

# Advanced Valve Centers: How will CMS Respond?

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# Conflicts of Interest

- Program Director of CMS/CMMI Support and Alignment 2.0 Federal Grant

# The US Healthcare System Does Have Regionalized Care

- Transplantation of solid organs
- Regionalization promoted and developed by professional societies, especially ISHLT
- CMS accepted those recommendations
- Volume based accreditation morphing into quality (14 down to 10, UNOS quality introduced)
- No differential payment except for geographic variation based on wage index

# How Do would the Advanced Valve Center Concept get approved by CMS

- Professional societies need to approach them with the ideas
  - transplant
  - TAVR NCD
- If you want the Advanced Valve center concept to be successful you must:
- Measure quality, costs and demonstrate value

# Advanced Valve Centers

- Provide convincing evidence that Medicare Beneficiaries will have better clinical outcomes including QOL
- Establish some easy metrics that CMS can track and enforce through Program Integrity
  - Volume
  - Quality from the preferred source (TVT registry)
  - costs

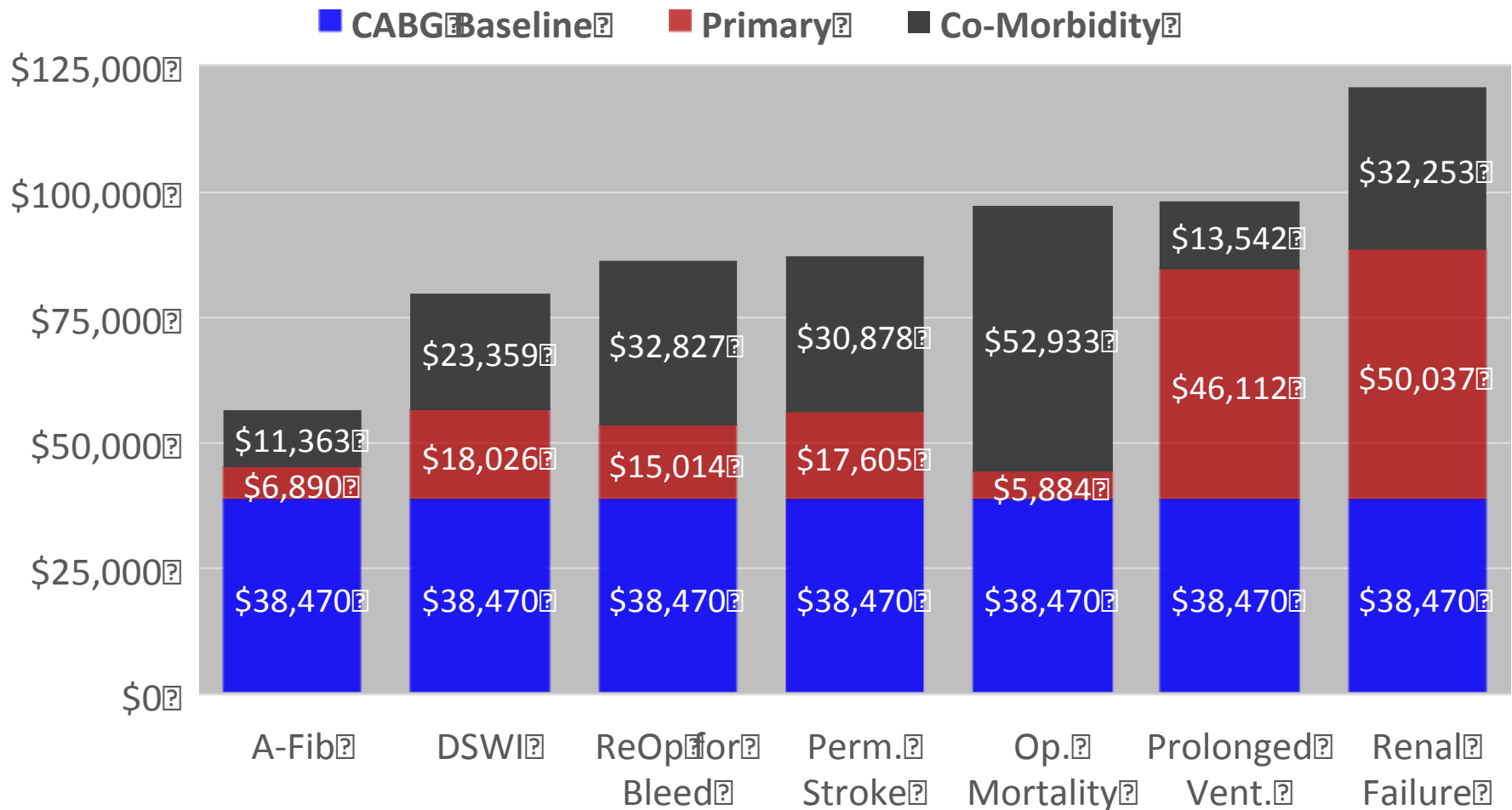
# Will CMS pay more for care at Advanced Valve Centers?

