



June 20, 2016

**VIA ELECTRONIC MAIL**

Lew Sandy, MD  
Chair  
Clinical Episode Payment Work Group  
Health Care Payment Learning and Action Network

Re: Comments on Draft White Paper: Coronary Artery Disease

Dear Chair Sandy:

The Health Care Transformation Task Force (“HCTTF” or “Task Force”)<sup>1</sup> appreciates the opportunity to comment the work of the Health Care Payment Learning and Action Network (“LAN”) Clinical Episode Payment Work Group’s (“Work Group”) draft White Paper on Coronary Artery Disease (“CAD”) Framework (“White Paper” or “Framework”). As with all LAN projects, the Task Force looks forward to collaborating with the LAN and all of its work groups to help facilitate widespread health care delivery transformation.

The Task Force supports innovative, person-centered, valued-based payment models. We applaud the Work Group’s bold step forward with proposing this type of broad-based bundle, and agree that patients may benefit greatly from comprehensive management of coronary artery disease. However, we are unable to support the proposed CAD framework at this time. Our members found the proposal to be not completely developed and difficult to evaluate fully, and therefore challenging to support. Also, given the considerable complexities and comorbidities associated with CAD patients, there was uncertainty about the appropriate APM to manage this medical condition. There was a widely-held sentiment that the elements and

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<sup>1</sup> The HCTTF is a group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

definitions related to this type of bundle may be more conducive to a population health management approach.

Thus, we believe the White Paper would benefit from further discussion about the interaction between the CAD bundle and other population-based payment models in which the CAD patient may be included. The HCTTF urges the Work Group to continue development of the model and address these APM overlap concerns, with the next step being a second draft released for public comment before a final Framework is issued.

Should the LAN proceed with further development of the CAD bundle, we believe the Framework would benefit from more detail addressing patient population identification, assignment of accountable entity, and issues associated with the type and level of risk. We believe that sharing more Work Group thinking on these important issues is critical to fully understanding and evaluating the CAD Framework.

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology and data for setting target prices and the way issues such as attribution are handled. We also believe that bundled payments can promote greater transparency for patients in the evaluation and selection of health care providers.

With regard to the context of the current draft, our recommended refinements to the CAD bundle design are provided below:

### ***Episode Definition***

The Task Force supports the framework of 12 months of active care management for patients diagnosed with CAD. Percutaneous Coronary Intervention (PCI) and/or Coronary Artery Bypass Graft (CABG) procedures deemed necessary during the 12-month period will also be delivered within an episodic payment model. We also recognize that it may be advisable to extend the episode length beyond 12 months due to the chronic disease management nature of the episode. Twelve months for a chronic disease management bundle may be too short as it may limit full realization of the benefits or investments of prevention on long-term outcomes. In addition, the threshold to do CABG or PCI procedures, based on Appropriate Use Criteria, is higher if there is short term (12 month) financial risk. The threshold for appropriate revascularization would be lower if length of follow-up is longer and the investment in a more durable therapy is rewarded by lower total costs over more than one year.

### ***Episode Timing***

The Task Force recommends that the CAD condition bundle begin at time of clinical presentation, not at the start of the calendar year. If the patient initially experiences an acute event that requires a procedure, the CAD condition bundle should begin 30-90 days post the procedure bundle.

### ***Patient Population and Transparency in Episode Creation***

As a general consideration, we continue to advocate for full transparency in all matters related to bundled payment programs, including the specific methodology for setting target prices for each hospital or participant. Data is key to fostering consensus and reaching agreement on appropriate structures to manage bundled payment programs. We believe greater transparency will lead to shorter cycle times to refine program designs while also creating greater trust in the technical aspects of any bundled payment program.

The White Paper advocates for a patient population including all patients who are under “active management” for CAD. It will be important to clearly define the CAD diagnosis criteria to support consistent identification of the population within the condition bundle. As a chronic illness punctuated by emergent acute events that may occur unpredictably, initial diagnosis can occur anywhere and at any time along this clinical spectrum.

We suggest that the LAN give consideration to the further development of the identification of the patient population in light of heterogeneity of the coronary artery disease as a diagnosis, and establish a more defined threshold. For example, a patient who had a CABG or PCI procedure 20 years ago and has been healthy since, but checks in with his or her cardiologist annually is very different than a newly diagnosed patient on the heels of a cardiac event. Segments of the bundle population should be risk-stratified, accounting for other chronic illnesses that are common and significant co-morbidities (e.g. diabetes, COPD).

