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June 20, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1518-P
PO Box 8011
Baltimore MD 21244-8011

Dear Dr. Berwick:

The American College of Cardiology (ACC) is pleased to offer comments on the notification of proposed rulemaking **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates** as published in the Federal Register on May 5, 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>.

Proposed Additions and Revisions to the Hospital-Acquired Conditions policy for FY2012

For many years, discharges for Medicare patients with complicating conditions have been paid at higher rates than those without complicating conditions. Several years ago, CMS identified a series of hospital-acquired conditions that should not result in this increased payment because the conditions could have been reasonably prevented based on the use of evidence-based guidelines. ACC strongly supports a CMS policy that does not pay more for clearly avoidable events such as retained objects after surgery. However, CMS later expanded that policy to include conditions that may not be reasonably prevented – we have expressed concern about this

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

expansion in comments on previous year's rules and continue to have the same concerns. In this rule, CMS proposes to expand the list of hospital-acquired conditions which will not qualify for additional payment to include contrast-induced acute kidney injury. The ACC strongly opposes the proposal to include this as a preventable hospital-acquired condition. While the ACC is committed to reducing the occurrence of acute kidney injury, it is not a condition that can always be prevented. In many cases, the acute kidney injury is understood to be a possible or even likely outcome, but is understood as a side effect of an effort to protect the patient's life by addressing cardiovascular disease. Because this proposal is based on a payment rate for individual cases, there is no mechanism for exceptions for cases in which this acute kidney injury was an understood complication. This may provide a financial incentive for hospitals to provide care that is not appropriate merely to avoid this complication. This could include not providing angiography at all which could lead to a far worse outcome.

We believe that this proposal points to two significant problems that should be avoided as CMS moves towards "value-based purchasing". The first problem is adjusting payment for quality on an individual case. There are far too many variables related to patients and conditions to allow for a meaningful quality adjustment on an individual case. This policy would not differentiate between an appropriate and well managed case with the unfortunate complication of acute kidney injury from the reckless and dangerous application of a high volume of contrast in a patient that could have been managed in a different fashion. A much better approach to adjust payment for quality would examine an entire year of claims history to determine if a particular institution had a high rate of acute kidney injury which would be more likely to be a sign of a quality issue.

Even examining an entire year of claims data would not tell us if the patients seen by an institution were different from others and more prone to these types of events. That is why we believe that claims data must be supplemented by clinical data in order to truly understand the quality of care being provided. In this particular case, the majority of hospitals that are providing cardiac catheterization and percutaneous coronary intervention services are participants in the ACC Cath-PCI registry. This registry captures information on contrast volume, creatine level before and after the procedure and if dialysis is newly required after the procedure. A longitudinal examination of this data in combination with the claims data would provide an even more robust and complete understanding of the quality of care provided and allow Medicare to pay more for quality and less for volume.

Hospital Inpatient Quality Reporting (IQR) Program

ACC strongly supports the development and use of performance measures in all healthcare environments. As CMS notes in the rule, this year is an important transition from hospital quality reporting to value-based purchasing, in which hospitals will have their payment adjusted on the basis of the quality of care provided. We have submitted detailed comments on the implementation of the hospital value-based purchasing in response to that specific rule. However, in context of the development of value-based purchasing, the hospital quality reporting program takes on an added importance as Medicare intends to adjust payment based on a subset of these performance measures.

We urge CMS to remain focused on the overall goal of performance measurement, the improvement of that performance.

Retirement of Measures

In this rule CMS proposes to retire a number of measures because of nearly universal high performance. Although we support this in concept, we are concerned that its implementation in this specific case may degrade care because some of the measures that are proposed to be eliminated are not being replaced by measures that were developed later to replace them. Specifically, CMS proposes to eliminate the following measures that were originally developed by ACC along with the American Heart Association:

- AMI-1 Aspirin at arrival
- AMI-3 ACEI/ARB for left ventricular systolic dysfunction
- AMI-4 Adult smoking cessation advice/counseling
- AMI-5 Beta-blocker prescribed at discharge
- HF-4 Adult smoking cessation advice/counseling

We oppose the CMS proposal to eliminate AMI-3 ACEI/ARB for left ventricular systolic dysfunction and AMI-5 Beta-blocker prescribed at discharge. Improvement in these care processes has been a significant advance in the field of cardiology and we recommend continuing to measure these until they can be replaced by measures of processes of care that have equal or greater value. The two measures that CMS proposes to eliminate in this rule have far greater positive impact on outcomes than measures that CMS proposes to continue to require such as Discharge Instructions provided for patients with heart failure.

We understand the importance of focusing measures on those that can demonstrate a meaningful difference among providers for the purposes for Hospital Compare and Value-Based Purchasing. However, we believe that eliminating the measures as proposed could degrade patient outcome. Doing so would be contrary to the primary mission of performance measurement – to improve the care provided to patients.

Registries

CMS notes an interest in exploring registries as an alternative source of hospital data for the hospital IQR program. The ACC strongly supports an option that would allow hospitals to report data directly from registries, rather than requiring separate chart abstraction. As CMS notes in the rule, hospitals across the country are already reporting this data into registries and requiring a separate step for quality reporting is redundant. The ACC has spent years developing registries that track quality data for common cardiovascular conditions and procedures. Registries focusing on diagnostic cardiac catheterization, implantable cardioverter defibrillators, and acute coronary syndrome are used by thousands of hospitals. These registries are not just repositories of quality data, but instead drive quality improvement. As noted earlier in our discussion of hospital-acquired conditions, the information collected in these registries is often precisely the information that CMS needs to differentiate high quality hospitals from low quality

hospitals. We urge CMS to streamline reporting and allow all measures to be reported directly through a registry if such a registry is available.

Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window

CMS has an existing policy that prohibits hospitals from charging for diagnostic services related to an admission that occur in the three days prior to admission. . This is intended to prevent hospitals from unbundling services that might normally be provided as part of an admission. In this rule, CMS proposes to expand this policy to all services provided by the hospital in the three days prior to the admission, specifically including services provided at hospital-owned physician practices.

In the past two years, there has been a considerable shift in the practice of cardiology towards a hospital employment model. Because of this, cardiologists are often billing the technical component of their services through the hospital outpatient prospective payment system. The proposed policy will be problematic because cardiologists might see a patient for an office visit or other service and then have the patient admitted to the hospital a day or a two later for an unplanned event. Many physician practices submit bills on a daily basis. Adopting this policy could require physicians to hold bills until they were certain that a patient was not admitted in the subsequent three days. In addition, it is unlikely that these outpatient visits that were recorded before the inpatient admission would be properly recorded on a cost report, so their costs would not be captured as part of an inpatient admission. While CMS allows for a hospital to attest that such work is unrelated to the admission, we think that this will be the case for the majority of the admissions. For this reason we urge CMS to not adopt this proposal to expand the three day window to include non-diagnostic services.

The ACC greatly appreciates the opportunity to comment on these proposed regulations in an effort to improve inpatient cardiovascular care. If you have any questions, please contact Brian Whitman, Associate Director of Regulatory Affairs, at bwhitman@acc.org or (202) 375-6396.

Sincerely,



David R. Holmes, Jr, MD, FACC
President