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2024 Top 10 Environmental Challenges Facing The CV Team

Cathleen Biga, MSN, FACC
Vice President, American College of Cardiology
President/CEO, Cardiovascular Management of Illinois

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Minneapolis Heart Institute Foundation

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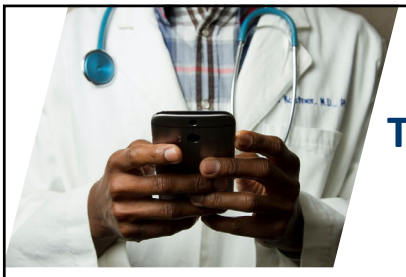

THERE ARE 7 FACTORS THAT WILL SHAPE THE INDUSTRY MOVING FORWARD

The 7 Cs of Health Care

1. ***Compression*** *of margins*
2. ***Contraction*** *of inpatient volume*
3. ***Changing care models***
4. ***Consolidation***
5. ***Consumerism***
6. ***Connectivity***
7. ***Competing on value***

- The health care industry of the future will be ***fundamentally different in how it is organized, how and where care is delivered, and how it is funded***
- There will likely be ***fewer hospitals and more access points*** (both physical and virtual). Of the hospitals that remain, they will have ***higher levels of acuity and be more specialized*** (with few "general" facilities)
- Technological advances will make the industry ***more personalized, more precise, and more predictive***

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Top 10 Environmental Trends

- Value-based care
- Team-based care
- Sub-specialty CV clinics
- Compression of hospital margins
- Site neutrality
- Rapidity of change in physician alignment
- Workforce shortage
- AI/Digital transformation
- Care delivery redesign
- Equity and access to care

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12 MAJOR TRENDS AND CHALLENGES

1. **Rising Healthcare Costs**
   Driven by Technology, Aging Pop, Inflation, Construction, and Chronic Diseases
2. **Scaling in Competitive Markets**
   Horizontal and Vertical Consolidation, Private Equity, Volume-Outcome Challenges
3. **Evolving Regulatory Landscape**
   Antitrust, Insurance Regulations, Privacy Laws, Price Transparency, Nonprofit Status, Cyber security and Data Protection Standards
4. **Workforce Shortages**
   Recruiting, Retaining, Skill Acquisition, Training, Turnover, Burn-out, Work-Life Balance
5. **Population Health Management**
   Preventive Care, Chronic Disease Management, SDoH, Care Coordination, and Community Engagement
6. **Value-Based Reimbursement Models**
   Shift from Volume to Value, Reimbursement Models, Quality Measurement, ACOs, Payor-Provider Integration
7. **Health Equity and DEI**
   Discrimination, Physical Environment, Workplace Conditions, Health Literacy, Food Insecurity, Homelessness, Wealth Gaps
8. **Patient Experience and Satisfaction**
   Patient-Centered Care, Communicating Expectations, Access, Wait Times, and Patient Outcomes
9. **Patient-Reported Outcomes and Shared Decision-Making**
   Considering Patient Preferences & Values in Treatment Decisions, Improved Satisfaction and Adherence
10. **Digital Technological Advancements**
    AI Solutions (Virtual Command Center), EHR, Scheduling Platforms, Telemedicine and Remote Monitoring
11. **Clinical Technological Advancements:** Personalized Medicine & Targeted Therapies
    Genetic Profiling, Molecular Diagnostics, Device-Intensive Interventions, Immunotherapies, 3D Imaging, Augmented Reality
12. **Collaborative Care Models**
    Interdisciplinary Care, Team-Based Approach, Enhanced Recovery After Surgery (ERAS) Protocols

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Value-Based Care

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Population

2022: 65M
2032: 82M

Medicare Advantage
Enrollment now exceeds 50%

As of September 2022, 65,103,807 people are enrolled in Medicare. This is an increase of 160,823 since the last report.

- 34,984,295 are enrolled in Original Medicare.
- 30,119,512 are enrolled in Medicare Advantage or other health plans. This includes enrollment in Medicare Advantage plans with and without prescription drug coverage.
- 50,574,579 are enrolled in Medicare Part D. This includes enrollment in stand-alone prescription drug plans as well as Medicare Advantage plans that offer prescription drug coverage.

2023: 65,748,297 enrolled in Medicare
30.8M in Medicare Advantage - $454B

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Circulation …. October 3, 2023

EDITORIAL

Value-Based Payment for Cardiovascular Care: Getting to the Heart of the Matter

Rishi K. Wadhera, MD, MPP, MPhil

The US health care system has undergone unprecedented payment transformation since the passage of the Affordable Care Act in 2010. Numerous value-based payment models have been launched by the Centers for Medicare & Medicaid Services (CMS) over the past decade, with the goal of reducing health care spending and improving quality of care. Cardiovascular disease has been a major focus of "value-based" payment reform

dial infarction, heart failure, or most other conditions over 3 years.[1,2] In addition, nearly 50% of participating hospitals eventually dropped out of the program.[3]

Building off the BPCI experience, BPCI-Advanced (BPCI-A) was launched in 2018 and differed from its predecessor in several ways. Most notably, target prices were set differently, quality measures (eg, readmissions) were incorporated into the program, and hospitals could

BPCI-A is on pace to **cost Medicare $2B**

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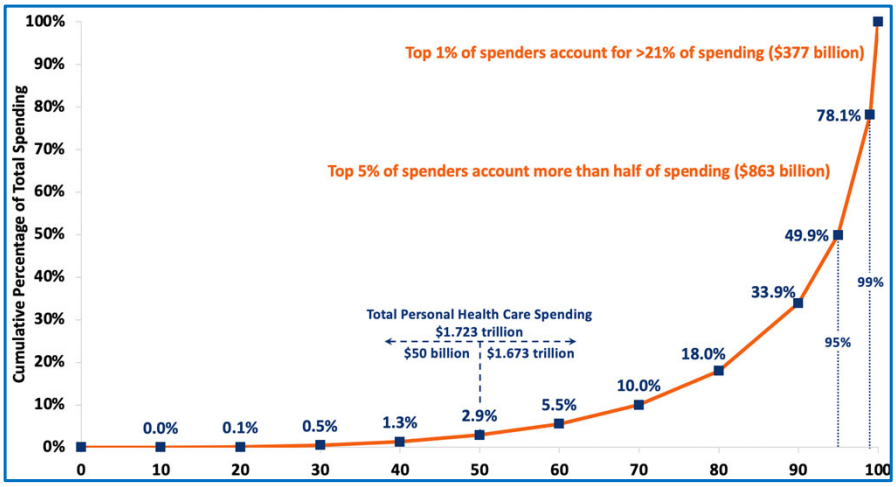
Did You Know?