- Possibly
- Pathways include:
- 1) Advocate at the AMA Relative Value Scale Update Committee (RUC)
  - CMS does not have to accept these recommendations
- 2) Provide convincing data that clinicians involved with care at these centers have improved quality and lowered costs by reduction in costly complications and resource utilization
  - Argue that these intensified activities should be rewarded by higher fees or more likely: shared savings

# Payment Redesign

- The shared savings approach will not change the total of payments (Part A and Part B ) but will help the hospitals reduce costs/increase profits and allow surgeons/cardiologists to increase their fee up to 125% of Medicare allowable
- It will take at least two years to do as it is based on the fee-for-service architecture
- It will require retrospective reconciliation

# Additive Costs: Primary and Secondary Complications: (CABG only) 2011-2015; N=15,358





# Payment Redesign

- Alternatively, proposed that Advanced Valve Centers become involved in a mandatory bundle for valvular heart disease as treated in episodes of care
- This will be complicated due the number of different procedures and establishing pricing will be hard unless you limit the bundle to TAVR/AVR
- Pricing of the bundle will a challenge

# Mandatory CABG Bundle

- Across regions
- Includes all care from 30 days pre-op to 90 days post-op, including post acute care destination
- Transitioning to geographic pricing over 3 years

# Payment Redesign

- Differential payment for level 1 and 2
- This would take time
- CMS will need to collect several years of data to see if costs as compared to non AVCs are significantly
- The DRG payment could be renamed and payment adjustment made
- Remember, there are DRGs w/wo MCC

# Advanced Valve Center Payment

- Use the PROM to establish clinical risk corridors that define cost
- We have already done that in Virginia for AVR and MVR
- Clearly would place AVCs in higher payment category

