Piecing Together the MACRA Puzzle: How the ACC and NCOR will Help Members Navigate Radical Changes Ahead

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Disclosures

Senior Medical Officer, NCDR
Message to Clinicians: Prepare for the Future

Don’t Get Caught Sleeping on the Tracks
The Bridge to Nowhere
Choluteca Bridge, Honduras
What is Your Value & Worth?

The answer is not monetary, but what is your value and worth to...

1. Your Patients
2. Your Peers
3. Your Hospital System
4. The Payer(s)
5. The Government

We will be graded by them all.
Your data will be critical to your success—real and perceived.
Clinician Self-Awareness
5 Realities over next 5 Years

1. Know your **Personal Data!!!**
2. Certainty of Transparency & Public Reporting
3. Accountability for Patient & Peer Satisfaction
4. Accountability for Efficiency and Cost-Savings
5. Accountability for Demonstration of Value
MACRA

Merit Incentive Based Payment (MIPS)

Alternative Payment Models (APMs)

Bundled Payments

Core Quality Measures Collaborative

CV Quality Measures
>2,500 hospitals
>5,700 cardiologists
>60 million clinical records
<table>
<thead>
<tr>
<th>Name</th>
<th>Disease or Device</th>
<th>Facility</th>
<th>Sites</th>
<th>Patient Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>PINNACLE</td>
<td>Coronary artery disease, heart failure, atrial fibrillation, hypertension, diabetes, peripheral arterial disease</td>
<td>Outpatient</td>
<td>445</td>
<td>35,000,000</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes and cardiometabolic care</td>
<td>Outpatient</td>
<td>329</td>
<td>1,000,000</td>
</tr>
<tr>
<td>CathPCI</td>
<td>Percutaneous coronary interventions Diagnostic catheterizations</td>
<td>Hospital/Free Standing</td>
<td>1,730</td>
<td>20,000,000</td>
</tr>
<tr>
<td>ICD</td>
<td>Implantable cardioverter defibrillators</td>
<td>Hospital</td>
<td>1,815</td>
<td>2,000,000</td>
</tr>
<tr>
<td>ACTION-GWTG</td>
<td>Acute coronary syndrome STEMI and NSTEMI</td>
<td>Hospital/EMS</td>
<td>1030</td>
<td>1,200,000</td>
</tr>
<tr>
<td>PVI</td>
<td>Carotid artery revascularization Lower extremity</td>
<td>Hospital/Free Standing</td>
<td>214</td>
<td>350,000 (CAS &amp; CEA)</td>
</tr>
<tr>
<td>IMPACT</td>
<td>Congenital heart disease Pediatric and Adult</td>
<td>Hospital</td>
<td>100</td>
<td>70,000</td>
</tr>
<tr>
<td>STS/ACCTVT</td>
<td>Transcatheter Valve Therapy</td>
<td>Hospital</td>
<td>470</td>
<td>75,000</td>
</tr>
<tr>
<td>LAAO</td>
<td>Left atrial appendage occlusion procedures</td>
<td>Hospital</td>
<td>159</td>
<td>1,500</td>
</tr>
<tr>
<td>AF Ablation</td>
<td>AF ablation procedures</td>
<td>Hospital</td>
<td>41</td>
<td>1,500</td>
</tr>
</tbody>
</table>
Clinical Registries
Not Just _Data_

Clinical data
(standardized data elements and definitions)

Database

Other data sources
(administrative, electronic health record, etc).