1% of population
21% of spending

5% of population
>50% of spending



Source: AHRQ 2017

2023 MN: 1.1M in Medicare
640,000 in Medicare Advantage

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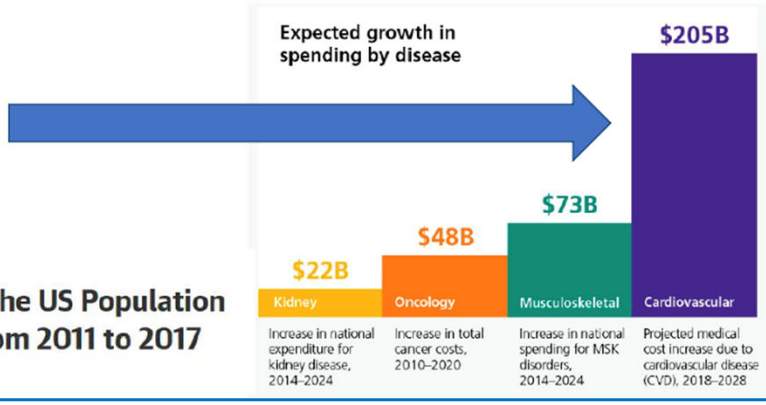
Cost of CVD Care

$320 B annually and growing



October 30, 2019

Association Between Aging of the US Population and Heart Disease Mortality From 2011 to 2017

Stephen Sidney, MD, MPH[1]; Alan S. Go, MD[1,2,3,4,5]; Marc G. Jaffe, MD[6]; et al

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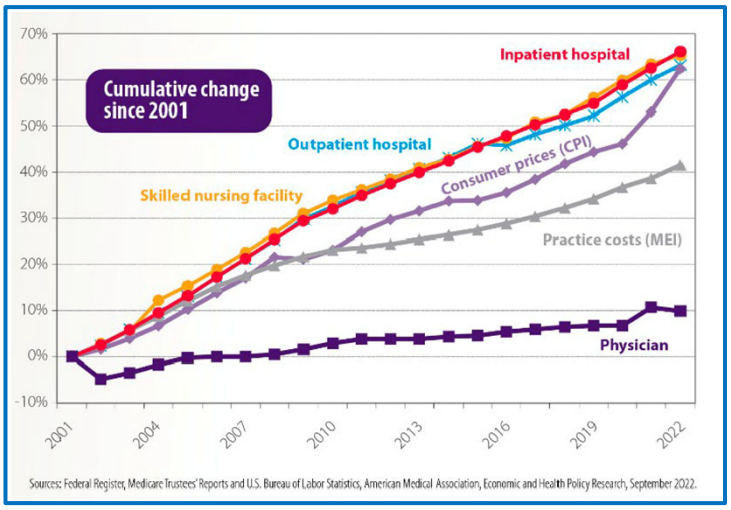
Did You Know?

According to an AMA analysis of the Medicare Trustee data, Medicare payments to clinicians have declined 22% from 2001-2021 (adjusted for inflation).



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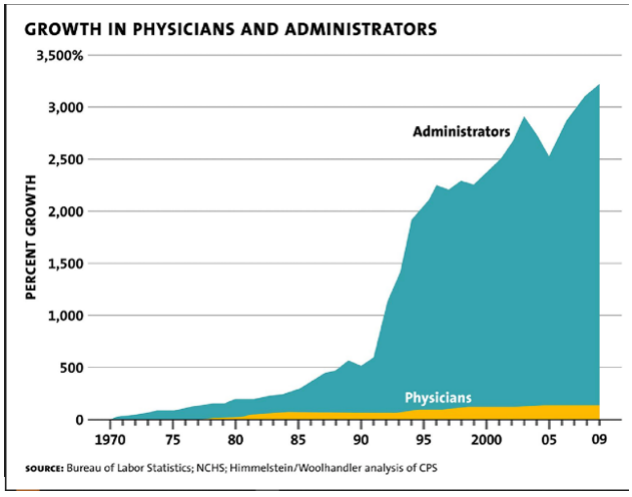

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CMS Innovation Center's Strategic Objectives

Five strategic objectives will guide the CMS Innovation Center's implementation of its vision.

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Aug. 1 Release from CMMI

Drive Accountable Care

- **Aim:** *Increase the number of beneficiaries in a care relationship with accountability for quality and total cost of care.*
- Accountable care reduces fragmentation in patient care and cost by giving providers the incentives and tools to deliver high-quality, coordinated, team-based care. Models should increase the number of beneficiaries in accountable care relationships with providers, such as advanced primary care providers and ACOs. Quality of care and outcome measures should be measures that matter and include patient values and perspective.

Measuring Progress:

- ***All Medicare*** fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

Advance Health Equity

- **Aim:** *Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.*

We have heard that CMMI plans to release a proposed rule soon after the completion of this RFI

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Value…….

- BPCI-A is on pace to COST Medicare …….. $2B
- Medicare vs Medicare Advantage
  - Almost 2300 diagnoses previously mapping to an HCC - like chronic angina and protein-calorie malnutrition – no longer will.
  - This move from HCC v24 > HCC v28 is **projected to save $11B in 2024 alone**.