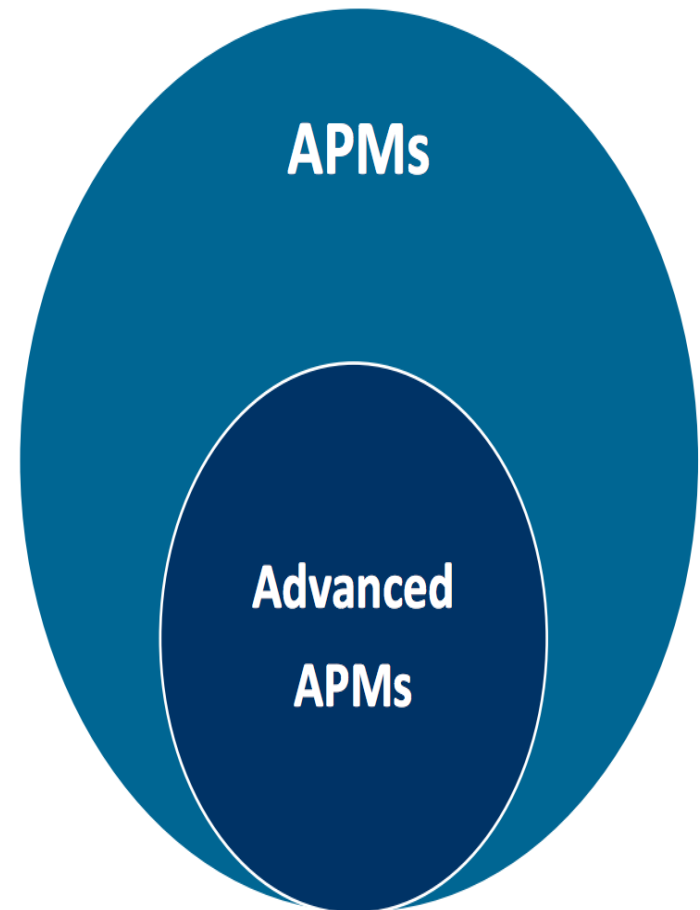
# Payment Redesign

- Mandate that all Advanced Valve Centers participate in an Advanced Alternative Payment Model (APM)
- Self designed by participants
- Reviewed by PTAC and possibly accept by CMS
- Much more favorable reimbursement than current fee for service and any bundle