### ***Patient Engagement***

We support the use of patient-centered tools including the ACC Framingham and Reynolds Atherosclerosis CV Disease Risk Calculators. We encourage inclusion of recommendations for inclusion of shared decision making tools for PCI and CABG such as from the Foundation for Informed Medical Decision Making (FIMDM) and others. Such tools should take into account patient expectations and outcome goals, risk tolerance, understanding of recovery process, treatment options and consideration of stage of disease progression. As always, care coordination is also essential for accomplishing meaningful patient engagement.

### ***The Importance of an Accountable Entity***

In our view, episode definitions should not prescribe who can be an accountable entity in bundled payment contracting. We believe a wide range of organizations dedicated to integrating and coordinating the work of practicing physicians and health care providers across care setting may be appropriate for assuming risk and managing a bundled payment program. We urge the LAN to be inclusive, rather than exclusive, on the accountable entity question to encourage innovation and foster market-based arrangements dedicated to bundled payments.

Furthermore, we urge the LAN to consider the fact that primary care physicians (PCPs) and cardiologists will have a different portion of the insured total care meeting bundled criteria.

PCP accountable bundles will include more of a given insured's total care than for a cardiologist making a common financial incentive system more difficult. Overlap of primary care and cardiologist without adequate delineation and understanding of roles may be difficult. The ability to risk adjust and/or impose appropriate use criteria to avoid either over or underutilization of procedures is important. This is complicated when the condition based (cardiologist) and procedure based (cardiology interventionist) accountable physician may be the same person or at least in the same physician group.

### ***Type and Level of Risk***

As mentioned previously, it is critical to further consider the threshold for patient population identification as well as for purposes of patient severity within the CAD population. Potential criteria may include some risk adjustment to account for patients who are chronically stable or identification of inclusion criteria such as lipid level or abnormal stress test as the inclusion criteria. We recommend excluding patients whose first presentation is an acute event (e.g. STEMI, NSTEMI) that requires emergent revascularization. Their initial coverage might involve a procedural bundle, but the chronic management of their CAD as part of the CAD Bundle should begin 90 days after the initial event. We recommend this as another area of further development within the white paper.

The Task Force supports a more thorough review of the appropriate alignment of incentives, specifically appropriately incentivizing through care management.

### ***Quality Metrics***

We recommend inclusion of ACCF/AHA/AMA-recommended measures for CAD and hypertension, which include both symptom management and symptom assessment.<sup>2</sup> In keeping with the HCTTF advocacy for the adoption of patient-reported outcomes, we encourage use of Seattle Angina Questionnaire or similar PRO for this population to address key areas of importance to patients, including reduction of symptom burden and improvement in Quality of Life. Achieving positive patient-reported outcomes while reducing cardiac-related disability at lower cost by minimizing the need for acute interventions would recognize value in the total cost of care and effective stewardship of resources.

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<sup>2</sup> Joseph Drozda, Jr, MD, FACC, Joseph V. Messer, MD, MACC, FAHA, FACP, John Spertus, MD, MPH, FACC, FAHA, et al., "ACCF/AHA/AMA-PCPI 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association-Physician Consortium for Performance Improvement," *Circulation*. 2011;124:248 –270.

**Table 3. 2011 ACCF/AHA/AMA-PCPI Coronary Artery Disease and Hypertension Performance Measurement Sets: Dimensions of Care Measures Matrix**

Measure Name	Diagnostics	Patient Education*	Treatment	Self-Management*	Monitoring of Disease Status
<b>Coronary artery disease</b>					
1. Blood pressure control	✓		✓		
2. Lipid control	✓		✓		
3. Symptom and activity assessment					✓
4. Symptom management			✓		✓
5. Tobacco use: screening, cessation, and intervention	✓	✓	✓	✓	
6. Antiplatelet therapy			✓		
7. Beta-blocker therapy: prior myocardial infarction			✓		
8. ACE inhibitor/ARB therapy: diabetes or left ventricular systolic dysfunction (LVEF <40%)			✓		
9. Cardiac rehabilitation patient referral from an outpatient setting			✓	✓	
<b>Hypertension</b>					
1. Blood pressure control	✓		✓		

ACCF indicates American College of Cardiology Foundation; ACE, angiotensin-converting enzyme; AHA, American Heart Association; AMA-PCPI, American Medical Association-Physician Consortium for Performance Improvement; ARB, angiotensin II receptor blockers; and LVEF, left ventricular ejection fraction.

\*Although no current measures exist for this dimension, future development will examine how to address this dimension of care.

In summary, we urge at the very least continued development of the model given its unique nature, and another opportunity for the public to provide input to the LAN. We appreciate the opportunity to comment here and work further with the LAN’s CEP WG on this initiative.

Please contact HCTTF Executive Director, Jeff Micklos, at [jeff.micklos@leavittpartners.com](mailto:jeff.micklos@leavittpartners.com) or (202) 774-1415 with any questions about this communication.

Sincerely,

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