Cardiovascular Summit

Alternative Payment Models for Cardiology

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2021: Avoiding Medicare Cuts, Building the Case for Value-Based Care

- ACC and its members called for stability within the current system. Congress passed the ***Protecting Medicare and American Farmers from Sequester Cuts Act***, avoiding devastating cuts to Medicare payments that were set to take effect January 1.

- ACC continued its critical work to advance value-based care, consistently interfacing with policymakers and convening the ***third annual Value-Based Care in Cardiology Forum***.

December Patch: A Short-Term Fix

Through May 2022

- **Six-month partial reprieve from the 2% Medicare sequester**. This reduction would be paid for with an increase in the 2030 sequester.

Through Dec. 31, 2022

- **One year +3% adjustment** to the Medicare Physician Fee Schedule Conversion factor, offsetting a scheduled -3.75% reduction
- **Reprieve from the statutory PAYGO 4% Medicare cut**, pushed to 2023

Shortcomings of MACRA and QPP, combined with ongoing PFS pain have created SGR 2.0 environment

ACC's Message to Congress

"As Congress begins the complex process of identifying and considering potential long-term reforms, we must also create stability by addressing the immediate payment cuts facing health care professionals."

Current Value Questions

What is the role of specialists in population health models (e.g., ACOs)?

What should the future of specialty-specific models look like?

Key Payment Models

Medicare Shared Savings Program (MSSP ACO)

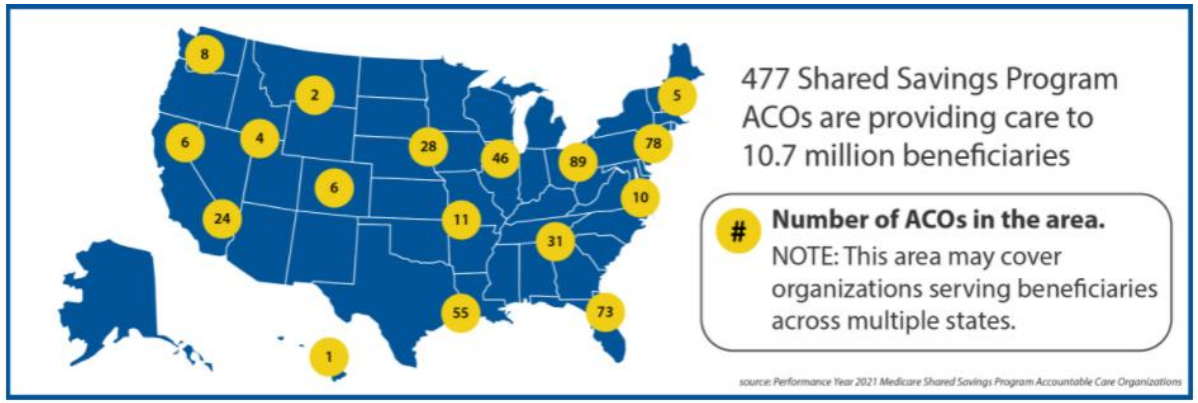
Bundled Payments for Care Improvement Advanced (BPCI-A)

Medicare Shared Savings Program

- Started with 32 Pioneer ACOs in 2012

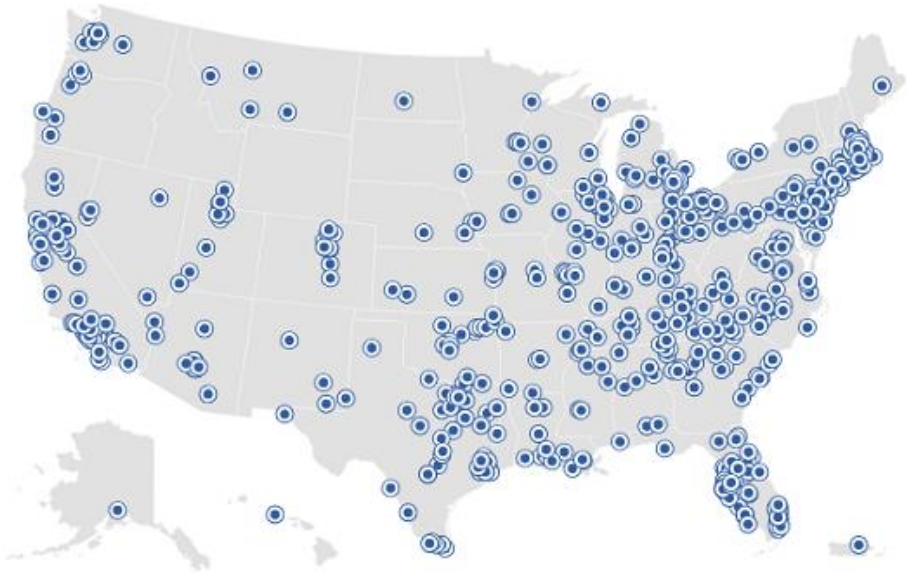
- Pathways to Success
  - BASIC: Glide path to increased financial risk
  - ENHANCED: highest risk/reward

