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May 25, 2012

The Honorable Dave Camp
Chairman, House Ways and Means Committee
1102 Longworth Building
Washington, DC 20515

Dear Chairman Camp,

The American College of Cardiology (ACC) is pleased to respond to your April 27 letter requesting input as you work towards a permanent solution to the flawed Medicare physician payment formula.

The ACC is a 40,000-member nonprofit medical society comprised of physicians, surgeons, nurses, 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 cardiovascular research. The ACC provides professional education and operates national registries for the measurement and improvement of quality care.

Due to advances in diagnostic tests, drug and device therapies, surgical innovations, prevention and public education, mortality related to cardiovascular disease has dropped by 30 percent in the past decade. Cardiovascular disease is still the leading cause of death in the US, however, with 1 in every 3 deaths attributable to heart disease. Cardiovascular disease can also result in serious illness, disability, and decreased quality of life. One in 3 Americans has some form of heart disease. Cardiovascular disease cost the nation more than \$444 billion in health care expenditures and lost productivity in 2010 alone—and these costs are expected to rise given the aging of the population.

Rewarding Quality and Efficiency

The College urges Congress to avert scheduled reimbursement cuts, repeal the SGR, provide stable payments for several years to allow testing of delivery and payment models, and allow for a transition to new models. The ACC supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system that aligns financial incentives with performance of evidence-based medicine and with improving care delivery systems. The College supports the testing of new payment models of delivering and reimbursing for care through the CMS Innovation Center, private payers, and other initiatives. The College believes there is no “one-size-fits-all” replacement and models are needed that work for a variety of settings, including small, independent practices and rural areas as well as large single specialty and multispecialty groups.

The mission of the American College of Cardiology is to advocate for quality cardiovascular care — through education, research promotion, development and application of standards and guidelines — and to influence health care policy.

Through years of experience, the ACC has learned that efforts to improve quality and efficiency must be grounded in the use of the best scientific evidence available, the collection of robust clinical data, measurement, and feedback on performance. Physicians must believe the data and trust it in order to act on it. The more confidence physicians can have in the underlying data, the more they will respond appropriately to the incentives. Rewarding physicians for providing the right care and using an appropriate amount of resources is essential to solving the long-term Medicare spending crisis.

Evidence-Based Guidelines and Performance Measures

The American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) have a long history of translating clinical science into clinical practice guidelines and performance measures, and have close to 20 guidelines and more than 70 performance measures on a range of cardiovascular topics. The guidelines are developed through a rigorous, evidence-based methodology, including multiple layers of review and expert interpretation of the evidence on an ongoing, regular basis. As the healthcare system continues to evolve towards better integration of health information technology (HIT), clinical decision support tools, and performance measurement, the need for meaningful clinical practice guidelines is even more essential.

The National Cardiovascular Data Registry

Clinical data registries can help medical professionals and participating facilities identify and close gaps in quality of care; reduce wasteful and inefficient care variations; and implement effective, continuous quality improvement processes. Clinical data registries capture clinical information that is evidence based and derived from clinical guidelines, performance measures and appropriate use criteria in order to accurately measure patient outcomes and clinical practice.

The ACC began development of the National Cardiovascular Data Registry (NCDR®) in 1998 partnering with other medical specialty organizations to monitor and improve existing and new cardiovascular care technologies. Today, NCDR® includes six hospital-based registries and one outpatient physician office-based registry representing over 20 million patient records, 216 clinical abstracts and 70 published manuscripts. NCDR® is operational in over 2500 US hospitals, and the NCDR® PINNACLE Registry® is in over 500 physician offices across the US.

WellPoint, Inc, United Healthcare Services, and Blue Cross Blue Shield of Michigan (by virtue of BMC2) formally require participation in NCDR® as part of reimbursement or recognition programs. The Blue Cross Blue Shield Association includes NCDR® participation as part of their national Blue Distinction Centers for Cardiac Care Program. Many states, including California, Florida, Maryland, Michigan, Missouri, Washington, and West Virginia, are aligning regional monitoring efforts with NCDR®. Health systems such as Hospital Corporation of America (HCA) and Kaiser Foundation Hospitals (of Kaiser Permanente) leverage NCDR® to support quality improvement efforts within their networks, as does the Veterans Administration.

Two regional programs that have been receiving national recognition in publishing results for their use of data and “moving the dial” in improving care rely on the NCDR® CathPCI Registry as their measurement tool for interventional procedures. These programs are the Northern New England Cardiovascular Disease Study Group and the Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2). The Leapfrog Group identified the NCDR® CathPCI Registry as their preferred data source for percutaneous coronary intervention (PCI) outcome reporting in their voluntary Hospital Survey aimed at encouraging health providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices.