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10/20/23

AHA POLICY STATEMENT

Value-Based Payment for Clinicians Treating Cardiovascular Disease: A Policy Statement From the American Heart Association

Alexander T. Sandhu, MD, MS, Vice Chair; Paul A. Heidenreich, MD, MS, FAHA, Chair; William Borden, MD, FAHA; Steven A. Farmer, MD, PhD; P. Michael Ho, MD, PhD, FAHA; Gmerice Hammond, MD, MPH; Janay C. Johnson, MPH, CHES; Rishi K. Wadhera, MD, MPP, MPhil; Jason H. Wasfy, MD, MPhil; Cathie Biga, MSN; Edwin Takahashi, MD; Khamal D. Misra, MSN; Karen E. Joynt Maddox, MD, MPH, FAHA, Vice Chair; on behalf of the American Heart Association Advocacy Coordinating Committee

ABSTRACT: Clinician payment is transitioning from fee-for-service to value-based payment, with reimbursement tied to health care quality and cost. However, the overarching goals of value-based payment—to improve health care quality, lower costs, or both—have been largely unmet. This policy statement reviews the current state of value-based payment and provides recommended best practices for future design and implementation. The policy statement is divided into sections that detail different aspects of value-based payment: (1) key program design features (patient population, quality measurement, cost measurement, and risk adjustment), (2) the role of equity during design and evaluation, (3) adjustment of payment, and (4) program implementation and evaluation. Each section introduces the topic, describes important considerations, and lists examples from existing programs. Each section includes recommended best practices for future program design. The policy statement highlights 4 key themes for successful value-based payment. First, programs should carefully weigh the incentives between lowering cost and improving quality of care and ensure that there is adequate focus on quality of care. Second, the expansion of value-based payment should be a tool for improving equity, which is central to quality of care and should be a focal point of program design and evaluation. Third, value-based payment should continue to move away from fee for service toward more flexible funding that allows clinicians to focus resources on the interventions that best help patients. Last, successful programs should find ways to channel clinicians' intrinsic motivation to improve their performance and the care for their patients. These principles should guide the future development of clinician value-based payment models.

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ACC's Value Based Forum – 11/30/23

- CMMI Director – Dr. Fowler – presented an update
- Mandatory Hospital focused episode models coming
  - Will be presented Spring 2024 – w 2026 as target
- Using knowledge gained from BPCI-A
- How successful will this be?
  - Won't be the first time CMMI has proposed
  - Congressional oversight

Current CV Groupings

- **Cardiac Care**
  - Acute Myocardial Infarction (AMI)
  - Cardiac Arrhythmia
  - Congestive Heart Failure
- **Cardiac Procedures**
  - Cardiac Defibrillator (Inpatient)
  - Cardiac Defibrillator (Outpatient)
  - Cardiac Valve
  - Coronary Artery Bypass Graft (CABG)
  - Endovascular Cardiac Valve Replacement
  - Pacemaker
  - Percutaneous Coronary Intervention (PCI - Inpatient)
  - Percutaneous Coronary Intervention (PCI - Outpatient)

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You are the people you've been waiting for

Leadership:

- **Not making a decision is a decision**
- **Cultivate a culture where experimentation is rewarded**
- **Embracing uncertainty brings about agility**
- **Never say no…..never say yes unless you are sure you will complete "it"**

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Benefits of team-based care

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- Effective team dynamics can improve patient care coordination between physician colleagues[6]
- Team-based care can improve patient perception of confidence in care, care quality and coordination[7]
- Team-based care is fundamental in evidence-based models of care delivery that show improved outcomes for patients
- Effective teams associated with lower burn-out and increased satisfaction scores for physicians and staff[3,4]
- Good team dynamics can increase physician work satisfaction

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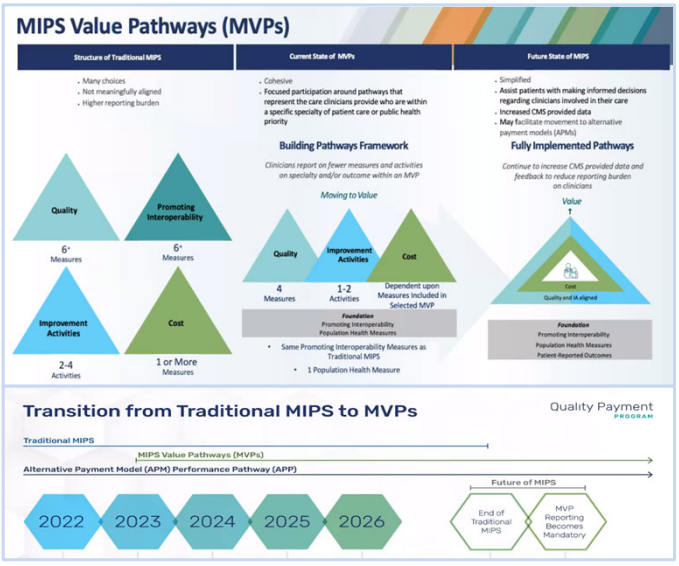
Team-Based Care

Traditional MIPS slated to convert to mandatory MVPs
After 2026

2024: based on 2022 Performance
75 Points (vs 82) – 9% penalty



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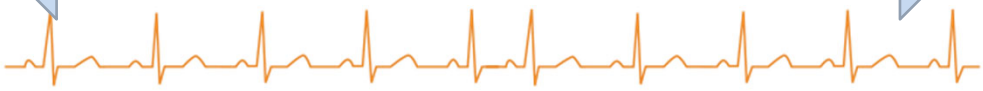
Care Organized Across The Continuum

Horizontal CV Care Stream Across Traditional Vertical Structures



Cardiovascular services organized the way patients experience them.