- 2019 Performance
  - $1.19 billion net savings to Medicare
  - Nearly all met quality benchmarks



Bundled Payments for Care Improvement Advanced

- Oct 2018 – Dec 2023 (2 cohorts)
- Voluntary retrospective payment for all items and services in a 90-day episode
  - Trigger: Procedure or admission
- As of Jan. 2021
  - 33% of eligible hospitals and 1,116 Physician Group Practices
  - 23% of eligible BPCI-A discharges
  - 24% of eligible clinicians



Source: Centers for Medicare & Medicaid Services

NET MEDICARE SPENDING

Despite hospitals reducing average episode payments in seven out of 13 clinical episodes analyzed over the first 10 months, after accounting for reconciliation payments made to participants, Medicare experienced estimated net losses under BPCI Advanced.

Clinical Episode	Decline in FFS Payments	Reconciliation Payments	Net Savings to Medicare	Percent Savings
Congestive Heart Failure	$14,971,891 *	$80,043,888	($65,071,997) *	-6.1%
Sepsis	$48,524,675 *	$105,962,104	($57,437,429) *	-2.8%
SPRI	$1,153,440	$28,984,998	($27,831,558) *	-4.4%
Stroke	$12,730,868 *	$24,434,484	($11,703,616) *	-2.2%
Renal failure	$2,108,594	$12,074,252	($9,965,658) *	-3.0%
COPD, Bronchitis, Asthma	$8,608,719 *	$18,390,596	($9,781,877) *	-2.6%
Cardiac Arrhythmia	$3,423,815	$11,897,536	($8,473,721) *	-2.9%
Acute Myocardial Infarction	$3,042,421	$7,449,651	($4,407,230)	-1.7%
Gastrointestinal Hemorrhage	($545,092)	$2,141,134	($2,686,226)	-1.7%
PCI (Outpatient)	$1,531,004	$677,957	$853,047	1.2%
Hip & Femur Procedures	$10,364,908 *	$4,429,872	$5,935,036 *	2.2%
Urinary Tract Infection	$12,796,218 *	$2,988,315	$9,807,903 *	2.9%
MJRLE	$15,933,866 *	($6,215,108)	$22,148,974 *	6.2%

Percent savings is calculated as a percent of baseline Medicare payments. FFS=fee-for-service; SPRI=simple pneumonia and respiratory infections; COPD=chronic obstructive pulmonary disease; PCI=percutaneous coronary intervention; Hip & Femur=hip and femur procedures except major joint; MJRLE=major joint replacement of the lower extremity. * indicates statistical significance, $p < 0.10$.