Quality Improvement

Clinical Research

Technology Assessment

Meaningful Role in Clinical Practice / U.S. Healthcare Reform

J Am Coll Cardiol; October 2015
Involvement in the NCDR such as PINNACLE allows clinicians to submit Physician Quality Reporting System to CMS. Additional NCDR-related practice improvement programs are being developed to leverage NCDR registries to make it easier for the 21,881 unique providers to successfully engage MACRA.
QCDR (CMS) certified registries: PINNACLE & Diabetes Collaborative Registry and hopefully CATHPCI coming year.
GAPS: ICD, PVI and ACTION
2019 MIPS Composite Weighting

**Advancing Care Information**
- Security Risk Analysis
- E-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care
- Bonus: Registry Reporting

**Clinical Practice Improvement**
- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM

**Quality**
- Most PQRS measures
- QCDR (non-MIPS) measures
- Bonus: “High-priority measures”
  - Outcome, appropriate use, patient safety, efficiency, patient experience, care coordination

**Resource Use** (0%) will be incorporated into MIPS score (10%) in 2018 performance period
Quality (60%)

Full Credit
• 6 quality measures, including 1 outcome measure or one specialty measure set
• Points will be allocated based on performance against prior year benchmarks
• QC DRs approved for group and individual level reporting

Can use MIPS and also non-MIPS measures from NCDR QCDR (CMS) certified and non-certified registries

Bonus Points

High Priority Measures collected in NCDR Registries:
- Outcomes and AUC
- GAPS: PROMS-SAQ, Cost data

MIPS APM participants will report the quality measure requirements of their program
Advancing Care Information (25%)

Full Credit

• Report 5 required measures for at least 90 days

Bonus Points

• Submit up to 9 additional measures for at least 90 days
  – Clinical Data Registry Reporting

Required Measures

- Security Risk Analysis
- E-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Bonus Points for QCDR Reporting

PINNACLE, Diabetes, next year CathPCI

Gaps: ICD, ACTION, PVI
Clinical Practice Improvement Activities
A Key Component of MIPS

Advancing Care Information
- Security Risk Analysis
- E-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/ Accept Summary of Care
- Bonus: Registry Reporting

Clinical Practice Improvement Activities
- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM

Quality
- Most PQRS measures
- QCDR (non-MIPS) measures
- Bonus: “High-priority measures”
  - Outcome, appropriate use, patient safety, efficiency, patient experience, care coordination

Resource Use (0%) will be incorporated into MIPS score (10%) in 2018 performance period
Clinical Practice Improvement (15%)

**Full Credit**
- 4 medium-weighted activities or 2 high-weighted activities
- At least 90 days of participation in each activity

**Bonus Points**
- None

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<table>
<thead>
<tr>
<th>Activity</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in MOC Part IV</td>
<td>Medium</td>
</tr>
<tr>
<td>Participation in CMMI Models such as the Million Hearts Risk Reduction Model</td>
<td>Medium</td>
</tr>
<tr>
<td>Use of QCPR data for ongoing practice assessment and improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Use of decision support and standardized treatment protocols</td>
<td>Medium</td>
</tr>
</tbody>
</table>

**A Strength of ACC and NCDR!!**

Development of Mobile APP
Clinical Practice Improvement Activities
A Mobile New Approach

Data Driven
Leverage ACC’s 8 inpatient and 2 outpatient registries to select areas for improvement
Registries provide ability to track performance overtime

Flexible Structure
Flexible coaching format that allows participant to construct an improvement activity to align with local goals and objectives rather than overly directive
Guided self-assessment of goal achievement and personal engagement allow participant to reflect on skills and knowledge gained, and sustaining clinical practice gains for patient care

Integrated
Incorporate ACC’s evidence-based strategies and toolkits and promote best practice sharing
Programs include: Door2Balloon, Hospital-to-Home, SurvivingMI, ACC Patient Navigator

Mobile
Access data and participate in clinical practice improvement activities in a mobile environment
Mobile
App Offering Overview

- **See My Data**: Clinicians can access their dashboard to track and compare their performance to national benchmarks and identify care gaps and areas of strength.

- **Choose My Improvement**: Convenient access to the ACC’s quality interventions as well as self-guided programs that allow clinicians to leverage insights and NCDR data in a self-guided clinical practice improvement activity. Provides access to a survey question instrument to provide reflection on QI activities.

