

TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.

Please email completed templates by **January 15, 2016**, to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	<p><i>Identify point person, telephone number, e-mail address</i></p> <p>Susan Frederick, MSN RN 360-487-5457 sufreder@lhs.org</p> <p><i>Which organizations were involved in developing this project suggestion?</i></p> <ul style="list-style-type: none"> • Legacy Health <p>Supported by</p> <ul style="list-style-type: none"> • SW Area Agency on Aging and Disabilities • Sea Mar CHC • NW Cardiovascular Institute
Project Title	<i>Title of the project/intervention:</i> Outpatient Cardiac Rehabilitation for Heart Failure
Rationale for the Project	
<p>Statement: Currently Washington Medicaid does not cover Outpatient Cardiac Rehabilitation for Heart Failure (HF) patients with reduced ejection fraction (35% or less). This service is covered by Private Insurance Carriers, Medicare, and Medicaid does pay for this service in our neighboring States (Oregon, Montana, Idaho, and California). We propose that Outpatient Cardiac Rehabilitation become a covered service for Medicaid in Washington State, similar to the Medicare coverage (see below).</p> <p>Medicare covers cardiac rehabilitation (CR) services to beneficiaries as per Sections 1861(s)(2)(CC) and 1861(eee)(1) of the Social Security Act and 42CFR410.49 which defines key terms and the cardiac conditions that would enable a beneficiary to obtain CR services for beneficiaries with stable, chronic HF defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks.</p> <p>Discussion: In 1 in 9 deaths in the United States, HF is mentioned on the death certificate. Approximately 7% of all cardiovascular deaths are due to HF. As previously noted, in 2013, HF costs in the United States exceeded \$30 billion.¹ This total includes the cost of healthcare services, medications, and lost productivity. The mean cost of HF-related hospitalizations was \$23,077 per patient and was higher when HF was a secondary rather than the primary diagnosis. Among patients with HF in 1 large population study, hospitalizations were common after HF diagnosis, with 83% of patients hospitalized at least once and 43% hospitalized at least 4 times.²</p> <p>HF is a syndrome characterized by high mortality, frequent hospitalization, poor quality of life, multiple comorbidities, and a complex therapeutic regimen. HF remains a major and growing societal problem despite advances in detection and therapy. There are 3 primary issues that must be considered when treating HF patients with reduced LVEF: (1) improving symptoms and quality of life, (2) slowing the progression or reversing cardiac and peripheral dysfunction, and (3) reducing mortality. Teaching is not sufficient without skill building and specification of critical target behaviors. It is recommended that essential elements of patient education (with associated skills) are utilized to promote self-care with associated skills.³</p> <p>In Europe, there are at least 15 million patients with chronic heart failure, and the prevalence is rising due to ageing of the population and improved treatment options. Non-pharmacological management of CHF exists of weight</p>	

monitoring, dietary rules, increasing daily activity, and exercise training. Systematic reviews and meta-analyses have shown that exercise training can reduce mortality and improve exercise capacity and quality of life. Therefore, nowadays the European Society of Cardiology advocates exercise training to all stable patients with CHF.⁴

It is recommended that patients with HF undergo exercise testing to determine suitability for exercise training (patient does not develop significant ischemia or arrhythmias). (Strength of Evidence 5 B) If deemed safe, exercise training should be considered for patients with HF in order to facilitate understanding of exercise expectations (heart rate ranges and appropriate levels of exercise training), to increase exercise duration and intensity in a supervised setting, and to promote adherence to a general exercise goal of 30 minutes of moderate activity/exercise, 5 days per week with warm up and cool down exercises. (Strength of Evidence 5 B)³

Cardiac/exercise rehabilitation offers a potential therapeutic approach in the management of patients with HF. The HF-ACTION trial (A Controlled Trial Investigating Outcomes of Exercise Training), a large, multicenter, randomized controlled study, failed to show significant improvement in all-cause mortality or all-cause hospitalization in patients who received a 12-week (3 times/week) exercise training program followed by 25e30 minute, 5 days/week home-based, self-monitored exercise workouts on a treadmill or stationary bicycle. **However, after controlling for HF etiology, atrial fibrillation, exercise duration and depression, patients who exercised had an 11% risk reduction in the primary endpoint. Additionally, cardiovascular mortality or HF hospitalization was reduced by 15% after adjustment, and at three months after enrolment, quality of life was significantly improved in the exercise group.**³