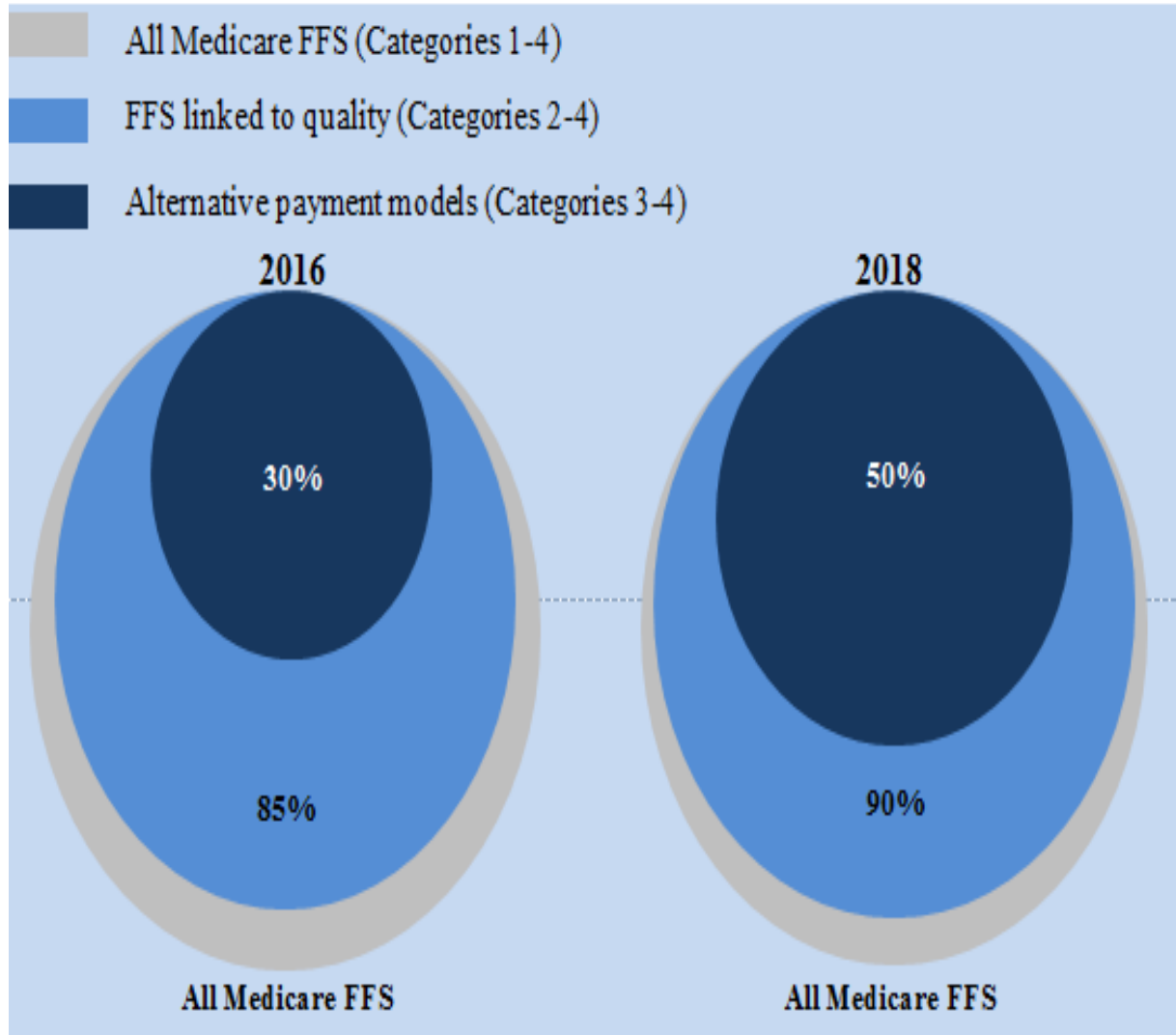
# Alternative Payment Models

- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.
- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.

Advanced APMs are a Subset of APMs



## Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



# The Quality Payment Program provides **additional** rewards for participating in APMs.

Potential financial rewards



Not in APM

MIPS adjustments

In APM

MIPS adjustments

+

APM-specific  
rewards

In **Advanced** APM

APM-specific  
rewards

+

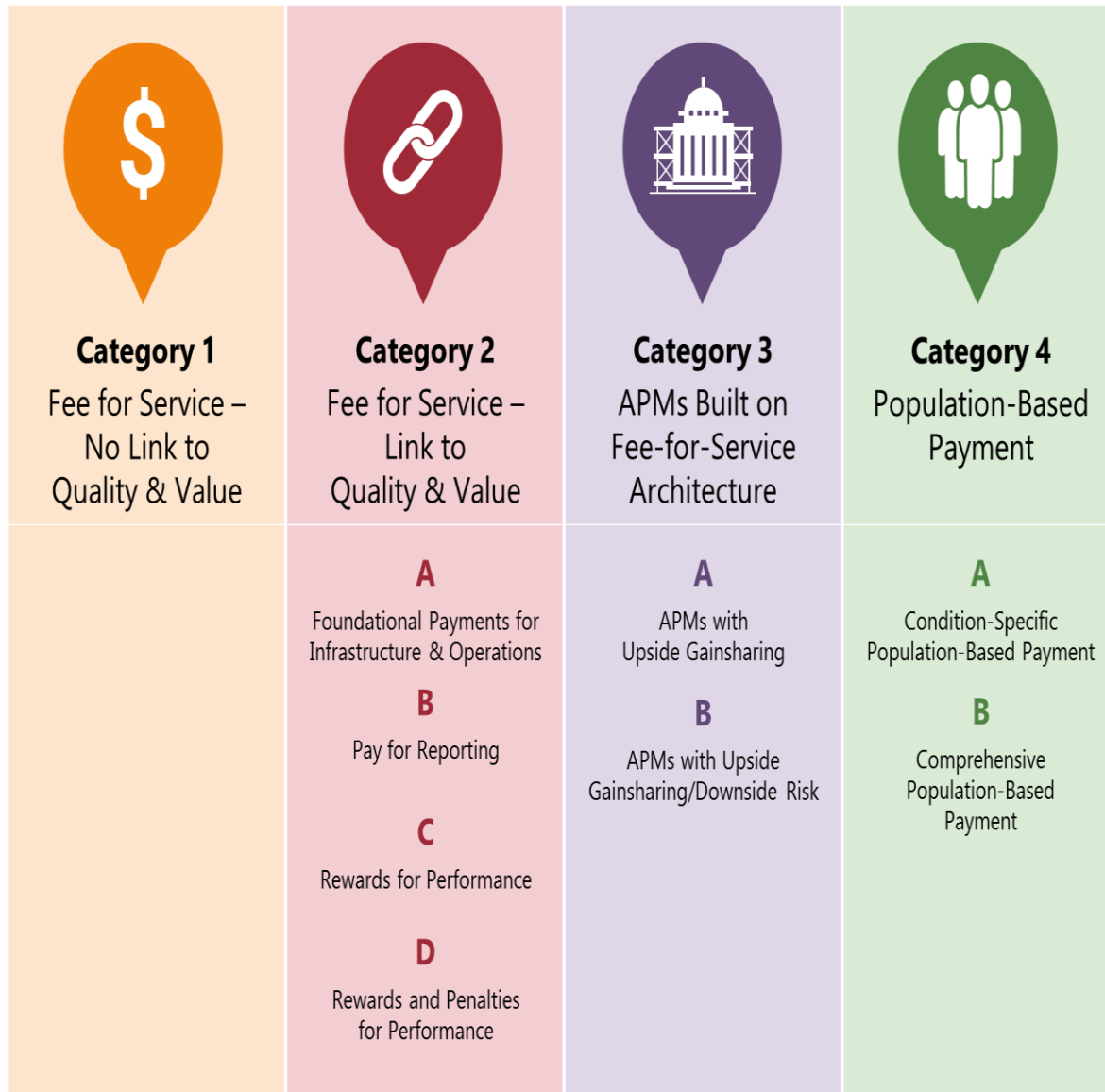
If you are a **Qualifying  
APM Participant  
(QP)**

