Affiliate Leadership Forum:
Policy + Payment = Change

Karen Lui
Phillip Porte
GRQ, LLC
Chicago, IL
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I have no disclosures.
Outline

• MAC Liaison Task Force
• Million Hearts Cardiac Rehabilitation Collaborative
• Regulatory “What would you do?”
• Current state of value-based purchasing payment models
• Real world considerations with VBP
AACVPR MAC Liaison Task Force

Purpose

- Est. Sept, 2015 to represent CR & PR with Medicare payers
- To develop pro-active relationship with each MAC
  - 12 MAC contracts held by 8 Medicare contractors
  - Hand-outs: list of MACs by state and map of MAC regions
- To assist CR & PR programs at the MAC level
Need

• CMS leaves a fair degree of interpretation & enforcement of Federal regulations to MAC Medical Directors

• Education of payers on clinical aspects of CR & PR services
  – AACVPR “executive ppt” presents evidence, outcomes, virtual “tour” of services, certification programs, performance measures, and challenges
AACVPR MAC Liaison Task Force

Progress

• Meetings have been held with 2 contractors
• Meetings in planning stages with 4 contractors
• Relationships are being maintained with 2 contractors
• MAC MD will speak at annual meeting in New Orleans
• Recent TF survey of affiliates to assess resource and information needs at program level
AACVPR MAC Liaison Task Force

MAC Resource Group (MRG) Survey findings

• 214 responses-half were AACVPR members
  – Who is your MAC?
    • 20%: I don’t know
  – Do you know who is your state representative for your MAC?
    • 45%: I don’t know
  – Do you know how to contact your state representative with local policy issues?
    • 43%: No
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HELP
AACVPR MAC Liaison Task Force

Significant Issues-Ranked
1. Co-pay barriers
2. Lack of information/communication
3. Inability to use NPPs for direct MD supervision
4. Low reimbursement amounts
5. Coming bundled payment models

Million Hearts (MH) Cardiac Rehabilitation Collaborative (CRC)

- MH-2012 CMS initiative to save 1 million cv events over 5 years through use of evidence-based interventions to achieve >70% performance with ABCS-Aspirin, BP, Cholesterol, & Smoking cessation
- CRC-independent initiative to achieve > 70% participation rate in CR by 2021
- Attainable goal through use of evidence-based interventions to improve referral, enrollment, & long-term adherence
Cardiac Rehabilitation Collaborative

• Multiple actions underway by CRC stakeholders
• Specific “turn-key” strategies for implementation at program level are being developed by AACVPR
  – Target: ready by annual meeting in New Orleans
  – Example:
    • d2s-discharge to start of early outpatient CR
      – Evidence that for every 1-day increment in wait time, patients are 1% less likely to enroll

Regulatory Dilemma # 1-CR

• Can a Phase II CR patient attend Phase II 3x/wk and self-pay for unmonitored Phase III 2x/wk?
• If no, why not?
• If yes, why?
Regulatory Dilemma # 1-CR

- CMS does not require ECG monitoring for Phase II
- CMS does not limit the # of Phase II sessions/wk
- Best practice-ex rx of 6-7 days/week (> 150 minutes per week)
- ITP is individualized to meet each patient’s needs
- When is a patient ready for transition to Phs III?
Regulatory Dilemma # 2-PR

• The PR Medical Director is required to have direct patient contact before a PR patient can return for 2\textsuperscript{nd} PR session.

• How do you operationalize that?

• If that doesn’t happen, what are the barriers to compliance with this requirement?
Regulatory Dilemma # 2-PR

“It is expected that the supervising physician would have initial, direct contact with the individual prior to subsequent treatment by ancillary personnel and also have at least one direct contact in each 30-day period.”

Federal Register, Nov 25, 2009, pg 61883 and CMS Medicare Benefit Policy Pub 100-02, Transmittal 124
Value-Based Purchasing (VBP)

Medicare Part B

• In 2015 MACRA repealed SGR
• Fee-for-Service payments are adjusted based on value metrics
• CMS goals:
  – 2016: 85% of all traditional Medicare payments tied to quality or value
  – 2018: 90% of payments
  – Payment in CY 2019 will be based on CY 2017 performance
Value-Based Purchasing (VBP)

Medicare Part B

• Physicians select option to receive financial bonuses & penalties tied to performance:

  1. Merit-based Incentive Payment System (MIPS)
     - Combines current measure programs
       - PQRS, Meaningful Use, Value-based Modifier

  2. CMS Alternative Payment Models (APMs)
     - ACOs, Pt-centered Medical Homes
Hospital Value-Based Purchasing

- Hospitals will be scored on 4 domains:
  - Safety
  - Efficiency & cost reduction
  - Clinical care
  - Person & community engagement
- Each domain is 25% of a Total Performance Score used to calculate a value-based incentive payment adjustment
  - Bonus or penalty
- Begins CY 2017
Current State of VBP Programs

• Overall effectiveness of VBP programs marginal so far
• Why?
  – Financial incentives inadequate to drive change?
  – Overly complex quality measurement systems?
  – Delay in time between performance & incentive $?
  – Incentives part of % adjustment rather than “bonus”?
  – Multiple Medicare & private programs too confusing to identify which ones work?
• Private payers are following Medicare’s lead
• Fee-for service will have incentives linked to payment
Clinical Episode Payment Model

• CMS white paper has proposed episode-based payment for CAD
• Provides incentives for:
  – Coordination among all providers (PCPs/cardiologists and surgeons/intensivists)
  – High-quality preventive and care management has potential to reduce need for more expensive interventions (PCI, CABG, ...)
  – Use of low-resource tools such as medication & lifestyle change to manage condition
Clinical Episode Payment Model

• *Condition episode*
  – Payment for 12 months of preventive care, disease management, & procedures
  – Begins in 1\textsuperscript{st} benefit year post-CAD dx

• *Procedure episode*
  – Begins 30 days pre-procedure (PCI or CABG) and lasts 30-60-90 days post-discharge
  – “Nested” within condition episode

• HCP LAN Draft White Paper & submitted AACVPR comments linked on *AACVPR Regulatory & Legislative Actions* web page
Bundled Payments for Care Improvement (BPCI)

- Center for Medicare & Medicaid Innovation (CMMI or “Innovation Center”)
- BPCI are 4 models that link payments for multiple services during an episode of care
- Goal to “provide higher quality and more coordinated care at lower cost to Medicare”
- Participation is voluntary
Bundled Payments for Care Improvement (BPCI)

• Model 2: retrospective bundled payment
• Actual expenditures are reconciled against a target price for episode
• Episode includes hospital stay through 90 days post-discharge
• 48 clinical episodes, including COPD, AMI, CHF, CABG
• https://innovation.cms.gov/initiatives/bundled-payments/
Comprehensive Care for Joint Replacement (CJR)

- Implemented April, 2016
- Mandatory in 800 hospitals in 75 markets
- Bundled payment covering all services for hip & knee replacement procedures, starting with hospital admission and extending for 90 days – $25,000/episode
Real World Considerations with Value Based Purchasing

VBP = quality and cost

• What does your hospital think?
• What do you think?
• What metrics are you (and/or your hospital) framing?
• As payment shifts to quality, what IS quality CR/PR?
“Bundled Payment” Considerations

• When bundle is based on “condition,” are you confident that CR and PR will be included in the range of bundled conditions?
• Likewise, for “procedure” bundles, how inclusive, or exclusive, do you want to be?
• In both cases, >36 sessions can become a remnant of the past (fee for service). The entire management equation changes.