardized reporting including the extent of the severity of ischemia**
- **Development of criteria for stress testing; both for referral process & interpretation of the test.**

The Joint Commission

PCPI

2012 AUC Revasc Focused Update in NCDR CathPCI Registry® Institutional Outcomes Reports:
Proportion of Evaluated PCI Procedures that were "Inappropriate"



Data Source: NCDR data, unpublished

NCDR™ National Cardiovascular Data Registry

JAMA 2011: ICD Appropriate Use

Non–Evidence-Based ICD Implantations in the United States 22.5%

Sana M. Al-Khatib, MD, MHS
Anne Hellkamp, MS
Jeptha Curtis, MD
Daniel Mark, MD, MPH
Eric Peterson, MD
Gillian D. Sanders, PhD
Paul A. Heidenreich, MD, MS
Adrian F. Hernandez, MD, MHS
Lesley H. Curtis, PhD
Stephen Hammill, MD

Context Practice guidelines do not recommend use of an implantable cardioverter-defibrillator (ICD) for primary prevention in patients recovering from a myocardial infarction or coronary artery bypass graft surgery and those with severe heart failure symptoms or a recent diagnosis of heart failure.

Objective To determine the number, characteristics, and in-hospital outcomes of patients who receive a non–evidence-based ICD and examine the distribution of these implants by site, physician specialty, and year of procedure.

Design, Setting, and Patients Retrospective cohort study of cases submitted to the National Cardiovascular Data Registry-ICD Registry between January 1, 2006, and June 30, 2009.

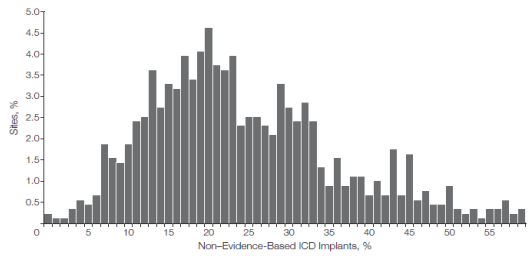
Main Outcome Measure In-hospital outcomes.

Results Of 111 707 patients, 25 145 received non–evidence-based ICD implants (22.5%). Patients who received a non–evidence-based ICD compared with those who

NCDR™ National Cardiovascular Data Registry

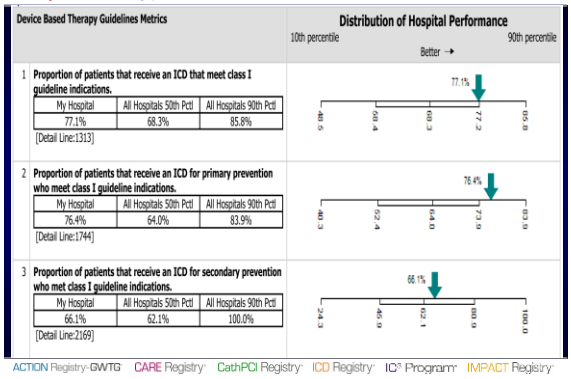
Hospital Variation of Non-Evidence ICDs

Figure 1. Rates of Non–Evidence-Based Implantable Cardioverter-Defibrillators (ICDs) Across Sites



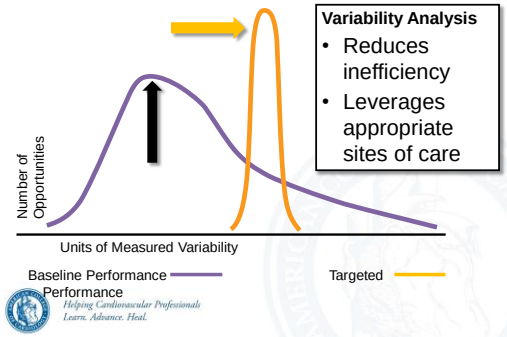
ACTION Registry-GWTG™ CARE Registry® CathPCI Registry® ICD Registry® IC³ Program™ IMPACT Registry®

ICD Registry Dashboard



ACC Chapter - Payer projects

Variation Is the Enemy of Good



Wisconsin SMARTCare

- Focus: the most expensive area under our control:
  Dx & Rx of Stable Ischemic Heart Disease

- Knits together Clinical tools developed & in use,
  - **Registries: CathPCI and PINNACLE**
  - **Decision Support: FOCUS and PRISM**
    - **AUC Imaging and Revascularization**
  - **Shared Decision-Making**
- Mechanism for feedback and quality improvement

Helping Cardiovascular Professionals Learn. Advance. Heal.

Purchasers' Concerns
(Also Every Patient's Concern)

Evidence Based Guidelines
A Method to Reduce Variation
Shared Decision Making
Fiscal Stewardship

Helping Cardiovascular Professionals Learn. Advance. Heal.