- **Know My Progress**: See a summary of current quality improvement activities, data review history, and status on all MOC activity: licensure, lifelong learning/self-assessment, board certification and practice self-assessment.

- **Submit My Activities**: Choose to have the ACC automatically submit clinical practice improvement activities based on NCDR data to multiple accrediting boards and receive email confirming participation.

- **Get My Alerts**: Provides new data notifications, MOC reminders, when there is an opportunity for an MOC activity, when a practice has claimed you as a physician as well as other helpful reminders.

- **Learn More**: Provides helpful resources for clinicians including MOC, reimbursement, quality improvement and PQRS reporting information.

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Program components via a convenient, streamlined app as well as online within acc.org

- Performance based on ACC registry participation (e.g. PINNACLE, CathPCI, ICD).
- Dashboard provide all metrics as well as recommended metric sets.
Data Driven
“See My Data”

Select Group of Metrics to Review

Save Metrics to Review and Track

Compare Performance to National Benchmarks

Prototype displayed, actual product may vary
Data Driven
“See My Data”

Compare specific benchmarks to national averages

Prototype displayed, actual product may vary
Flexible, yet Structured
“My Clinical Practice Assessment”

Describe problem you improved

Identify QI methodology

Prototype displayed, actual product may vary
Flexible, yet Structured

“My Clinical Practice Assessment”

Evaluate practice assessment activities

Prototype displayed, actual product may vary
Integrated Future Releases

Clinical Toolkits

H2H
HOSPITAL-TO-HOME

D2B
DOOR-TO-BALLOON

ACC Patient Navigator Program

Surviving MI

Quality Improvement
AN ACC CLINICAL TOOLKIT

SOCIETY OF CARDIOVASCULAR PATIENT CARE
INSTITUTE OF THE AMERICAN COLLEGE OF CARDIOLOGY

AMERICAN COLLEGE OF CARDIOLOGY
Member Survey: Clinical Practice Improvement App

• Do users understand the value proposition?
  – Yes, users very enthusiastic about having an easy to use tool for managing this task, which they were not anxious to have to added to their workload

• Can users use the tools on the tool as intended?
  – Does the product help users identify opportunities for CPIAs, create evidence, and track compliance with MACRA?
    • Users want help with defining a practice improvement activity and understanding the types of evidence that would apply.
  – Does App navigation work with minimal error/recovery?
    – It appears to… not thoroughly tested as the prototype was not interactive.

• Do users think the tool has useful content?
  – Users really liked NCDR data on their phone and said they would look at NCDR data more often

• What are areas of confusion or frustration?
  – What would constitute a practice improvement activity and how a photograph would document it.
Variation in the Use of PCI - Why?

Source: Dartmouth Atlas of Health Care; 2010 CMS Data on Medicare beneficiaries
Bloomberg News: September 26, 2013

Helping Cardiovascular Professionals
Figure 1. Geographic Variation in Elective PCI, California, 2005–2009

Note: This is a static representation of a portion of the data that can be seen on an interactive map at: www.chcf.org.
Moses Delivering
The AUC Tablets
### Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were appropriate

<table>
<thead>
<tr>
<th></th>
<th>My Hospital</th>
<th>US Hospitals 50th Pctl</th>
<th>US Hospitals 90th Pctl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion</td>
<td>20.35%</td>
<td>47.62%</td>
<td>75.05%</td>
</tr>
</tbody>
</table>

Proportion of PCI procedures that were evaluated as "Appropriate", among patients without ACS, meaning coronary revascularization is generally acceptable and is a reasonable approach for the indication and is likely to improve the patients' health outcomes or survival. [Detail Line:1585]

### Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were of uncertain appropriateness

<table>
<thead>
<tr>
<th></th>
<th>My Hospital</th>
<th>US Hospitals 50th Pctl</th>
<th>US Hospitals 90th Pctl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion</td>
<td>46.90%</td>
<td>33.39%</td>
<td>55.35%</td>
</tr>
</tbody>
</table>

