A Shift to A More Global Approach: Moving From Disease Management to Disease Prevention

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Disclosures

- Nothing to Disclose

A Change in the Health Care Landscape

- Global Focus on Reduction in CV Disease
  - Prevention
  - Secondary Prevention
- Health Care Reform in the US
  - Shifting Emphasis on Quality instead of Volume for Reimbursement
  - Totally changing the landscape
  - ACA-Put dollars towards preventative care
    - Making health care attainable

AMERICAN
COLLEGE *of*
CARDIOLOGY

4 STRATEGIC THEMES

Population Health

Purposeful Education

Member Value and Engagement

Transformation of Care

Globally

- Cardiovascular diseases number 1 cause of death around the world
- 1 in 3 deaths globally are as result of CVD
- Majority of premature heart disease and stroke is preventable
- In 2010 CVD cost $ 863 billion – this is estimated to rise by 22% to $ 1,044 billion by 2030

Institute for Health Metrics and Evaluation (IHME). The Global Burden of Diseases, Injuries and Risk Factors Study 2010 (GBD 2010). Generating Evidence, Guiding Policy Report
World Economic Forum, The Global Economic Burden of Non-communicable Diseases, Harvard School of Public Health, 2011
http://www.heart.org/HEARTORG/General/Heart-and-Stroke-Association- Statistics_UCM_319064_SubHomePage.jsp
http://www.cdc.gov/healthyschools/obesity/facts.htm

In the USA

- Non-communicable diseases, including CVD, account for 88% of total adult deaths in the USA
- CVDs account for ~ 31% of deaths
- Nearly 801,000 people in USA died from CVDs in 2013 =
  - 2,200 deaths every day, one every 40 seconds
- Direct and indirect costs for CVDs, including health expenditure and lost productivity, total more than $316.6 billion

In The US

- Some of the CVD related risks factors in adults in the USA are outlined below:
  - 19% of men and 15% of women are smokers
  - 9.2 litres of pure alcohol consumed per person
  - 18% have hypertension which can increase risk of MI, HF, kidney disease or CVA
  - 33% adults in the USA are obese

Did You Know?

- ~ 5,700 new cigarette smokers every day in 2013
- 6% of adolescents aged 12 to 17 report being current smokers
- 2014-2105 increase in adolescent use of e-cigarettes by 19%
- E-cigarette manufacturers must register with FDA by August 8, 2016, have 2additional yrs to apply to remain in the marketplace
- 500 brands and 7,700 flavors of e-cigarettes will remain on the market – before FDA is able to fully evaluate them.
- 80 million adults in USA have HTN; despite 75% using antihypertensive meds, ~54% have their condition controlled

Did You Know?

- 69% adults overweight/obese
- 30% adults in do no leisure time physical activity
- 32% children are overweight/obese
- ~24 million are overweight and 17 million (17%) are obese
- Number of overweight children ⇧x2

  Number of overweight adolescents 3 x > since 1980.

WORLD HEART FEDERATION

National Programs

- Million Hearts
- Million Veterans
- System Wide Programs

What is value-based care?

Value Based Care is a care model intended to at least partially link payments to patients' health outcomes and/or quality of care, unlike traditional fee-for-service care models.

What is "MACRA"?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

MACRA Goals

Through MACRA, HHS aims to:

- Offer **multiple pathways** with varying levels of risk and reward for providers to tie more of their payments to value.
- Over time, **expand the opportunities** for a broad range of providers to participate in APMs.
- **Minimize additional reporting burdens** for APM participants.
- **Promote understanding** of each physician's or practitioner's status with respect to MIPS and/or APMs.
- Support **multi-payer initiatives** and the development of APMs in Medicaid, Medicare Advantage, and other payer arrangements.

MIPS changes how Medicare links performance to payment

There are currently multiple individual **quality and value** programs for Medicare physicians and practitioners:

Physician Quality Reporting Program **(PQRS)**	Value-Based Payment Modifier	Medicare EHR Incentive Program

MACRA streamlines those programs into **MIPS**:

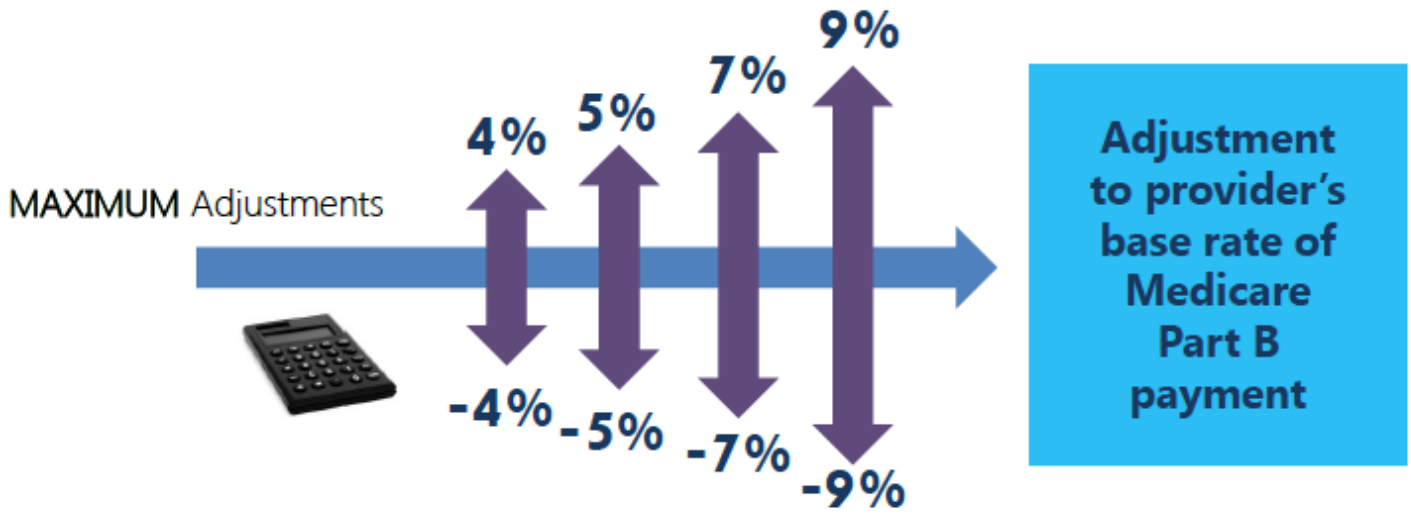
Merit-Based Incentive Payment System **(MIPS)**

How will physicians and practitioners be scored under MIPS?

A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:

How much can MIPS adjust payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments <u>up to</u> the percentages below.
- MIPS adjustments are **budget neutral**. A **scaling factor** may be applied to upward adjustments to make total upward and downward adjustments equal.



2019	2020	2021	2022 onward
Merit-Based Incentive Payment System **(MIPS)**			

Alternative Payment Models (APMs)

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value.**

According to MACRA law, APMs include:

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by Federal Law

- MACRA **does not change how any particular APM rewards value**.
- APM participants who are not "QPs" will receive **favorable scoring under MIPS**.
- Only **some** of these APMs will be **eligible** APMs.

How is it working in other practices?

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QUESTIONS?