Project Description

Which Medicaid Transformation Goals¹ are supported by this project/intervention? Check box(es)

- Reduce avoidable use of intensive services
- Improve population health, focused on prevention
- Accelerate transition to value-based payment
- Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

- Health Systems Capacity Building
- Care Delivery Redesign
- Population Health Improvement – prevention activities

Target Population: HF patients with reduced ejection fraction (40% or less) are estimated to be approximately half of the HF patients.² HF affects over 5.5 million Americans, and more than 650,000 incident cases are diagnosed each year. Moreover, the prevalence and incidence of HF are increasing, in large part owing to the aging of the population. Indeed, HF is the leading cause of hospital admissions and readmissions in the Medicare age group, and it is associated with a poor prognosis: 1-year mortality rates of 20%–30% and 5-year mortality rates of 50%–60%. In addition, HF is a major source of disability and impaired quality of life.⁵

During a year (Calculated April 20145 to March 2015), we treated 288 Medicaid patients with an exacerbation of HF (decompensated/acute HF). Given the time restraints of this application, we were not able to sift through the charts to know how many of these patients would have qualified for Cardiac Rehabilitation (have Heart Failure, with an ejection fraction of 35% or less (after being stable for a minimum of 6 weeks), and be able/willing to participate).

Title XIX (Medicaid) patients in the CARE DB system (representing 5 counties: Clark, Cowlitz, Skamania, Klickitat, and Wahkiakum) showed some 5200 clients and 440 had HF. Again, we were not able to sift through the patients to know which patients would have qualified for Cardiac Rehabilitation under the current Medicare Coverage.

Transformation Goals: CR services is an exercise and education program geared towards improving the patient’s

<p>quality of life. The program helps modify cardiac risk factors and incorporates exercise without exceeding safe limits. CR services helps decrease spending of health care dollars by decreasing visits to the emergency rooms and admissions to the hospital. This is line with the <i>Medicaid Transformation Goals</i> by reducing avoidable use of intensive services and by improving population health while focusing on management of cardiovascular disease.</p>
<p>Core Investment Components</p> <p>Activities & Cost: Outpatient Cardiac Rehabilitation Services is an exercise and education program that consists of 36 sessions, three time a week, and is run by a team of health professionals. During each session, patients have vitals taken, continuous EKG (heart monitoring) while they undergo their exercise and education program. The education is focused disease management and risk factor modification. Cost is \$172 per session or \$6192 for the full program per patient.</p> <p>Best Estimate: (See Target Population Above) Estimated to be less than half of the Medicaid patients with HF in the State of Washington.</p> <p>Implementation: CR services are already well established in our communities in Washington. They already service private insurance and Medicare patients with HF. Implementation would only require expanding the coverage and disseminating the information to the medical field.</p> <p>Financial: As mentioned in the “Discussion” above, HF-related hospitalizations are common after a HF diagnosis costing approximately \$23,077 per visit. With 83% of patient being hospitalized at least once and 43% hospitalized at least 4 times, this cost is between \$23,077 and \$92,308. The cost of hospitalization far exceeds the cost of CR services at \$6192 for 36 sessions that have proven to help reduce hospitalizations.²</p>
<p>Project Metrics</p> <p><i>The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.</i></p> <p><i>Wherever possible describe:</i></p> <ul style="list-style-type: none"> • <i>Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application http://www.hca.wa.gov/hw/Documents/waiverappl.pdf pages 46-47ⁱⁱ.</i> • <i>If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation?</i>

References

- 1) Go AS, Mozaffarian D, Roger VL, et al. Heart disease and stroke statistics–2013 update: a report from the American Heart Association. *Circulation* 2013;127:e6–245.
- 2) Yancy et al. (2013). 2013 ACCF/AHA Heart Failure Guideline. *JACC*, 26(16)147–239.
- 3) Albert et al., (2010). Executive summary: HFSA 2010 comprehensive heart failure practice guideline. *Journal of Cardiac Failure*, 16(6), 475-539.
- 4) Van der Meer et al., (2012). Effects of outpatient exercise training programmes in patients with chronic heart failure: a systematic review. *European Journal of Preventive Cardiology*, 19(4):795-803.
- 5) Rich, M. W., (2011). The year in quality of care in heart failure. *Journal of Cardiac Failure*, 17(6), 443-450.