Controlling our Destiny
for American Healthcare

John Maynard Keynes

Milton Friedman

Global Budgets
- A gutsy move in Massachusetts
- Little detail on enforcement mechanisms

?

Capitation 2.0
- Population-specific budgets combined with vastly superior transparency and sensible regulation
- ACOs, PCMH, SDM, PMs, etc., all part of clinical toolkit

Fee for Service
- Current status quo

Single Payer
- Not in our lifetimes

Bundled Payment
- In theory good idea but in practice gets overwhelmingly complicated
- Only applied to a tiny percentage of current healthcare transactions

?

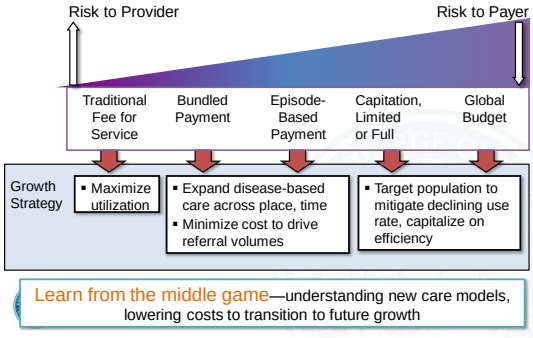
Pay-for-Performance
- Maybe better care, but no viable cost-control mechanism
- Too little, too late

Unfettered Free Market
- Eliminate pricing rigidities for both consumers *and* producers

?

Helping Cardiovascular Professionals Learn. Advance. Heal.

Emerging Payment Models Define Future Incentives, New Care Delivery Models



The Official Definition

What is an "Accountable Care Organization?"

A group of providers who are "accountable for the quality, cost, and overall care" of patients.

Viewed as a "shared savings program"

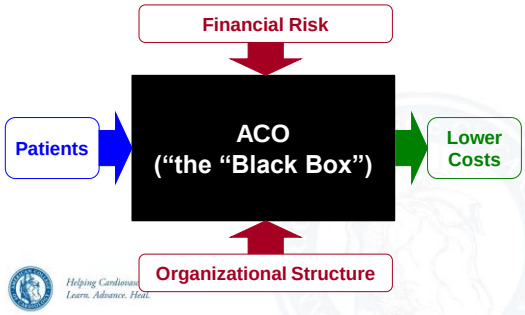
Section 3022, Patient Protection and Affordable Care Act

The Real Definition

What is an "Accountable Care Organization?"

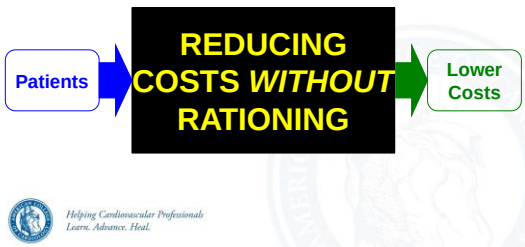
A group of providers who can figure out how to save money in health care

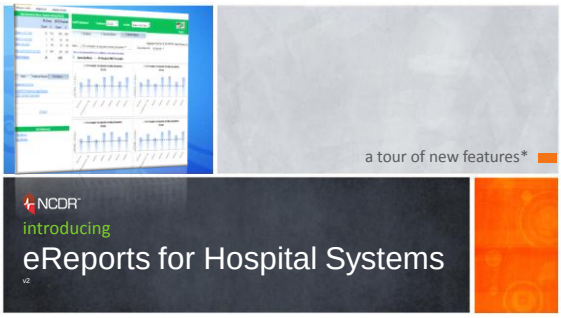
How Will ACOs Generate All These Savings?



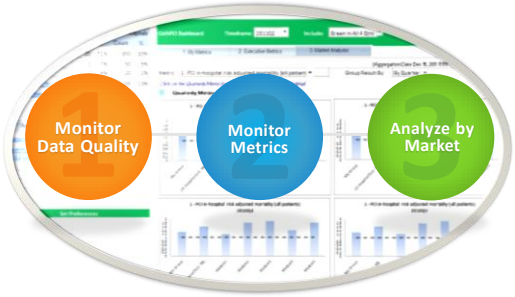
What's In That Black Box Can't Be Good For Consumers, Can It?

Focus Should Be On Improving Care to Reduce Costs



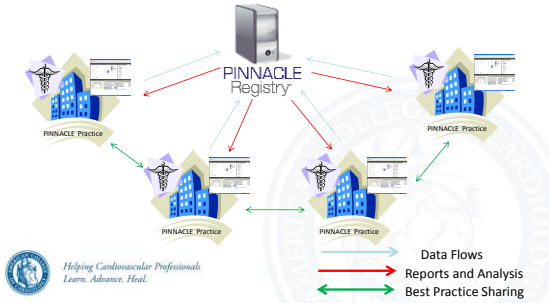


NCDR eReports for Hospital Systems

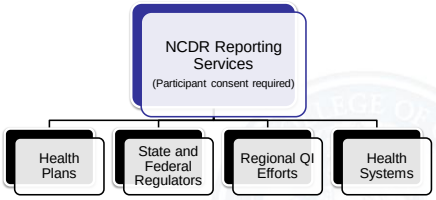


We have features for every step of the way

Leveraging the PINNACLE Network for Practice-Level CV Care Delivery in the ACO Environment



3rd Party Reporting Services Increasingly Important with HCR



Helping Cardiovascular Professionals Learn. Advance. Heal.