Consolidated Strategy – Budget – Operations - Management

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Sub-Specialty Clinics

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- AFib
- Cardio-Onc
- Cardio–OB
- Pulmonary HTN
- Cardio-metabolic
- HF/AHF
- Remote Monitoring/RPM/Device

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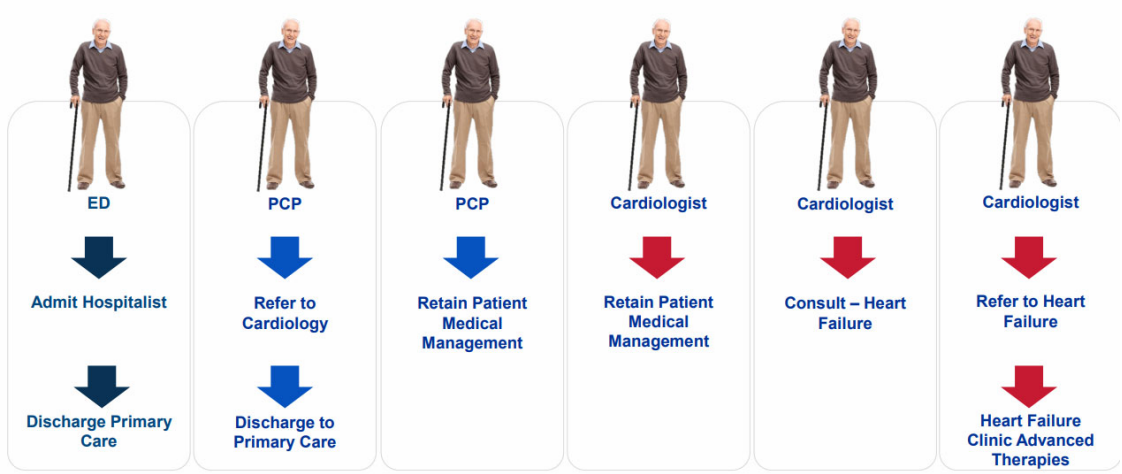
Goal: Patient access points for HF



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Reality…..

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THE SOLUTION…
MEDAXIOM
AN ACC COMPANY
Development of Alignment and Navigation to create order
CARE PLAN ACROSS CONTINUUM
Primary Clinic
HF Clinic
Other Specialty Clinics
E.D.
Transitional Care Clinic
Home Care
SNF
Engaged Patient
ORGANIZED SYSTEM TO MEET DEMANDS
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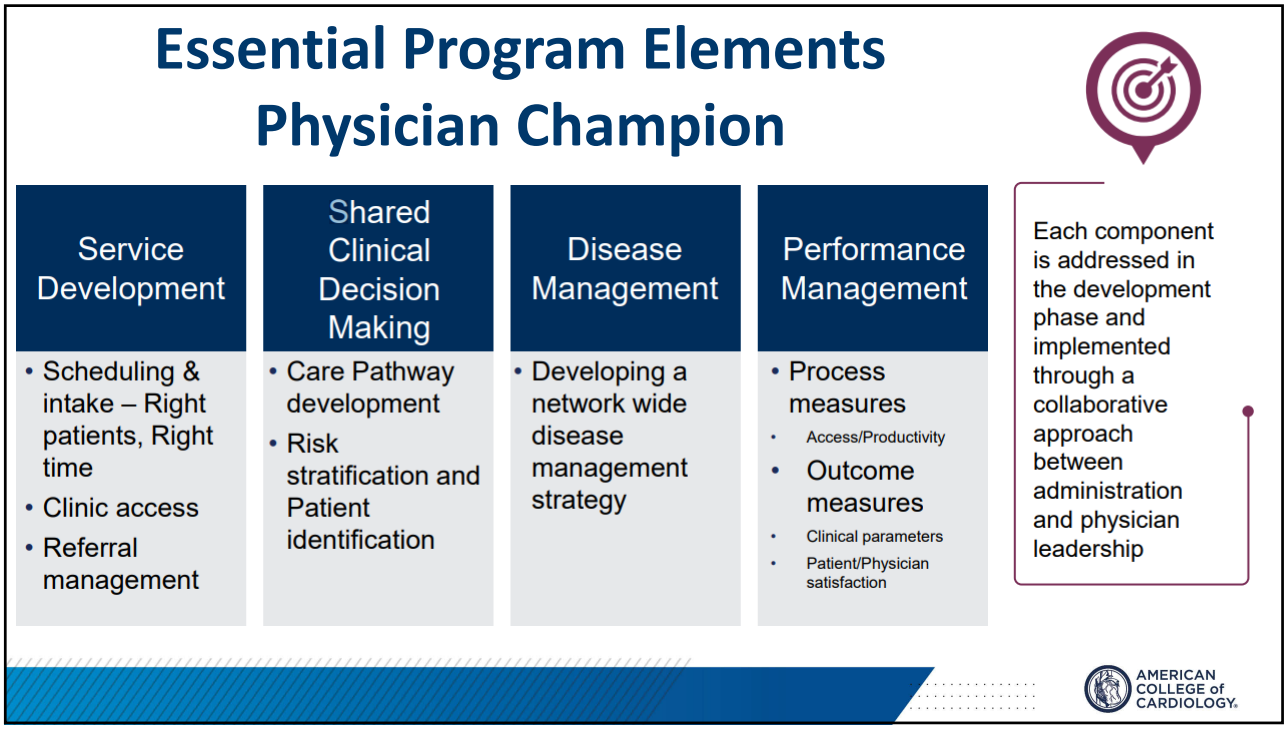
Essential Program Elements
Physician Champion
Service Development
• Scheduling & intake – Right patients, Right time
• Clinic access
• Referral management
Shared Clinical Decision Making
• Care Pathway development
• Risk stratification and Patient identification
Disease Management
• Developing a network wide disease management strategy
Performance Management
• Process measures
• Access/Productivity
• Outcome measures
• Clinical parameters
• Patient/Physician satisfaction
Each component is addressed in the development phase and implemented through a collaborative approach between administration and physician leadership
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#4: Compressed Hospital Margins

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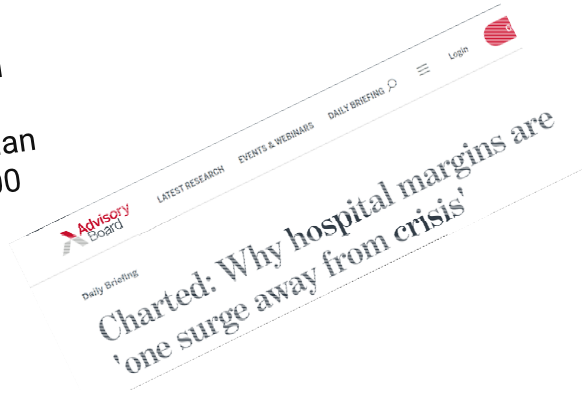
Hospitals' and health systems' median operating margins declined by 11.8% in February and 26.7% year over year, according to a new report from Kaufman Hall based on data from more than 900 hospitals.



