The existing unrestrained practice of visits, investigations, and interventions in medicine within the United States is becoming untenable. The inevitable transition from the current “fee-for-service” reimbursement models to global payment strategies is underway. This will have a significant effect on the practice of clinical electrophysiology. Notably, because heart rhythm services are comparatively well reimbursed, they stand out as “high cost” within the newer payment schemes. Market forces are, in fact, beginning to compel subspecialists to redefine the “value” of what they do on a daily basis, while aiming to gradually cut back on expensive (often times high-tech) “low-value services.” Needless to say, this will significantly affect the revenue stream for subspecialists and will also alter their practice patterns. Even though immediate strategies are aimed at a short list of high-cost services, the effect of this approach will plateau quickly and shift attention toward a value proposition that will gradually replace volume (1). Along with other subspecialists, the electrophysiology community will need to step up and not only help redefine the value of their contributions, but also play a leadership role in the delivery of high-value, patient-centered care. Electrophysiologists spend several additional years in training. Unless efforts are made to restructure the delivery of subspecialty services, it is possible that the climate change in the health care industry may undervalue the additional training and acquired expertise. Much of this change in subspecialty care will revolve around what will be defined as “high-value” care. Notably, value is not a static variable. Ratings of value will continue to change as “outcomes science” increasingly focuses on outcomes that matter to patients.

The evolving payment models seem to largely revolve around primary care physicians (PCPs), just as they did in the 1990s (2). PCPs will once again serve as gatekeepers and play a more active role in decisions about what is most appropriate for the patient. However, in many situations, a more effective care model could be disease-specific teams led by specialists. Some initial progress in this direction has already been made. For example, multidisciplinary teams, led by electrophysiologists, have been envisioned for patient groups with atrial fibrillation (3,4), resynchronization devices (5), ventricular tachycardia (6), and syncope (7). Also, which services and interventions remain well reimbursed within a global payment scheme will be a moving target. The true worth of an intervention will not be judged by the acute success of the procedure or operation itself, but by its effect on long-term outcomes associated with the chronic underlying conditions prompting intervention. This in turn reinforces the need for greater integration of the acute procedural component (i.e., atrial fibrillation ablation, device implantation, and so on) with other outpatient services and resources (i.e., risk factor modification, remote monitoring, and so on). Although some of this may already be in practice, it is still not being implemented in a systematic “generalizable” manner.

One classic approach to engaging specialists has been to pay them for performance on metrics related to their specialty. The National Quality Forum has over 450 measures and includes several from most specialties (8). The majority of these are process measures related to performance on a single metric. However, the current climate of primary care is focused on the delivery of high-value care. The model for primary care is likely to move away from a volume-based fee-for-service approach to one that focuses on patient outcomes. This will necessitate a shift in payment models toward global payment strategies that incent providers to deliver care that does not simply address acute care but also focuses on prevention and chronic disease management. In this new paradigm, electrophysiologists will need to play a leadership role in developing and implementing strategies that not only improve outcomes but also reduce costs. This will require a focus on outcomes science that can be used to inform decisions about the most effective interventions for patients. By working together with primary care physicians and other subspecialists, the electrophysiology community can help redefine the value of their contributions and develop strategies that align with the goals of delivering high-value care.
measures, and the experience of pay-for-performance on process measures has not been impressive. Although pay-for-performance may encourage adherence to specific quality metrics, it is unclear if these truly lead to better clinical outcomes. Furthermore, the administrative burden of this approach is substantial.

The evolution of our practices to providing collaborative, comprehensive longitudinal supervision with the goal of improving quality of care and population health seems inevitable. Patient-centric care is the fundamental premise, and as alluded to before, there are a variety of disease conditions where, to deliver this care, it may become necessary to shift the focus from the PCP to the specialist. However, broad systemic changes to replace the current fee-for-service system that rewards volume will need to begin moving toward redesigned practices even before the new payment structures are clearly defined. Importantly, this adaptive process may be different for community and academic centers, on the basis of resources and personnel.

CHALLENGES AND OPPORTUNITIES

Important challenges include a culture change, leadership, and investment in the structural changes required for delivering on the new value proposition. Leadership is required because electrophysiologists will need to begin moving toward redesigned practices even before the new payment structures are clearly defined. Importantly, this adaptive process may be different for community and academic centers, on the basis of resources and personnel. Poor outcomes will be penalized. As reimbursement gets squeezed, it is likely that redo-procedures and complications will not be reimbursed, or if they are, the revenue value units for the encounter will be substantially lower. This is where collaborative decision-making will become indispensable; electrophysiologists will need to ensure that their value within the equation does not falter and remains commensurate to their training and the risks that they take on. Although accountable care organizations continue to proliferate in the short-term, their effect on the quality of care and costs remain to be seen. Bundled payments have already begun shifting the focus from highly reimbursable interventional procedures to outcome-oriented integrated care. We will need to begin looking at patients beyond the immediate disease-specific interaction to the global risk perspective. Teams led by subspecialists may actually provide the much-needed multidisciplinary care to certain subgroups of patients while redefining clinical endpoints and setting expectations to make this a more cost-effective endeavor. Heart rhythm specialists will need to expand their value proposition by playing leadership roles in the redesigning of clinical practice and care delivered, with the intent of improving value, enhancing efficiency, and sustaining innovation while still keeping it patient-centered. This may seem to be a huge challenge, but it ought to be perceived as a phenomenal opportunity.

REFERENCES


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