Advanced Valve Centers: How will CMS Respond?

American College Cardiology
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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

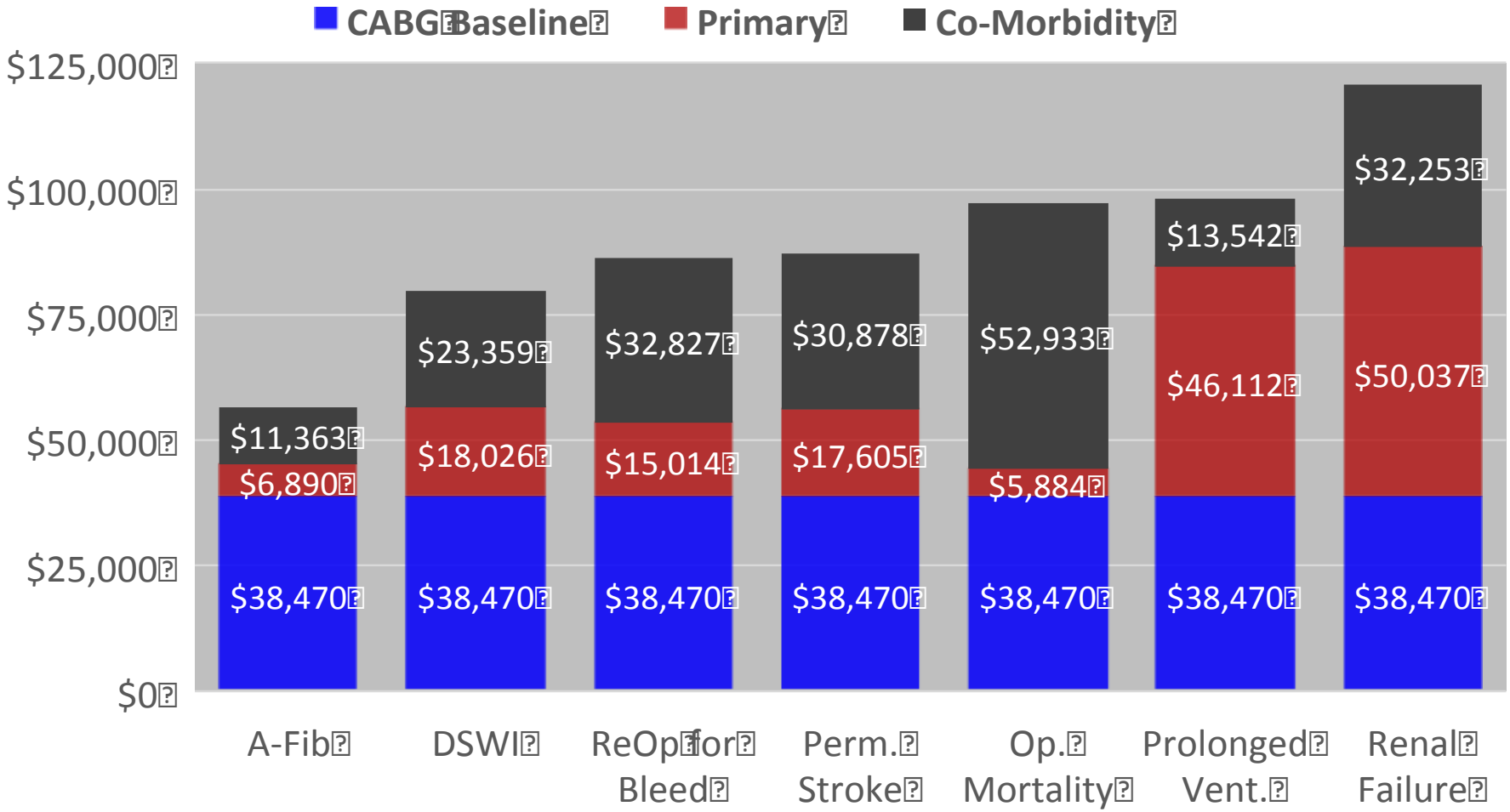
Will CMS pay more for care at Advanced Valve Centers?