Proportion of PCI procedures that were evaluated as "Uncertain", among patients without ACS, meaning coronary revascularization may be acceptable and may be a reasonable approach for the indication. However, some degree of uncertainty exists, implying that more research and/or patient information is needed to determine whether the procedure would improve patients' health outcomes or survival. [Detail Line:1586]

### Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate

<table>
<thead>
<tr>
<th></th>
<th>My Hospital</th>
<th>US Hospitals 50th Pctl</th>
<th>US Hospitals 90th Pctl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion</td>
<td>32.74%</td>
<td>14.95%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Proportion of PCI procedures that were evaluated as "Inappropriate", among patients without ACS, meaning coronary revascularization is not generally acceptable and is not a reasonable approach for the indication and is unlikely to improve the patients' health outcomes or survival. [Detail Line:1587]
Top Reasons for which CAD Revascularization is Rarely Appropriate

1. Asymptomatic with 1 or 2 vessel disease
   • No or minimal anti-ischemic mediations
   • Low or intermediate risk findings on noninvasive study

2. Asymptomatic with 1 or 2 vessel disease
   • Maximal anti-ischemic medications
   • Low risk findings on noninvasive study

3. CCS Class I or II with 1 or 2 vessel disease
   • No or minimal anti-ischemic mediations
   • Low risk findings on noninvasive study
Appropriateness of Percutaneous Coronary Intervention

Paul S. Chan, MD, MSc
Manesh R. Patel, MD
Lloyd W. Klein, MD
Ronald J. Krone, MD
Gregory J. Dehmer, MD
Kevin Kennedy, MS
Brahmajee Nallamotu, MD, MPH
W. Douglas Weaver, MD
Frederick A. Masoudi, MD, MSPH
John S. Rumsfeld, MD, PhD
Ralph G. Brindis, MD, MPH
John A. Spertus, MD, MPH

APPROXIMATELY 600,000 PER-CUTANEOUS CORONARY INTERVENTIONS (PCIs) ARE PERFORMED IN THE UNITED STATES EACH YEAR, at a cost that exceeds $12 billion. Patients who undergo PCI are exposed to risks of peri-procedural complications and longer-term bleeding and stent thrombosis. Moreover, recent trials in stable patients without acute coronary syndromes have shown that PCI, compared with medical therapy, may provide only a modest population-average improvement in symptom relief. Given the cost and

500,154 PCIs from 1091 hospitals

Design, Setting, and Patients Multicenter, prospective study of patients within the National Cardiovascular Data Registry undergoing PCI between July 1, 2009, and September 30, 2010, at 1091 US hospitals. The appropriateness of PCI was adjudicated using the appropriate use criteria for coronary revascularization. Results were stratified by whether the procedure was performed for an acute (ST-segment elevation myocardial infarction, non-ST-segment elevation myocardial infarction, or unstable angina with high-risk features) or nonacute indication.

Main Outcome Measures Proportion of acute and nonacute PCIs classified as appropriate, uncertain, or inappropriate; extent of hospital-level variation in inappropriate procedures.

Results Of 500,154 PCIs, 355,417 (71.1%) were for acute indications (ST-segment elevation myocardial infarction, 103,245 [20.6%]; non-ST-segment elevation myocardial infarction, 105,708 [21.1%]; high-risk unstable angina, 146,464 [29.3%]), and 144,737 (28.9%) for nonacute indications. For acute indications, 350,469 PCIs (98.6%) were classified as appropriate, 1,055 (0.3%) as uncertain, and 3,893 (1.1%) as inappropriate. For nonacute indications, 72,911 PCIs (50.4%) were classified as appropriate, 54,988 (38.0%) as uncertain, and 16,838 (11.6%) as inappropriate. The majority of inappropriate PCIs for nonacute indications were performed in patients with no angina (53.8%), low-risk ischemia on noninvasive stress testing (71.6%), or suboptimal (≤1 medication) antianginal therapy (95.8%). Furthermore, although variation in the proportion of inappropriate PCI across hospitals was minimal for acute procedures, there was substantial hospital variation for nonacute procedures (median hospital rate for inappropriate PCI, 10.8%; interquartile range, 6.0%-16.7%).

