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March 1, 2011

Nancy Wilson, MD, MPH  
Agency for Health Research and Quality  
Immediate Office of the Director  
Room 3028  
540 Gaither Rd  
Rockville MD 20850

Dear Dr. Wilson:

The American College of Cardiology (ACC) is pleased to offer comments on the development of the initial core set of health quality measures for Medicaid –Eligible Adults. 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 39,000-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>.

As you may know, the ACC has been at the forefront of the performance measurement process in medicine. In collaboration with the American Heart Association (AHA), we developed our first performance measurement more than ten years ago. We continue to work to identify and refine measurements of performance in the care of patients with cardiovascular care. When we took on the work of creating performance measures, they were intended as confidential feedback tools to allow physicians to compare their work to that of their peers. In recent years, the use of performance measures for public reporting and soon payment adjustment has made precision in performance measurement even more important.

While we understand that the performance measures are intended to be reported by those that administer Medicaid programs in the states, it is the providers of health care such as physicians and hospitals that will most likely be required to report this data. Otherwise such an exercise would be enormously burdensome for those Medicaid agencies.

*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.*

Performance measures are already in regular use by the vast majority of hospitals, who report these measures as part of a Medicare program in order to receive annual payment updates. For physicians, performance measures will be commonplace in the near future if they are not already. In the near future, physicians will report performance measures as part of the Medicare Physician Quality Reporting System, as part of the electronic health record meaningful use incentive program, to professional boards for maintenance of certification in addition to whatever may be required for private insurers. With performance being measured by so many different entities, it is important to measure consistently.

Measurement consistency is best achieved by using consistent measures and the best way to develop consistent measures is through a careful consensus process that involves both experts in the particular field and a wider variety of experts. This process is best represented today in the physician world by the progression of performance measures from the American Medical Association Physician Consortium on Performance Improvement (AMA PCPI) to the National Quality Forum (NQF). These bodies are best set-up to allow meaningful discussion and consensus. We believe that this is the only process at this time that meets the standards that this kind of precise measurement demands. While CMS has followed this for the most part in the development of this rule, we believe that some of the measures may have some potential flaws and should be examined further before inclusion in this reporting program.

Notably, measure 32, developed by the National Committee for Quality Assurance, is a measure used to assess the quality of care provided to patients with ischemic vascular disease, an important population commonly treated by cardiologists. We strongly agree that blood pressure management is very important in these patients, but believe that the measure as constructed may provide an incentive to add anti-hypertensive drugs just to meet the goal blood pressure of 140/90. The majority of the benefit of BP control is typically already achieved with the use of the first 2 medications and the evidence base on the benefits of adding 3rd and 4th antihypertensive medications to get to a particular blood pressure target is still developing. Since we understand that the measures used are to be based on the specifications that were approved by the National Quality Forum, we would urge that this measure not be included before this issue is addressed more completely. Other measures related to controlling high blood pressure, such as measure 30, should also not be used if they might incentivize physicians to provide therapy that may only result in marginal improvement in a process measure at the detriment of a patient.

Measure 32 also includes a measure of LDL in patients with ischemic vascular disease. This is again important but the measure incentivizes physicians to add additional medications to marginally reduce LDL even if it has not been shown to be beneficial to the patient. This is a particularly important aspect for this measure as the preponderance of evidence for lipid-lowering therapy supports the use of statin drugs, whereas the benefits of other classes, particularly incremental to statins, is less clear. We understand the importance of establishing measures but it is important to retain a focus on the patient rather than lab results.

The ACC remains committed to the development and stewardship of quality measures that demonstrate a meaningful difference among providers and encourage full participation in continuous quality improvement process. It will be important to continue in this effort to more meaningfully serve our patients.

If you have any questions about our comments, please contact Brian Whitman, Associate Director of Regulatory Affairs at [bwhitman@acc.org](mailto:bwhitman@acc.org) or (202)375-6396. Thank you for the opportunity to contribute to the development of this list of measures.

Sincerely,

A handwritten signature in blue ink that reads "Ralph Brindis". The signature is fluid and cursive.

Ralph G. Brindis, MD, MPH, FACC  
President