STS/ACC TVT Registry in Era of HCR New Paradigm for NCDR Partnerships!!

CMS CENTERS for MEDICARE & MEDICAID SERVICES

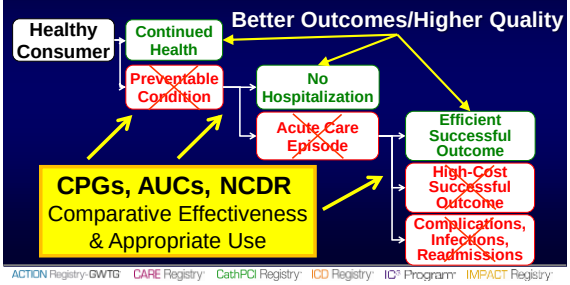
FDA U.S. Food and Drug Administration
Protecting and Promoting *Your* Health

Helping Cardiovascular Professionals Learn. Advance. Heal.

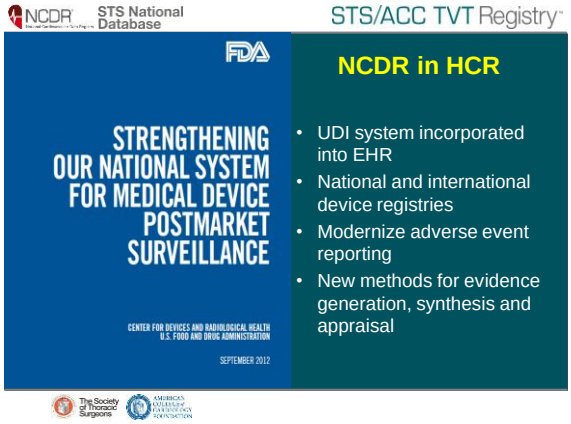
Accountable Care Organizations

Reducing Costs Without Rationing

Still Missing: Payment Alignment !!



ACTION Registry-GWTG · CARE Registry · CathPCI Registry · ICD Registry · IC³ Program · IMPACT Registry



Public Reporting: It Can and Will be Done

NCDR partnering with CMS - Hospital Compare

CathPCI and ICD Registry Quality Elements

NCDR Metrics for Public Reporting

Measure	Source Registry	External Data	NQF Endorsed
HF/LVSD: ACE/ARB Therapy at Discharge	ICD	No	Yes
CAD/MI Beta Blocker at Discharge *	ICD	No	Yes
HF/LVSD: Beta Blocker at Discharge	ICD	No	Yes
Aspirin at discharge	CathPCI	No	Yes
Thienopyridine at discharge *	CathPCI	No	Yes
Statins at discharge	CathPCI	No	Yes
PCI in-hospital risk adj. mortality *(patients with STEMI and patients without STEMI)*	CathPCI	No	Yes
ICD 30 or 90 day complication rates	ICD	Yes – CMS	Yes
30-day all cause risk adj. mortality *(patients without STEMI or cardiogenic shock and patients with STEMI or cardiogenic shock)*	CathPCI	Yes – CDC	Yes
30-day risk standardized readmission rates for PCI	CathPCI	Yes – CMS	Yes

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* Composite measure requested by NQF

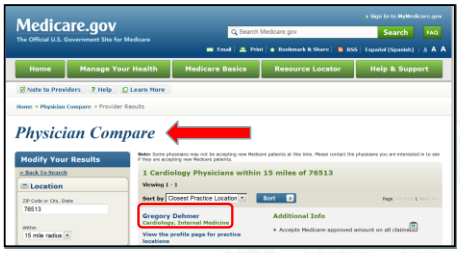
Your Performance is Being Tracked and Reported

Whether you know it or not !

www.hospitalcompare.hhs.gov

Physician Level Public Reporting on Horizon!!

CMS – www.physiciancompare.hhs.gov



Mandated by the Affordable Care Act of 2010. By 2014 this site will have information on **your** quality of care and patient experience that can help consumers learn more about the care provided by Medicare-participating physicians.

Healthcare Reform

"Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

Winston Churchill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"The right objective for health care is to increase value for patients, which is the quality of patient outcomes relative to the dollars expended."
- Michael Porter


President Obama:
"Congratulations!! ACC's NCDR registries are a key component for successful ACA implementation to achieve meaningful HealthCare Reform"