In a 2023 midyear report (login required), Moody's Investors Service noted that margins are below 3% for a third of the company's rated hospitals. Before the pandemic, only about 6% had margins in that range. Jul 27, 2023

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Site Neutrality

6

Payment Type	Inpt Hosp #21	On-campus HOPD #22	Off campus HOPD #19	Office #11
DRG Hosp Payment	*			
APC Hosp Payment		*	*	
CPT codes – PFS – Prof Physician Pay	*	*	*	*

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Politico……September 20, 2023

Transforming Healthcare: Site-Neutral Payments

Bipartisan legislation in the House and Senate would align costs for services across hospitals and doctors' offices and could reduce out-of-pocket spending and potentially save the federal government billions of dollars.

At Politico panel, AHA highlights why site-neutral proposals would jeopardize access to patient care

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Payment methodology/site of service

Site "intended to provide outpatient procedures to patients who do not require an overnight stay after the procedure."

	Inpatient	Outpatient		
Medicare Payment Model	DRG	HOPD	ASC	Office-based Lab
MD payment	RVU	RVU	RVU	RVU*
Facility payment	DRG rate or bundle rate	OPPS rate	ASC rate	

The Site-based Invoicing and Transparency Enhancement (SITE) Act (S. 1869) would impose site-neutral payment cuts for items and services in grandfathered off-campus HOPDs. Starting in 2025, all services furnished in grandfathered off-campus HOPDs, other than evaluation and management (E&M) services, which are already paid at a site-neutral rate, would be subject to site-neutral payment

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Site of Service reimbursement differences

While we expect this to normalize, we have been waiting a long time now – and it won't change in 2024 – but when it does will we be ready?

	Nat'l		
	MPFS	HOPPS	Diff
CCT	$ 222.64	$ 180.34	$ (42.30)
CMR	$ 262.63	$ 368.43	$ 105.80
Carotid	$ 155.88	$ 233.52	$ 77.64
Echo	$ 130.80	$ 503.13	$ 372.33
EKG	$ 6.44	$ 57.48	$ 51.04
LHC	$ 765.85	$ 2,958.46	$ 2,192.61
Nuc	$ 368.35	$ 1,327.27	$ 958.92
PET		$ 1,489.35	

Medicare pays approximately $6,500 for the placement of a coronary stent as an outpatient in a free-standing ambulatory care facility and $10,600 for the same procedure performed in a hospital.

*Based on CMS National Fee Schedule 2019

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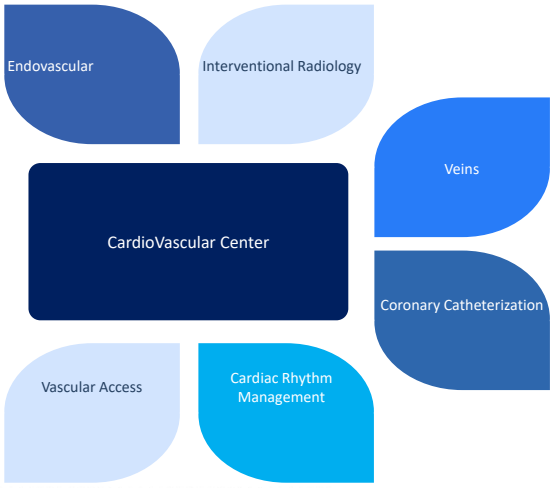
Developing an Ambulatory Based Procedural Care Strategy



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CMS OPPS/ASC rule impacts

Off Campus Provider Based Departments (PBDs)

CMS implemented a payment policy whereby non-excepted off-campus PBDs receive 40% of the APC payment; Excepted off-campus PBDs receive 100% of the APC payment

CMS is concerned about the continued growth in outpatient services, and believes that payment differentials between the OPPS and PFS may be a driver of this growth

CMS finalized a policy change for G0463, Hospital outpatient clinic visit
- This will be paid at the same discounted rate regardless of excepted status
- This was challenged in the courts – and is now in place
  - Approx $115 – on campus
  - Approx $46 – off campus

CMS did **not** finalize the proposal Payment for excepted off-campus Provider Based Diagnostic services
- CMS will continue to monitor this

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Physician Alignment

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- Academia
- Independent
- Employed
- Private Equity
- Multi-state MSO's
- Unionization

Figure 8: Cardiology Group Ownership Trend (Survey Participants)

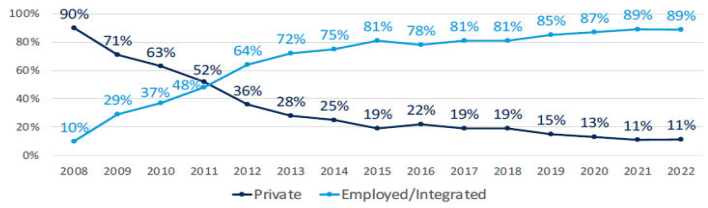
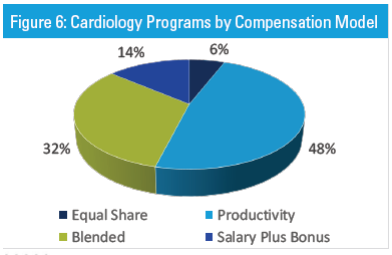


Figure 6: Cardiology Programs by Compensation Model



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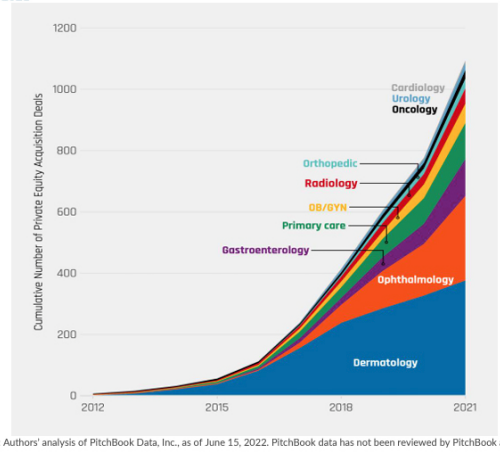
Trends in PE

Figure 2: Cumulative Number of Private Equity Acquisition Deals of Physician Practices by Specialty, 2012-2021



Source: Authors' analysis of PitchBook Data, Inc., as of June 15, 2022. PitchBook data has not been reviewed by PitchBook analysts.