- 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

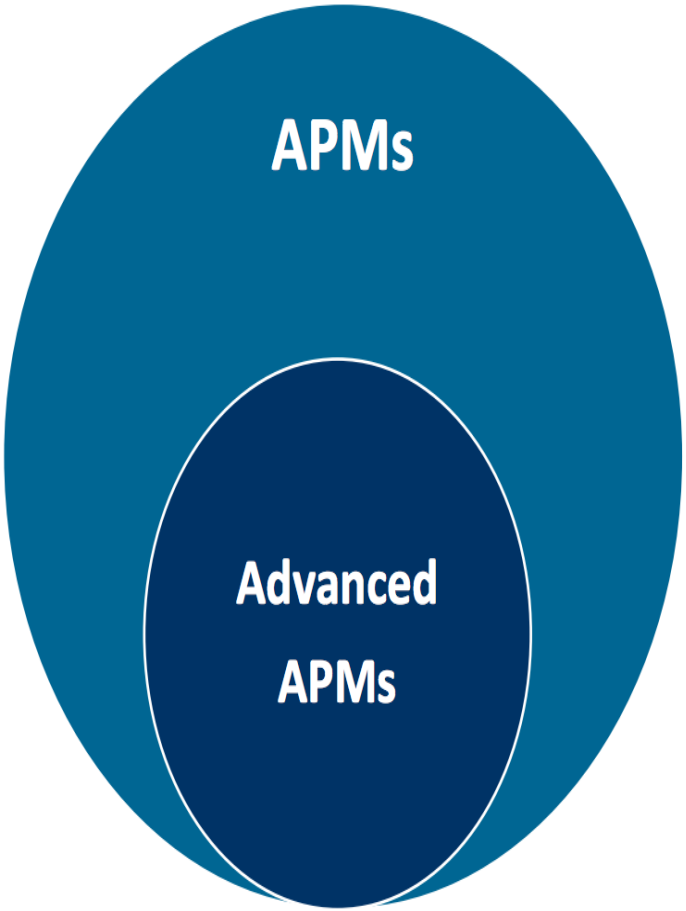
- Mandate that all Advanced Valve Centers participate in an Advanced Alternative Payment Model (APM)
- Self designed by participants
- Reviewed by PTAC and possibly accept by CMS
- Much more favorable reimbursement than current fee for service and any bundle

Alternative Payment Models

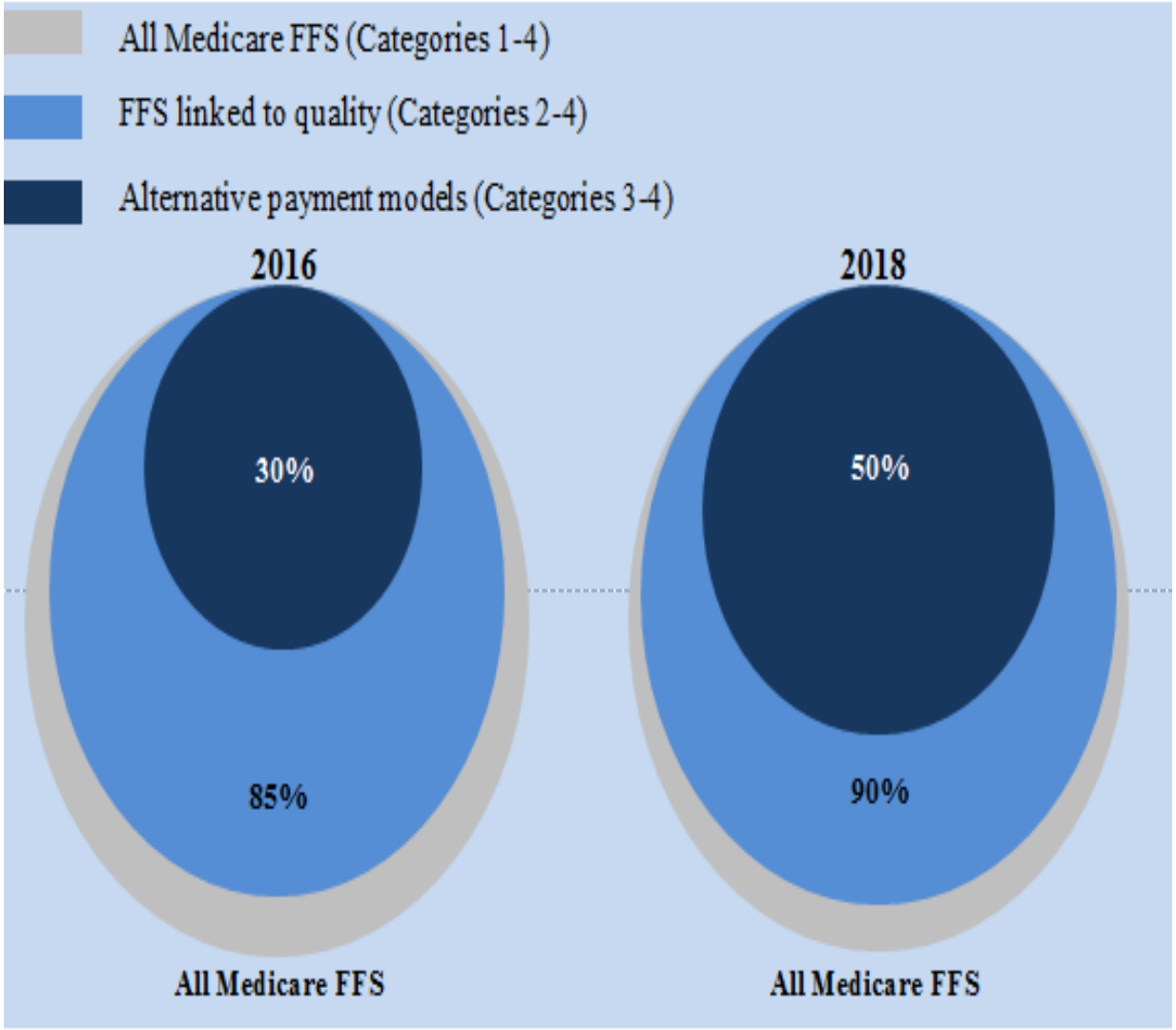
- An Alternative Payment Model (APM) is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- 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.