=

5% lump sum  
bonus



# CMS APM Framework



# The Possible Future of Payments

- Population disease management
- Its already under conceptual design by HCP-LAN for ischemic heart disease
- Single annual payment for all care for all providers

# HCP-LAN APM Framework



## Category 1

Fee for Service –  
No Link to Quality & Value



## Category 2

Fee for Service –  
Link to Quality & Value



## Category 3

APMs Built on  
Fee-for-Service Architecture



## Category 4

Population-Based  
Payment

Fee-for-Service	A Foundational Payments for Infrastructure & Operations	B Pay for Reporting	C Rewards for Performance	D Rewards and Penalties for Performance	A APMs with Upside Gainsharing	B APMs with Upside Gainsharing/ Downside Risk	A Condition-Specific Population-Based Payment	B Comprehensive Population-Based Payment
Traditional FFS	Foundational payments to improve care delivery, such as care coordination fees, and payments for investments in HIT	Bonus payments for quality reporting	Bonus payments for quality performance	Bonus payments and penalties for quality performance	Bundled payment with upside risk only	Bundled payment with up- and downside risk	Population-based payments for specialty, condition, and facility-specific care (e.g., via an ACO, PCMH, or COE)	Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)
DRGs Not Linked To Quality		DRGs with rewards for quality reporting	DRGs with rewards for quality performance	DRGs with rewards and penalties for quality performance	Episode-based payments for procedure-based clinical episodes with shared savings only	Episode-based payments for procedure-based clinical episodes with shared savings and losses		
		FFS with rewards for quality reporting	FFS with rewards for quality performance	FFS with rewards and penalties for quality performance	Primary care PCMHs with shared savings only	Primary care PCMHs with shared savings and losses	Episode-based, population payments for clinical conditions, such as diabetes	Population-based payment for comprehensive pediatric or geriatric care
					Oncology COEs with shared savings only	Oncology COEs with shared savings and losses		
					3N Risk-based payments NOT linked to quality		4N Capitated payments NOT linked to quality	

■ = example payment models will not count toward APM goal.

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

# Payment Redesign

- Aortic stenosis and mitral regurg are absolute set-ups for this type of payment. Cardiology and Cardiac already working closely.
- PCPs would be pulled and share in the care of the patient and it may actually lead to more appropriate referrals
- This regulation is talked about but not on CMS radar

# CMS Mantra

- Better Care, Healthier People  
and Lower Costs