$17B in 2021
$14.5B in 2022

Follow the Heart
An aging population and rising obesity rates are contributing to private equity's interest in cardiology, as is an uptick in outpatient procedures approved by Medicare.

Webster
Ares
Lee Equity &
Cardiovascular Logistics

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Unions and Cardiology??

2023 – nearly ¾ of all physicians are now considered ***employees***

Aug. 16, 2023, 4:10 AM CDT
Doctors Move Toward Unionization Amid Post-Pandemic Merger Wave

Northwestern Medicine physicians file to unionize

Doctors Unionize at Big Health Care System
The physicians, at Allina Health in Minnesota and Wisconsin, appear to be the largest group of unionized doctors in the private sector.

Advisory Board LATEST RESEARCH EVENTS & WEBINARS DAILY BRIEFING

Daily Briefing

Physician unionization is gaining traction.

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Workforce Issues

4

- Does anyone want to work?
- Shortage of most clinical and support staff

Shortage of Cardiologists

Overall 1:4 cardiologists is over the age of 61!!

8,024 median wRVUs per FTE over age 61 (9,898 overall)

For every 5 cardiologists there's a whole FTE missing here!

Source: 2020 MedAxiom Cardiovascular Provider Compensation & Production Survey

US CARDIOLOGY PROJECTIONS

Practicing Cardiologist [1]	32,000
Over the Age of 61 [2]	8,000
Estimated Annual Departures [3]	(2,000)
Current Total US Fellows [4]	3,745
Annual Number Entering Workforce [4]	1,453
Net Annual Workforce Impact	**(547)**

[1] Source: Statista 2019, ACC
[2] Source: 2020 MedAxiom Cardiovascular Provider Compensation & Production Survey
[3] MedAxiom projections considering production reductions, workload reductions, retirements & other departures
[4] Source: Accreditation Council for Graduate Medical Education, 2018 - 2019

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The reality is ….this will not improve

The American Hospital Association estimates that the industry will face a shortage of up to

124,000 physicians by 2033.

Meanwhile, it will need to

hire at least 200,000 nurses a year

to meet rising demands. Among support personnel, a shortage of home health aides is most acute

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Bottom Line: We MUST Redesign Care Delivery

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AI: The New Clinical Landscape

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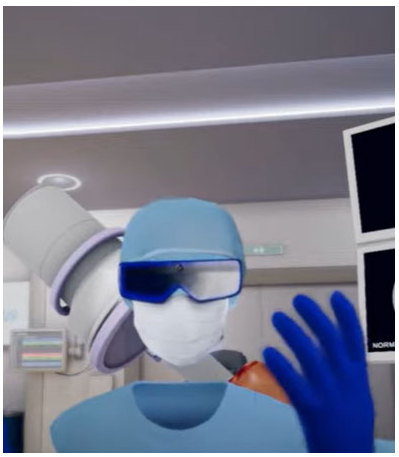
- Asynchronous Communication: PROMs, Electronic Consultation
- Blended Care: In-person and Virtual synchronous visits
- Clinical remote monitoring, medical grade devices
- Digital tracking and wearables, healthcare and social data
- Education: digital transformation, remote learning, virtual training



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AI: Within the Practice of Cardiology

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- Optimize administrative processes
- Accelerate the dissemination of new science
- Foster patient engagement AND optimize patient care
- Improve patient outcomes
- Enhance clinician education

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AI or Collaborative Intelligence....

ChatBOT

What is the perfect physician compensation model?

The perfect physician compensation model is one that rewards physicians for providing high quality care and for adhering to evidence-based practice guidelines. It should also account for operational and administrative duties, as well as student and resident teaching activities. In addition, the model should take into account physician goals, preferences, motivations, and specialties. Physician autonomy and professional satisfaction should also be factors in the model. Finally, the compensation model should strive to promote collaboration, leader|

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Re-Design…Innovation?

1962 ---------- 2023

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Out-Patient Care - Then

Out-Patient Care - Now

Courtesy of John Rumsfeld, MD, PhD, FACC

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Remember Care Transformation