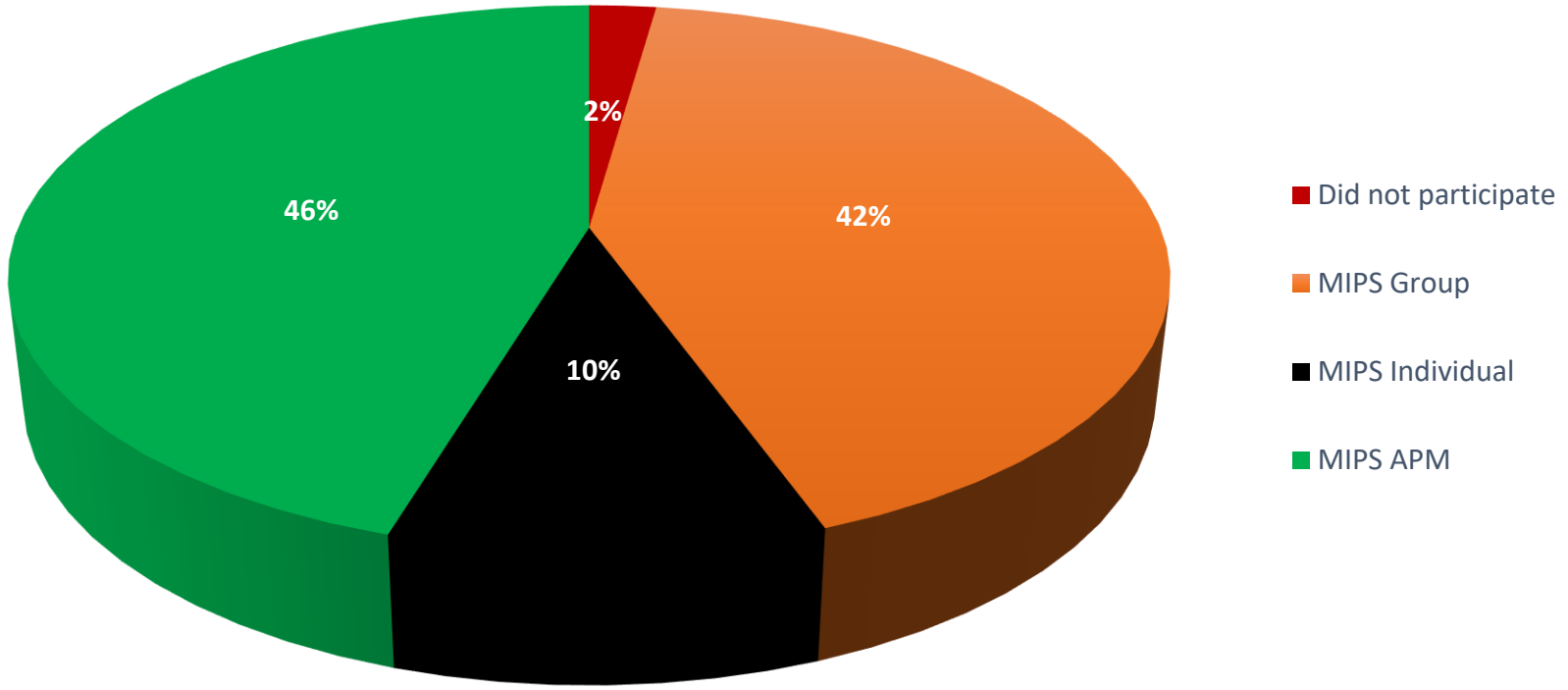
*BPCI Advanced Second Annual Evaluation Report (CMMI)

Landscape Takeaways

- ACOs most successful at generating savings
  - Primary-care focus can create a challenge to engaging cardiologists
- BPCI-A provides participant experience, but Medicare is losing money
  - Service line and mandatory models needed to eliminate selection bias

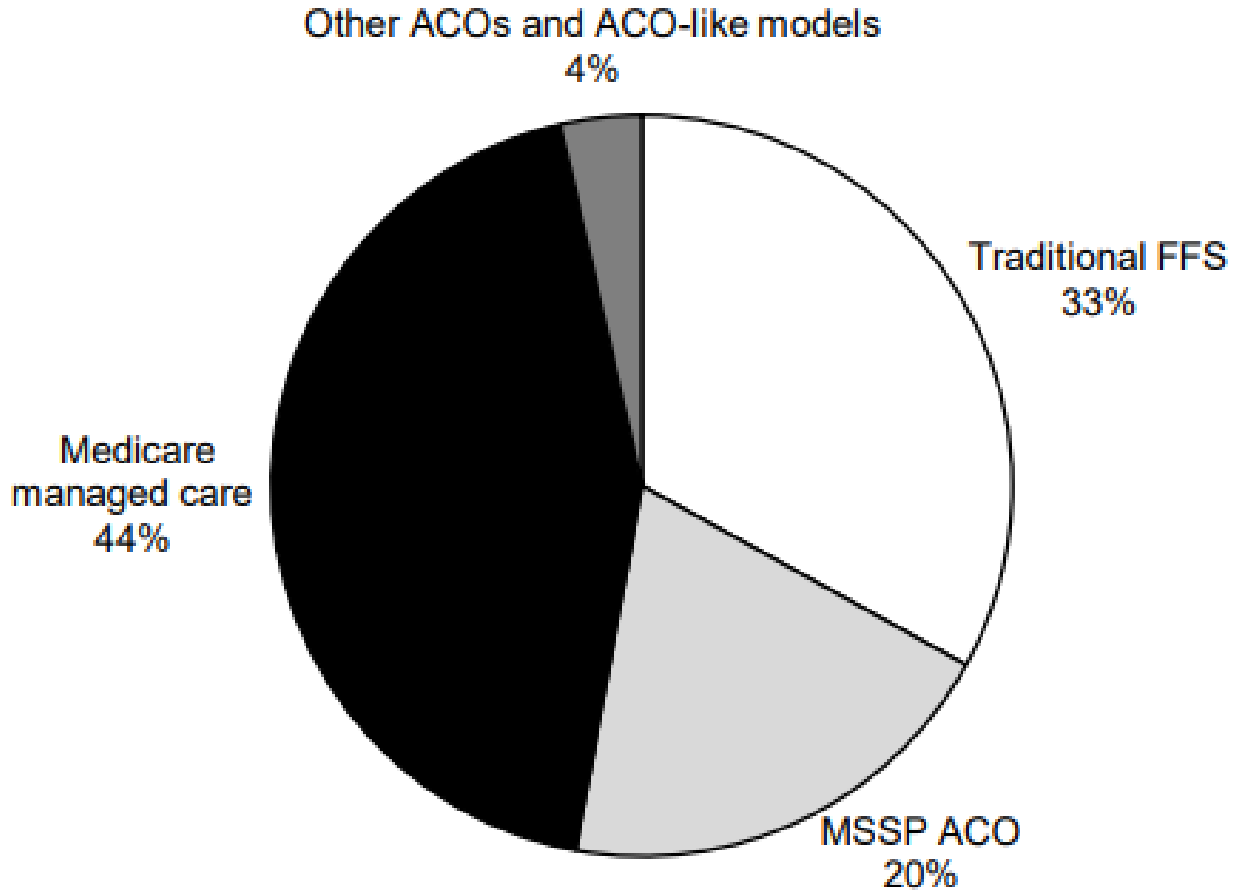
2018 Quality Payment Program Experience Report