Decision Support Tools

The ACC has developed appropriate use criteria (AUC) that define when and how often physicians should perform a given procedure or test in the context of scientific evidence, the health care environment, the patient’s profile and the physician’s judgment. The College has created point of order tools through which physicians can access the AUCs during a patient encounter with minimal workflow disruption.

Blue Cross Blue Shield of Delaware (BCBSD) is supporting use of the ACC's FOCUS: Cardiovascular Imaging Strategies tool by Delaware cardiologists to make more informed decisions about the appropriate use of certain diagnostic imaging tests this year. BCBSD is paying for cardiologists in the state to use the online tool, which allows for consistent application of AUCs to determine when and which cardiovascular imaging tests are needed. The program provides feedback reports on the patterns of appropriate use to physician practices and health plans. FOCUS participants then use the reports to complete action plans and share best practices. Other payers are also interested in the program. A voluntary community of 50 sites using FOCUS saw a 50 percent decrease in inappropriate use of medical imaging over a 12 month time period.

The Cardiology Practice Improvement Pathway (CPIP)

Payers approached the ACC to ask how to identify high quality cardiologists, leading the College to establish a program to standardize the methodology for assessing and recognizing quality in cardiovascular practice - the Cardiology Practice Improvement Pathway (CPIP). The College created a health plan advisory group and included them in program development to identify must-haves, nice to have and deal breakers. The ACC sought their reaction and guidance at regular intervals.

CPIP provides an unbiased, transparent, comprehensive, self-reported, all-payer assessment of a practice's performance against national benchmarks to better and more consistently understand how cardiology practices as a profession allowing cardiologists to demonstrate and quantify value while implementing practice improvements that facilitate efficient workflows and drive effective patient care. CPIP is approved through the American Board of Internal Medicine's (ABIM) Approved Quality Improvement (AQI) Pathway and eligible for points towards the Self-Evaluation of Practice Performance requirement of Maintenance of Certification (MOC).

Practices can choose to have their CPIP baseline performance data sent to Bridges to Excellence (BTE) to apply for the Cardiology Practice Recognition (CPR), awarded to practices that achieve quality thresholds established jointly by BTE and ACC. Numerous health plans are starting to provide incentives to practices that achieve BTE CPR. For example, in 2012, practices in the BCBS networks in Texas, New Mexico, and Oklahoma who achieve CPR are eligible for financial rewards. In addition, since 2011, practices taking care of patients in the Pennsylvania Employee Benefit Trust Fund who achieved CPR were eligible for financial rewards. Also, recognized practices were eligible for Quality Designation in Aetna Aexcel, Anthem Blue Precision, and United Premium Designation programs since 2011. This standardized approach to assessing and recognizing quality in cardiovascular practice could go beyond incentives for achieving recognition; it could serve to facilitate performance-based contracting and proof of quality for integrated systems and bundled payments.

The Door to Balloon Initiative

D2B: An Alliance for Quality™ illustrates how data collection and feedback can improve quality and outcomes. The Door to Balloon Initiative, or D2B, challenged cardiovascular specialists to meet the national guidelines developed by the ACC and the AHA that state that hospitals treating heart attack patients with emergency PCI should reliably achieve a door-to-balloon time of 90 minutes or less. "Door-to-balloon time" means the time it takes to diagnose a heart attack and restore blood flow to the heart by placing a stent in a blood vessel. Studies demonstrate strong associations between time to primary PCI and in-hospital mortality risk; however, accomplishing this level of performance was an organizational challenge. In 2006, the ACC partnered with many other organizations to address the challenge by sharing the key evidence-based strategies and supporting tools needed to reduce D2B times nationally. The program was very successful, with widely published studies showing that D2B times dropped to under 90 minutes in over 90 percent of US hospitals, with many now having D2B times under one hour. This initiative significantly improved patient outcomes.

Hospital to Home

The Hospital to Home (H2H) Initiative, led by the ACC and the Institute for Healthcare Improvement, is an important resource for hospitals and cardiovascular care providers to improve transitions from hospital to "home" and, equally important, to avoid any federal penalties associated with high readmissions rates. H2H is an online learning community of individuals and facilities committed to

reducing readmissions and improving patient care. The H2H initiative challenges communities to better understand and tackle readmission problems through the use of simple, targeted, and actionable strategies in three core concept areas: Early Follow-up, Post Discharge Medication Management, and Patient Recognition of Signs and Symptoms.