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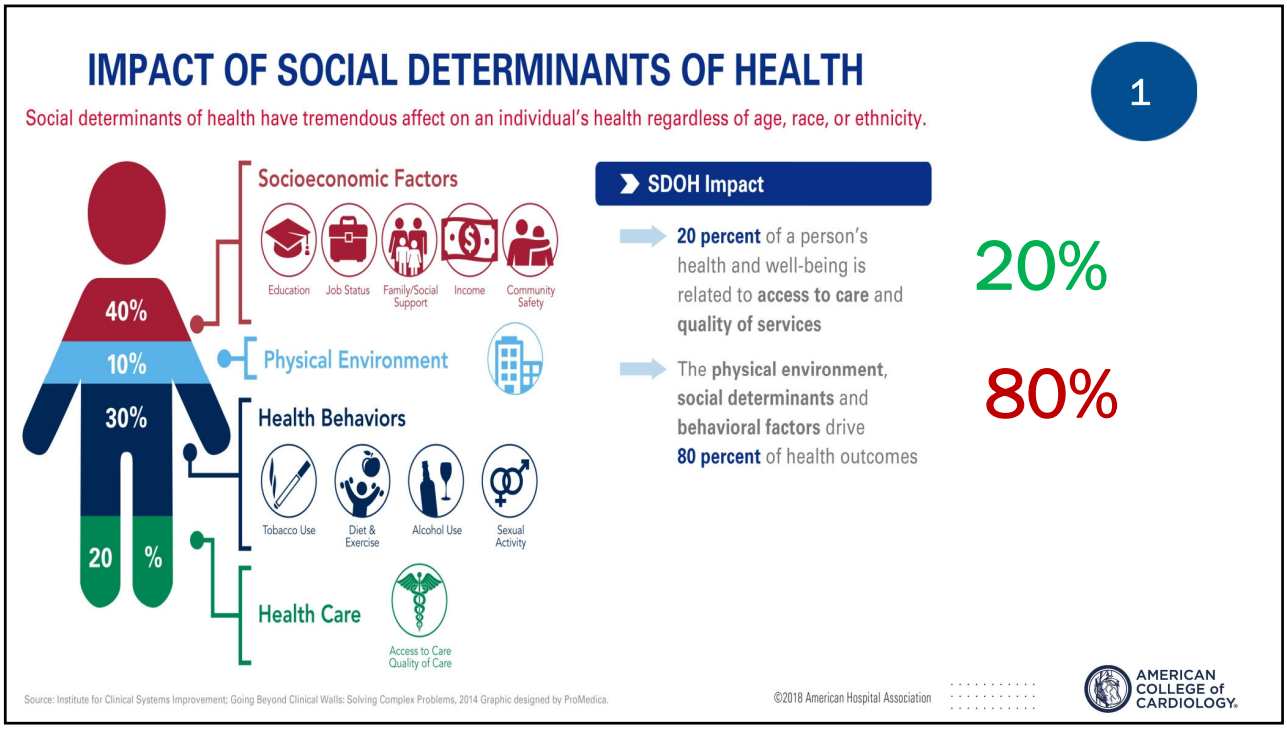
IMPACT OF SOCIAL DETERMINANTS OF HEALTH
Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.
1
Socioeconomic Factors
Education
Job Status
Family/Social Support
Income
Community Safety
40%
Physical Environment
10%
Health Behaviors
30%
Tobacco Use
Diet & Exercise
Alcohol Use
Sexual Activity
20 %
Health Care
Access to Care
Quality of Care
SDOH Impact
20 percent of a person's health and well-being is related to access to care and quality of services
The physical environment, social determinants and behavioral factors drive 80 percent of health outcomes
20%
80%
Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.
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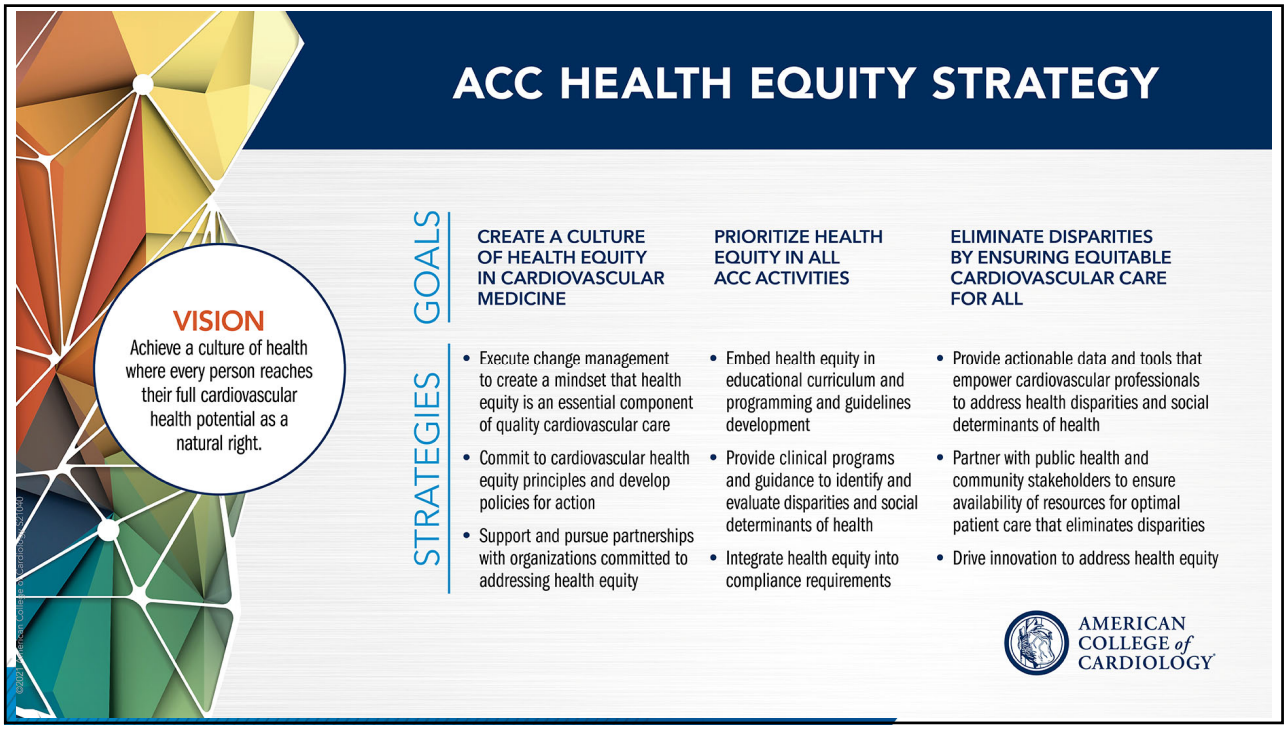
ACC HEALTH EQUITY STRATEGY
VISION
Achieve a culture of health where every person reaches their full cardiovascular health potential as a natural right.
GOALS
CREATE A CULTURE OF HEALTH EQUITY IN CARDIOVASCULAR MEDICINE
PRIORITIZE HEALTH EQUITY IN ALL ACC ACTIVITIES
ELIMINATE DISPARITIES BY ENSURING EQUITABLE CARDIOVASCULAR CARE FOR ALL
STRATEGIES
• Execute change management to create a mindset that health equity is an essential component of quality cardiovascular care
• Commit to cardiovascular health equity principles and develop policies for action
• Support and pursue partnerships with organizations committed to addressing health equity
• Embed health equity in educational curriculum and programming and guidelines development
• Provide clinical programs and guidance to identify and evaluate disparities and social determinants of health
• Integrate health equity into compliance requirements
• Provide actionable data and tools that empower cardiovascular professionals to address health disparities and social determinants of health
• Partner with public health and community stakeholders to ensure availability of resources for optimal patient care that eliminates disparities
• Drive innovation to address health equity
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Internal **Strategies** for Advancing Health Equity

