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August 30, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd
Attention: CMS-1525-P
PO Box 8013
Baltimore MD 21244

Dear Dr. Berwick:

The American College of Cardiology (ACC) is pleased to submit comments on the proposed rule on **Medicare Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital-Value Based Purchasing Program; Physician Self-Referral; and Provider Agreement Regulations on Patient Notification Requirements (CMS-1525-P)** as published in the Federal Register on July 18, 2011. The American College of Cardiology is transforming cardiovascular care and improving heart health through continuous quality improvement, patient-centered care, payment innovation and professionalism. The College is a 40,000 member nonprofit medical society comprised of physicians, nurses, nurse practitioners, physician assistants, pharmacists and practice managers, and bestows credentials upon cardiovascular specialists who meet its stringent qualifications. The College is a leader in the formulation of health policy, standards and guidelines, and is a staunch supporter of cardiovascular research. The ACC provides professional education and operates national registries for the measurement and improvement of quality care. More information about the association is available online at <http://www.cardiosource.org/ACC>.

Lower Extremity Revascularization APC

In this rule CMS proposes to move CPT code 37221 (Revascularization, endovascular, iliac artery, unilateral, initial vessel with stent) to Ambulatory Payment Classification (APC) 0229. The original placement of this code in APC 0083 did not reflect the costs of the stent itself. The data CMS cites in the rule demonstrates how much more expensive this service was than others in the APC in violation of the "two times" rule that governs placement within an APC. We strongly support the CMS correction of this initial error and appreciate the responsiveness to comments on this issue.

Cardiac Resynchronization Therapy Composite APC (APCs 0108, 0418, 0655, and 8009)

In this rule, CMS proposes to create a new composite APC that covers the

insertion of a pacing electrode (CPT code 33225) and insertion of leads and pulse generator for the ICD (CPT code 33249). CMS then proposes to limit the payment for this composite APC to what would be paid for a similar service in the inpatient setting under the inpatient prospective payment system. While the ACC understands that limiting the payment for these services to that paid in the inpatient setting may make intuitive sense, we are concerned that CMS may not have completed enough analysis to truly demonstrate that the services that are included in the APC are the same as those provided as part of this DRG. If this analysis has been completed, it has not been shared with the public. We urge CMS to not finalize this portion of the rule until such analysis has been produced for public review and consumption. We applaud CMS for taking the opportunity to explore the entire Medicare payment system rather than limiting to a particular payment area, but such a review requires careful analysis that can be examined by the public in order to ensure that there are not any unintended consequences.

Hospital Outpatient Quality Reporting Program Update and ASC Quality Reporting Program

The ACC is committed to improving the quality of care through the application of measurement into continuous quality improvement programs. The ACC, in collaboration with the American Heart Association and the Physician Consortium for Performance Improvement, has developed a series of measures for many common cardiovascular diseases. The ACC developed some of the earliest performance measures, many of which have been used since the inception of hospital quality reporting. We support the CMS goal expressed in this rule of moving from process measures to primarily outcome and patient experience measures. Outcome measures are more difficult to implement and require risk adjustment but we believe the science of performance measurement is moving effectively in this direction. We also strongly support the alignment of measures across payers using standardized measures that have been endorsed by consensus organizations such as the National Quality Forum – if multiple payers use different measures, physicians and consumers will be confused by conflicting information about a provider’s quality of care.

The ACC strongly supports the CMS intention to minimize reporting burden associated with chart abstraction. Hospitals throughout the country are measuring their performance in cardiovascular interventions through the use of the National Cardiovascular Data Registries (NCDR). Because hospitals receive reports on their data on a quarterly basis, they are able to act much more quickly in addressing quality issues. We hope that CMS will encourage the further adoption of registries by hospitals.

Proposed New Quality Measures for the CY 2014 and CY 2015 Payment Determinations

Cardiac Rehab Referral

The ACC supports the CMS proposal to include the measure for Cardiac Rehabilitation Patient Referral from an Outpatient Setting (NQF #0643) for the CY2014 payment determination. This measure was originally developed by the ACC and the AHA. Cardiac rehabilitation is needed for many patients following cardiovascular interventions

such as coronary stenting that may be provided in an outpatient hospital setting. By measuring this referral at the hospital level, CMS is encouraging the hospital to take responsibility for the patient beyond his or her stay for that procedure. The ACC strongly encourages a collaborative responsibility for patients and supports the implementation of this measure for inclusion in the hospital quality reporting program.

Hospital Outpatient Volume for Selected Outpatient Surgical Procedures

CMS proposes to add a new structural measure to the hospital reporting program to hospital outpatient volume for selected outpatient surgical procedures. CMS indicates that it will provide a count of all services within a range of certain CPT codes and report that information on Hospital Compare. The ACC opposes the inclusion of this measure in the hospital quality reporting program, particularly in this current form.

In the rule, CMS states that there is evidence that the volume of surgical procedures performed in an institution in a good indication of the likely quality of that procedure being performed. While that may be true, CMS does not propose to list volume for individual CPT codes or even families of CPT codes. Instead, CMS proposes to include totals based on eight broad categories. This would mean that a procedure like a heart transplant would not be differentiated from a lower extremity revascularization. Having information that a particular hospital performed a large volume of these broad categories is not helpful to patients and may be misleading as an overall indicator of quality for these particular services.

The ACC appreciates the opportunity to comment on this year's proposed rule for the hospital outpatient prospective payment system. If you have any questions regarding this letter, please contact Brian Whitman, Associate Director of Regulatory Affairs at bwhitman@acc.org or (202) 375-6396.



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President