Conclusions In this large contemporary US cohort, nearly all acute PCIs were classified as appropriate. For nonacute indications, however, 12% were classified as inappropriate, with substantial variation across hospitals.

Chan PS et al. JAMA 2011;306:53-61
Hospital Variation in Non-Acute PCI Inappropriateness

Overall 11.6% Inappropriate

Chan, PS, et.al
“ Appropriateness of PCI”
Appropriate Use Criteria for Coronary Revascularization and Trends in Utilization, Patient Selection, and Appropriateness of Percutaneous Coronary Intervention

NR Desai and coauthors

Available at jama.com and on The JAMA Network Reader at mobile.jamanetwork.com
Study Population

Percutaneous coronary interventions between July 1, 2009 and December 31, 2014 submitted to NCDR CathPCI Registry (n=3,604,365; 1561 hospitals)

Exclusions
- Hospital did not participate in NCDR CathPCI registry over the entire study period (n=550,836; 583 hospitals)
- Hospital with an average of fewer than 10 non-acute PCIs per year (n=273,167; 212 hospitals)
- Second PCI if multiple PCIs in a single visit (n=94,679)

Final Study Cohort (n=2,685,683; 766 hospitals)
### Trends in Indication for PCI

<table>
<thead>
<tr>
<th>PCI indication / Year</th>
<th>Overall</th>
<th>2009*</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, n</td>
<td>2,685,683</td>
<td>243,580</td>
<td>538,076</td>
<td>502,995</td>
<td>481,889</td>
<td>462,636</td>
<td>456,507</td>
</tr>
<tr>
<td>Acute, n (%)</td>
<td>2,047,853 (76.3)</td>
<td>168,366 (69.1)</td>
<td>377,540 (70.2)</td>
<td>373,423 (74.2)</td>
<td>380,331 (78.9)</td>
<td>373,650 (80.8)</td>
<td>374,543 (82.0)</td>
</tr>
<tr>
<td>Non-acute, n (%)</td>
<td>397,737 (14.8)</td>
<td>41,024 (16.8)</td>
<td>89,704 (16.7)</td>
<td>78,328 (15.6)</td>
<td>66,849 (13.9)</td>
<td>62,457 (13.5)</td>
<td>59,375 (13.0)</td>
</tr>
<tr>
<td>Non-mappable n (%)</td>
<td>240,093 (8.9)</td>
<td>34,190 (14.0)</td>
<td>70,832 (13.2)</td>
<td>51,244 (10.2)</td>
<td>34,709 (7.2)</td>
<td>26,529 (5.7)</td>
<td>22,589 (4.9)</td>
</tr>
</tbody>
</table>

*Includes 6-months of data (July 1 to December 31, 2009)
## Baseline Characteristics Among Patients Undergoing Non-acute PCI

