Who is Going to Pay for Expensive Vascular Care as the US Shifts from Obamacare (The ACA) to Whatever is Next: Are Alternative Payment Plans an Answer

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With Symposium 2017

Disclosures

- Consultant:
  - PQ Bypass, Biomet, Spectranetics, Endologix
  - VIVA Physicians, Board Member

- Research Studies:
  - Cordis, Trivascular, Bard, Gore, Bolton Medical, Endologix

Obamacare - 2009

- 2009 Patient Protection and Affordable Care Act (ACA)
  - Mandated quality reporting
  - Expansion Medicaid
  - Mandated insurance coverage
  - Elimination of preexisting conditions for insurance coverage
  - Created a Patient-Centered Outcomes Research Institute (PCORI)
    - Conduct CER research
    - Prohibited institute developing or using cost-per-QALY thresholds

Governmental Policy

- American Recovery and Reinvestment Act of 2009 mandated
  - "meaningful use" of electronic medical records (EMR) in order to maintain their existing Medicaid and Medicare reimbursement levels
- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
  - Best Known for repealing SGR
  - Making a new framework for rewarding health care providers for giving better care not more just more care. Combining our existing quality reporting programs into one new system.
  - Merit-Based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)

How CMS will move the field

- Merit-Based Incentive Payment System (MIPS)
  - Combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-Based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one program that Eligible Professionals (EPs) will be measured on: Quality, Resource use, Clinical practice improvement, Meaningful use of certified EHR technology

- MIPS eligible professionals 2019 & 2020

- Applies to individual EPs, groups of EPs or virtual groups
  - Physicians
  - Physician Assistants
  - Certified Registered Nurse Anesthetists
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Groups that include such professionals

Quality & Risk Not Going Away

- Payment Reform Marches On

With MACRA’s implementation

- Bilingual Support Guidelines
- Continued Implementation

2017 MIPS Reporting Structure

- Disclosures report all MIPS submissions for all years of MACRA implementation:
  - 2014-2015
  - 2016
  - 2017

- Disclosures are required only for those who achieve or exceed the performance threshold.
- Disclosures are required for all MIPS reporting systems.
- Disclosures are required or those who receive a positive adjustment or negative adjustment to payment.
How to Qualify as APM

• Requires significant share of revenue in contracts with two-sided risk, quality measurement and EHR requirements
• APM track participants would be exempt from MIPS payment adjustments and would qualify for a 5 percent Medicare Part B incentive payment in 2019-2024
• A practice would have to demonstrate that a substantial portion of their total payments comes from the APM.

APM Models

• Accountable care organization (ACO)
• Patient-centered medical home (PCMH)
  - PCMHs are required to accept financial risk, but would have to demonstrate to Medicare that they can improve quality without increasing costs, or lower costs without harming quality
• Condition-specific bundled payments

CMS Changes Bundles

• On August 15, 2017, CMS displayed a notice of proposed rulemaking in the federal register which announces proposed changes to the Episode Payment Models (EPMs), Cardiac Rehabilitation (CR) Incentive Payment Model, and Comprehensive Care for Joint Replacement Model (CJR).
  - We are proposing to cancel the EPMs and the CR incentive payment model established by the Center for Medicare and Medicaid Innovation (Innovation Center) under the authority of section 1115A of the Social Security Act (the Act) and to rescind the regulations at 42 CFR part 512.

CMS Cancels CABG Bundles

• CMS sent a proposed rule to the Office of Management and Budget last week. The title of the rule indicated CMS would cancel mandatory bundled payment initiatives for heart attacks, bypass surgery and hip and femur fractures. Details on the changes were revealed Tuesday when the proposed rule was made public.

CMS Delays Mandatory Joint Replacement Bundled Payment Model Expansion

• In addition, the interim rule will postpone, from July 1 to Oct. 1, the expansion of CMS’ Comprehensive Care for Joint Replacement (CJR) Model.
• The mandatory payment model, which launched in April 2016, currently applies to 800 hospitals located in 67 U.S. regions that bill Medicare for hip and knee replacements. Under the expansion, hospitals in those 67 regions would receive retrospective bundled payments related to surgical hip/femur fracture treatment and recovery, under the Surgical Hip and Femur Fracture Treatment Model.

Conclusions

• Cost evaluation & quality scrutiny: here to stay
• Expensive procedures and high spend areas will come under scrutiny first
• MIPS and APMs will require increased reporting
• ACOs will come with upside and downside risks
• The form may change but will not go away