Leadership and Governance Setting the Tone for Combating Structural Racism and Advancing Health Equity	People and Culture Building and Supporting a Diverse, Culturally Competent Workforce	Data and Analytics Measuring Progress and Impact
Board and leadership team to: a. Define, and affirm importance of, health equity for the organization b. Adjust performance dashboards and compensation models to promote equity c. Diversify the board and leadership teams d. Ensure leaders of equity initiatives are appropriately recognized and resourced	a. Strengthen diversity recruitment efforts (See External Strategies → Purchasing Power) b. Enhance diversity retention and leadership development programs c. Shape an inclusive culture through mandatory training and facilitated conversations about cultural competency, humility and implicit bias	a. Refine the data collection and reporting tools to support goal setting and tracking of equity measures in support of other strategies, e.g., – Care Delivery Strategy (a) Embed health equity metrics into quality improvement strategy – Governance Strategy (b) Adjust performance dashboards and compensation models to promote equity b. Harness the power of big data, AI and ML to root out bias in health care

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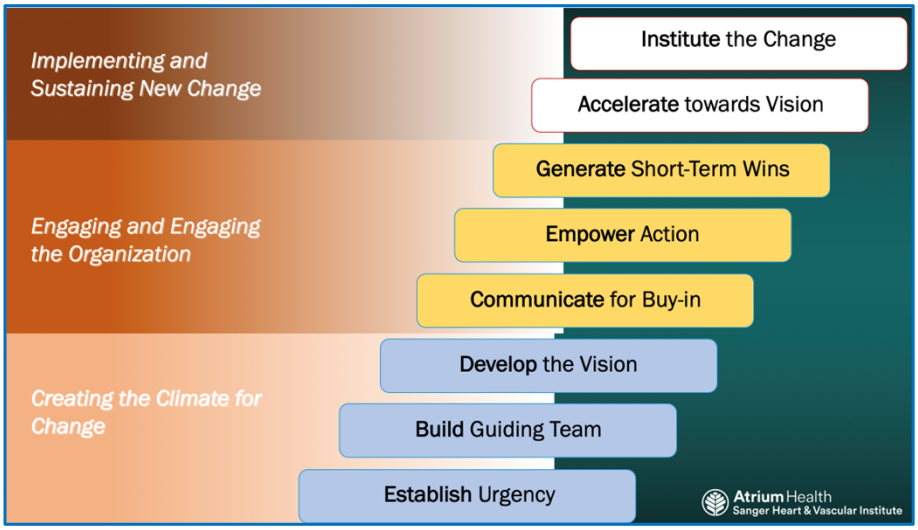
Did You Know?

8 Steps to Drive Organizational Change



Adapted from Kotter

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Key Take-Aways
Keep an open mind to innovation
Prioritize workforce flexibility
Dyad Leadership
Solve practice problems, meet strategic needs
Monitor Trends
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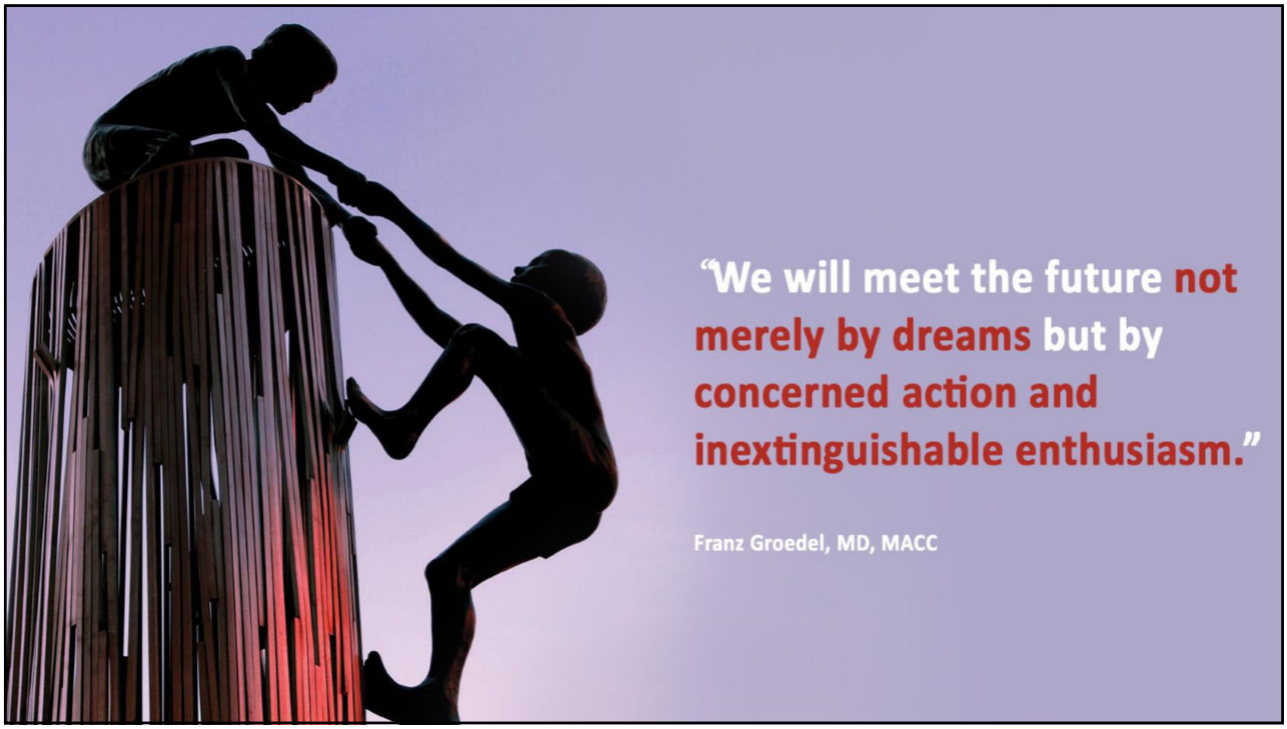
"We will meet the future not merely by dreams but by concerned action and inextinguishable enthusiasm."
Franz Groedel, MD, MACC

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