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>2010 #</th>
<th>2014 #</th>
<th>Absolute Change from 2014-2010 #</th>
<th>2010 %</th>
<th>2014 %</th>
<th>Absolute Change from 2014-2010 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>89,704</td>
<td>59,375</td>
<td>-30,329</td>
<td>22.6</td>
<td>14.9</td>
<td>-7.7</td>
</tr>
<tr>
<td><strong>Angina</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No symptoms</td>
<td>26,313</td>
<td>12,890</td>
<td>-13,423</td>
<td>29.3</td>
<td>21.7</td>
<td>-7.6</td>
</tr>
<tr>
<td>CCS I or II</td>
<td>47,710</td>
<td>23,689</td>
<td>-24,021</td>
<td>53.2</td>
<td>39.9</td>
<td>-13.3</td>
</tr>
<tr>
<td>CCS III or IV</td>
<td>15,681</td>
<td>22,796</td>
<td>+7,115</td>
<td>17.4</td>
<td>38.4</td>
<td>+21.0</td>
</tr>
<tr>
<td><strong>No. of antianginal medications</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>27,076</td>
<td>11,521</td>
<td>-15,555</td>
<td>30.2</td>
<td>19.4</td>
<td>-10.8</td>
</tr>
<tr>
<td>1</td>
<td>42,610</td>
<td>27,031</td>
<td>-15,579</td>
<td>47.5</td>
<td>45.5</td>
<td>-2.0</td>
</tr>
<tr>
<td>&gt;=2</td>
<td>20,011</td>
<td>20,816</td>
<td>+805</td>
<td>22.3</td>
<td>35.1</td>
<td>+12.8</td>
</tr>
<tr>
<td><strong>Stress test results (those with a test)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unavailable</td>
<td>10,328</td>
<td>4,708</td>
<td>-5,620</td>
<td>18.4</td>
<td>11.2</td>
<td>-7.2</td>
</tr>
<tr>
<td>Low or intermediate risk</td>
<td>33,468</td>
<td>23,475</td>
<td>-9,993</td>
<td>59.5</td>
<td>55.6</td>
<td>-3.9</td>
</tr>
<tr>
<td>High risk</td>
<td>12,460</td>
<td>14,018</td>
<td>+1,558</td>
<td>22.2</td>
<td>33.2</td>
<td>+11.0</td>
</tr>
<tr>
<td>Multi-vessel CAD on angiography</td>
<td>39,231</td>
<td>28,192</td>
<td>-11,039</td>
<td>43.7</td>
<td>47.5</td>
<td>+3.8</td>
</tr>
</tbody>
</table>

Helping Cardiovascular Professionals
Patient-level Trends in Appropriateness of Non-acute PCI

Non-acute PCIs, %

Year

2009*  2010  2011  2012  2013  2014

43.7  43.6  42.5  43  50.2  53.6

30.1  32.1  36.5  39.4  35  33

26.2  24.3  21  17.6  14.9  13.3

*Includes July to December 2009

Helping Cardiovascular Professionals Learn. Advance. Heal.
Patient-level Trends in Appropriateness of Non-acute PCI

- **Appropriate**
- **Uncertain**
- **Inappropriate**

Non-acute PCIs, %

- **2009***: 43.7%
- **2010**: 43.6%
- **2011**: 42.5%
- **2012**: 43%
- **2013**: 50.2%
- **2014**: 53.6%

*Includes July to December 2009

50% relative reduction, p<0.001

[Helping Cardiovascular Professionals Learn. Advance. Heal.]
### Hospital-level Trends in Inappropriate Non-acute PCIs

<table>
<thead>
<tr>
<th>Year</th>
<th>Median (IQR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009*</td>
<td>25.8 (16.7-37.1)</td>
</tr>
<tr>
<td>2010</td>
<td>24.3 (15.2-33.3)</td>
</tr>
<tr>
<td>2011</td>
<td>21.4 (13.3-30.7)</td>
</tr>
<tr>
<td>2012</td>
<td>17.0 (9.1-26.8)</td>
</tr>
<tr>
<td>2013</td>
<td>14.3 (6.3-24.4)</td>
</tr>
<tr>
<td>2014</td>
<td>12.6 (5.9-22.9)</td>
</tr>
</tbody>
</table>

*Includes July to December 2009
The train has left the station, and it ain’t coming back
The Privilege of Self-Regulation

The Role of Appropriate Use Criteria

Manesh R. Patel, MD,* Michael J. Wolk, MD,† Joseph M. Allen, MA,‡ Gregory J. Dehmer, MD,§ Ralph G. Brindis, MD, MPH‖