Alternative Payment Models

SMARTCare

The ACC combined many of its tools into a project to address documented clinical quality, resource use and cost variation in the treatment of stable ischemic heart disease (SIHD) called SMARTCare. In Wisconsin, the project is driven by the American College of Cardiology Foundation (ACCF) State Chapter in collaboration with integrated health care systems, statewide, multi-stakeholder collaborative groups, including business coalitions, measurement and data collaborative groups, and a payment reform partnership. A parallel effort in Florida is led by the ACCF State Chapter in collaboration with 6 provider organizations across the state.

The goal of SMARTCare is to reduce complications, procedures not meeting current appropriate use standards, and episode cost; achieve high levels of patient engagement; improve quality of life; and increase the number of patients at risk reduction goals. The project seeks to accomplish these changes by impacting decision points on appropriateness of noninvasive cardiac imaging; treatment decision between medical therapy, stenting, and bypass surgery; and optimizing medication and lifestyle interventions. Combining these tools would provide customized patient benefit and risk information based on evidence and registry data in real time. Information provided in these tools and registries would then be used to assess patterns of care. Feedback about impact on overall clinical care and cost would be made available through an interactive dashboard and analysis tool. Ongoing tracking using NCDR® and PINNACLE registries would allow sites to modify use of their tools over time to enhance impact. The information is intended to be used to support an episode of care shared savings/bundled payment model and quality incentive payments.

The College has learned through its work on SMARTCare, accountable care organizations (ACOs), and other efforts that new payment models offer significant promise. Not every payment model will work in every area because of the large differences in patient population and health infrastructure. The clinicians and caregivers of a particular area are often the most attuned to the problems in their area. A successful new payment model, therefore, must be crafted with the collaboration of clinicians and payers in an iterative process. Other key elements are flexibility for governance and administrative structure, functional health information technology and registries, and a rigorous approach to quality measurement and reporting.

Patient Involvement and Regulatory Relief

Shared Decision Making

Health care decisions are not black and white. ACC believes engaging patients in decision making is crucial to achieving the best outcome for a patient, as determined by the clinical situation and the patient's preferences and values. More emphasis must be placed on shared decision making, the process by which a health care provider communicates to the patient personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options and the patient communicates his or her values and the relative importance he or she places on benefits and harms. Through CardioSmart.org, ACC is providing content and tools to achieve this goal.

Medical Liability Reform

The ACC believes the current medical liability system is an obstacle to delivery and payment reform and encourages Congress to address it. The Congressional Budget Office estimates that medical liability reform would result in cost savings to the federal budget of more than \$50 billion over the next ten years.

The ACC supports a system that increases patient safety, ensures that injured patients are compensated quickly and fairly, improves provider-patient communications, and ensures affordable and accessible medical liability insurance. Any federal reform effort must not impact reforms already enacted and working at the state level.

The ACC has long supported caps on non-economic damages and other reforms such as those contained in H.R. 5, the HEALTH Act. The College also is open to supplemental reforms that could receive broader support, including adherence to clinical practice guidelines, certificate of merit, and expert witness standards among others.

Prior Authorization

The use of prior authorization for imaging services by private payers is a significant burden on physicians and patients. The College urges Congress not to enact prior authorization in Medicare. Under prior authorization, physicians must receive approval from a for-profit radiology benefit manager (RBM) before ordering a medical imaging service for a patient. RBMs intrude on the physician-patient relationship and delay or deny important imaging studies. Patients may be steered by RBMs to lower-precision tests, which may not provide needed clinical information, or may be forced to wait days or weeks to receive vital services.

Prior authorization is a large administrative and financial burden for physician practices, particularly small practices. The average physician spends close to \$70,000 dealing with insurers and their RBMs. Additional costs are generated when imaging tests (and therefore appropriate treatments) are delayed. Additional costs result when RBMs initially allow only a less expensive test and then later allow a more expensive test because the initial test was inconclusive.

Prior authorization is not effective at enhancing the quality and appropriateness of imaging tests. RBMs focus on individual patient cases and do not consider the context of practice patterns or use transparent algorithms. RBMs also fail to provide physicians with feedback on their overall use of resources. Experience with private payers suggests that a prior authorization requirement in Medicare would impose a significant burden on the Medicare program, increase affected physicians' practice costs, and lead to delay or denial of medically necessary care.

Conclusion

Providing physicians and other healthcare providers with longitudinal data on their performance and tools to improve their performance will result in improved quality and efficiency and lower costs. To establish the infrastructure and data necessary, Medicare and private payers should encourage the development and widespread use of clinical data registries that allow the tracking and improvement of healthcare quality in concert with payment programs that encourage higher quality.

The College appreciates the opportunity to provide feedback to you and offers itself as a resource to you as you work with your colleagues to permanently repeal the SGR and transform the Medicare physician payment system.

Sincerely,