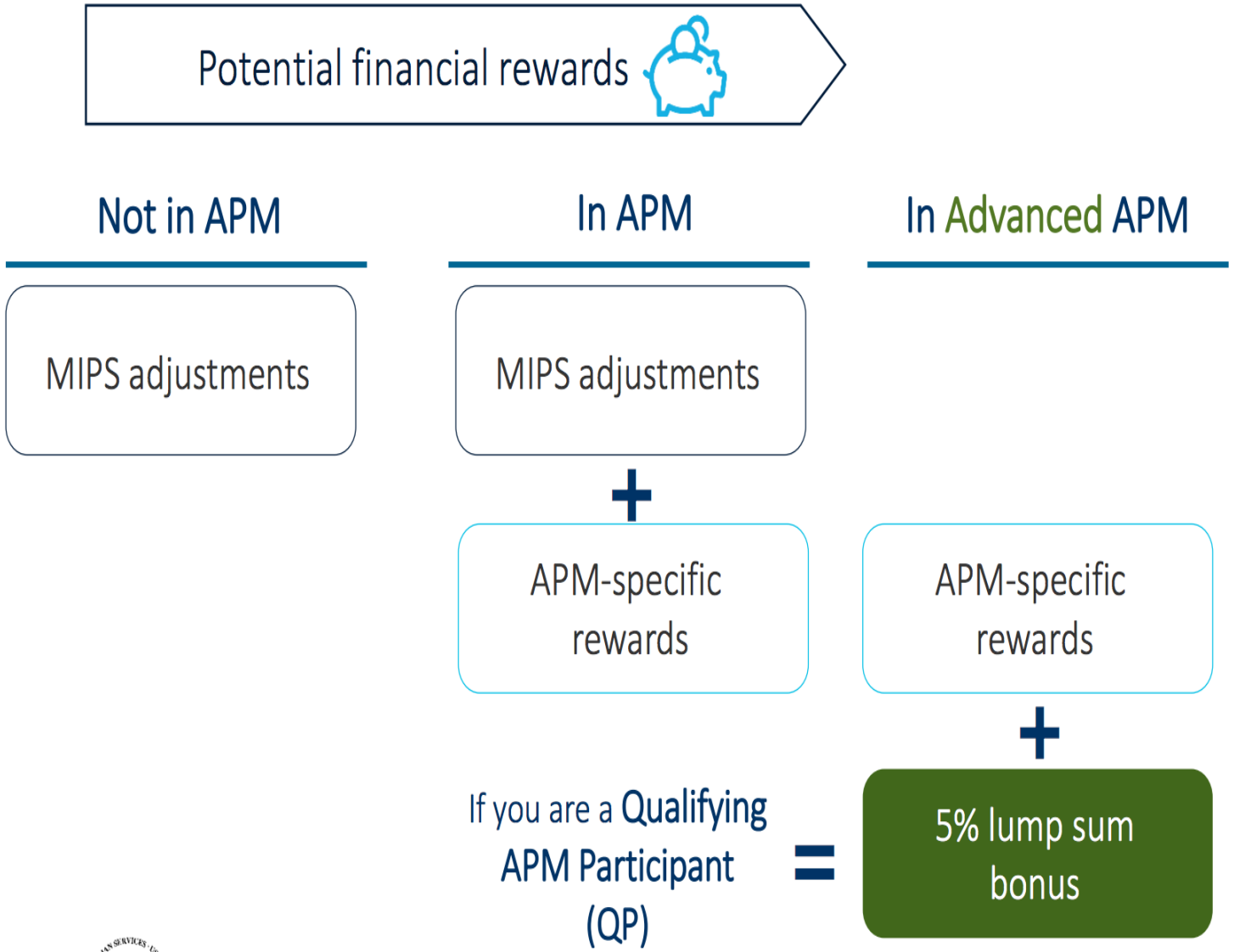
Advanced APMs are a Subset of APMs



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.



CMS APM Framework

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

- **A** Foundational Payments for Infrastructure & Operations
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance

Category 3

APMs Built on Fee-for-Service Architecture

- **A** APMs with Upside Gainsharing
- **B** APMs with Upside Gainsharing/Downside Risk

Category 4

Population-Based Payment

- **A** Condition-Specific Population-Based Payment
- **B** Comprehensive Population-Based Payment

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

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