Durham, North Carolina; New York, New York; Washington, DC; Temple, Texas; and Oakland, California

“Although this sounds onerous, is it not better for us to impose these controls on ourselves than what is done currently by payers to control costs and procedures.”
SMARTCare: Smarter Management And Resource Use for Today’s Complex Care Delivery

Center for Medicare Medicaid Innovation
Project Grant

Florida Chapter
Wisconsin Chapter
American College of Cardiology
SMARTCare: Smarter Management And Resource Use for Today’s Complex Care Delivery

A collaborative effort sponsored by the American College of Cardiology to:

Improving the Outcomes of Medicine

☑ Appropriate Access to Care
☑ Improving Quality
☑ Reducing Cost and Enhancing Value

By Improving the Science of Medicine

☑ Evidence-based Guidelines
☑ Technology at the point-of-care
☑ State-of-the-Art Data Analytics

Reduce variation and cost while
• Improving the quality of care in patients with established or potential CAD
• Employing proven clinical software tools at the point of care
SMARTCare: Overview

Patient-Provider Encounter

Is A Stress Test Appropriate? FOCUS

Need For Cath? Shared Decision Tool
Cath Lab Shared Decision Tool ePRISM
Is Stenting Appropriate? Shared Decision Tool ePRISM eLUMEN

Continuous Feedback: Quality Reports

Overall Quality Assessment
Seattle Angina and Quality-of-Life Surveys
CV Risk Reduction IndiGO Pinnacle Registry

Procedure Quality
CMS Data and Metrics NCDR: CathPCI Registry
Expected Impact

- Decrease imaging not meeting AUC for 12-15% to <8%
- Decrease PCI not meeting AUC from 9-20% to <6%
- Reduce the average rate of bleeding and complications to less than 2%
- Improve patient quality of life (based on the patient surveys)
CMS Bundled Payments Proposed Model

- **Mandated bundled payments** for 3 episodes of care announced August 2, 2016
  - Acute MI
  - CABG
  - Hip or Femoral Fractures

- **5-year Demonstration Project** for increasing participation/retention in cardiac rehab post CABG & MI
  - Beginning July 2017 in 98 randomly selected areas
MACRA and Population Health Management

Preparing for a Value-Based Health Care System

Discusses the need to focus on Population Health Management and upcoming CV Bundled Payments
The Medicare Access and CHIP Reauthorization Act of 2015, commonly referred to as MACRA, introduces a new Medicare physician payment system called the Quality Payment Program (QPP).

The QPP is comprised of two pathways in which clinicians will participate in order to receive Medicare payment: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Most clinicians will participate in MIPS, which bundles the Physician Quality Reporting System, the Value Modifier and the Electronic Health Record (EHR) Incentive Program into one program. The Advanced APM track provides incentives for clinicians who participate in new payment models that incorporate financial risk.

Regardless of which pathway in which a clinician participates, he/she will be measured on four core components: quality, clinical practice improvement activities (CPIA), meaningful use of certified EHRs and resource use. Under the Advanced APM track, these elements are incorporated into the way a specific model is designed and assessed. Under MIPS, these components make up the categories that make up a clinician's or group's MIPS composite
Quality Payment Program Information
- Merit-Based Incentive Payment System
- MIPS: Clinical Practice Improvement
- MIPS: Resource Use
- Advanced Alternative Payment Models
- Advanced APM Overview

Articles

ACCAction

Education and Meetings
- 2017 Cardiovascular Summit

Resources

Videos
Message to Physicians

Don’t Get Caught Sleeping on the Tracks

• Be aware of the changing landscape
  – “You can run, but you can’t hide”
  – Sticking your head in the sand will not work

• Understand that this will affect your practice and how you are paid in the future

• Now is the time to get involved with your data
  – If you’re not at the table, you’re on the menu
“The right objective for health care is to increase value for patients, which is the quality of patient outcomes relative to the dollars expended.”

- Michael Porter