Mechanisms Supported by CMS that Would More Quickly Generate an Improved Evidence Base

Sean P. Lyden MD
Chairman Vascular Surgery, Cleveland Clinic
on Behalf of VIVA Physicians

Cleveland Clinic

VIVA VASCULAR INTERVENTIONAL ADVANCES

Venous Care Partnership

My Disclosures

- Consultant: Spectranetics($0), Trivascular,(<$5K) TVA Medical ($0), Medtronic(<$1K)
- Research Studies: Cook, Endologix, Medtronic, Bard, Gore, Abbott, Bayer, Bolton Medical, Cordis (all grant $ goes to institution)
- VIVA Board: Travel Reimbursed to Board meetings/stipend for hours(<$10K)

The Need for New Approaches

- Our understanding of venous disease in its infancy
- Historically lack of interest and treatment options
- Novel successful therapies have renewed research interest
- Based on the numbers of published studies we are likely decades behind our understanding of venous disease as compared to peripheral and coronary artery disease
- We need novel large data sources to rapidly advance the field
- We need CMS to use newly acquired capabilities to spur novel methods of data acquisition in this cause.

CMS Needs to Use Mandate of Reasonable & Necessary in Defining Data to be Collected

1. Understand variations in local coverage determinations in the payment for chronic venous disease and policies for coverage of new technologies
2. Incentives or mandates to feed patient data into registries
3. Incentives or mandates for EMR discrete data to connect to registries
4. Incentives or mandates to support creation of open mega databases
5. Work with physician coalitions to define variables, study outcomes which improve quality of life

How CMS can move the field forward

- 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
  - 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)

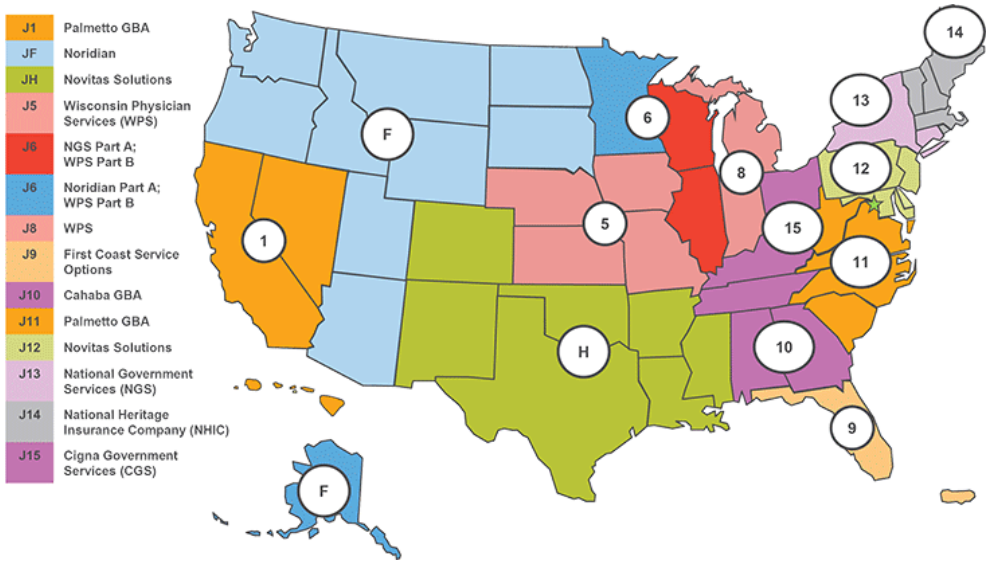
How CMS can move the field forward

- 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 single program in which 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**
      - **Venous Care Partnership fits this definition**

Medicare Access and CHIP Reauthorization Act (MACRA) -April 16, 2015

- Local coverage decisions can be very diverse in when to cover venous disease treatment
- It is reasonable to expect all Medicare beneficiaries have same requirements for receiving treatment
- Define coverage variability among the MAC jurisdictions
- Unify coverage policies among the regional groups
- Will allow same population to be examined

Medicare's MAC Jurisdictions



The Mechanism for Rapid Advance: Increase Registry Data Collection

- Address important questions in epidemiology & outcomes
- Large difference in venous disease population
  - Chronic venous insufficiency
  - Deep venous reflux
  - Superficial venous reflux with or without varicose veins
  - Venous Ulcers with or without reflux or obstruction
  - Deep venous thrombosis and obstruction
- Cared for by multiple physicians and specialties
- Registry Members can be seen as a Virtual Group for MIPS

Venous Registries

- Currently several registries exist
  - Data variables not standardized across registries
  - No registry captures all of the population
  - Overlap in some areas, but large gaps
  - No perfect registry
  - EMR interfaces needed

- Some examples:
  - Vascular Quality Initiative (VQI)
  - American College of Phlebology (ACP) PRO Venous Registry
  - Venous Patient Outcome Registry (VPOR)

Governmental Mandates for EMRs Use

- American Recovery and Reinvestment Act of 2009
  - mandated "meaningful use" of EMR in order to maintain existing CMS reimbursement levels

- EMRs now widely prevalent but have issues:
  - Hospital based systems built to maximize billing and coding
  - Office based don't always connect to inpatient systems
  - Mega amounts of data: not discreet, can't query, not abstractable
  - EMR Physician complaints
    - No aligned incentives
    - Increased time spent record keeping
    - Reduced patient face time

Meaningful Use as a Mechanism for Mandate

- CMS can use the meaningful use mandate now to push EMRs:
  - Allow systems to talk and interact
  - Allow capture of discreet data within EMR
    - Incentives or mandates for creation of common discreet data EMR collection fields
- Push of discreet data to registries
    - Mandates or incentives for discreet data push into registries
- Creation open access mega data files
    - Incentives or mandates for Hospitals, MDs, and EMR vendors and registries to push data to large open access files
- This will accelerate collection and study of data
- We as a virtual group can help define the data to be collected

Summary

- CMS can use new laws to push the field forward
- Eliminate variations in local coverage
- Incentives or mandates for
  - EMR common discrete data fields
  - Feed patient data into registries
  - Creation of open mega databases
- Work with physician coalitions to define variables, study outcomes which improve quality of life proving reasonableness and necessary

Working collaboratively to ensure appropriate care for our patients

Venous Care Partnership

VIVA Physicians
www.vivaphysicians.org

- 501 (c)3 not-for-profit organization dedicated to advancing the field of vascular medicine and intervention through education and research
- Board of 14 physician members
  - Interventional Cardiology
  - Vascular Medicine
  - Vascular Surgery
  - Interventional Radiology
- I am representing VIVA as the Treasurer of the Board
- All officers and board members donate time to the organization and receive payment for service to the organization based on documentation of specific hours worked