31,602 Eligible Cardiologists*



* By designation, Internal Medicine, APPs excluded

2020: Most Medicare beneficiaries in Medicare managed care plans or ACOs



Source: MedPAC Report – July 2020

Impact of the Pandemic

Weaknesses of Fee-for-Service

Need for policies/models to support virtual care

Unknown impact of COVID/delayed care on outcomes

Need for model flexibility to support sustainable participation

Increased focus on addressing social factors of health inequity

CMMI's Evolving Visio

- Streamline the number of models
  - Align across payers
- Mandatory models likely
  - Needed to eliminate selection bias
- Focus on health equity, transparency, and quality metrics that matter to the patient

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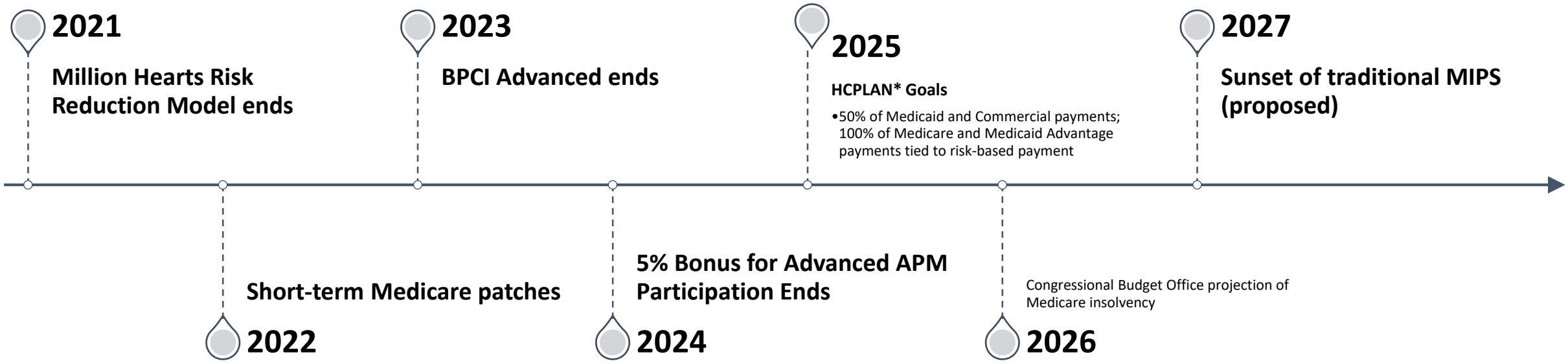
Looking toward the Next 10 Years



*HCPLAN: The Healthcare Payment Learning and Action Network is comprised of public and private stakeholders mainly representing payers and purchasers, that creates education and aligned goals toward value-based care