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**ex officio*

Chief Executive Officer

John C. Lewin, M.D.

August 29, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Attention: CMS-1524-P
Mail Stop C4-26-05
Baltimore MD 21244-8013

Dear Dr. Berwick:

The American College of Cardiology (ACC) is pleased to have the opportunity to offer comments on the **Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2012** as published in the Federal Register on July 19, 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>.

The members of ACC understand perhaps better than anyone the power that lies in CMS's rulemaking authority. The decisions of CMS in its rulemaking cycle for 2010 had an extraordinary impact on the provision of cardiovascular care in this country. That rule, which decreased payments for some cardiology services by more than 20%, led to an increasing movement of cardiologists into hospital employment and integration. Future proposals could have comparable impact on cardiovascular care – our goal in responding to these proposals is to ensure that patients continue to have access to high value cardiovascular care in the most appropriate environment at a fair price.

Potentially Misvalued Codes

CMS requests comments on the development of a validation process to establish a process by which to validate a “sampling” of work RVUs. The RBRVS is by design a relative system which intends to compare the levels of work, practice expense, and professional liability insurance of the thousands of services provided by physicians. It is not a system that is intended to measure actual dollar amounts, or actual physician times or other data. The advantages of a relative system are considerable – they allow scaling based on available funds and make it far easier for a payer such as Medicare to set rates for multiple services with a single adjustment to the conversion factor. However, one disadvantage of a relative system is that it cannot be externally validated unless all components are included in the validation. Services cannot be examined for absolute accuracy, only for relative precision. If we identify some component of the calculation used to generate the RVU that is incorrect, it is impossible to know whether this is a systemic error or an issue with an individual code. If it is a systemic error, then it does not invalidate the relative value system, which merely must operate on an even playing field. While we do not make any specific recommendations on what should be used, we would caution against some of those solutions that have been considered in the past. We are particularly concerned about the proposal made by MedPAC to establish a network of physicians who would provide data. While such data may be helpful in determining practice expense in a manner similar to a cost report completed for a hospital, such an effort would be misleading in the establishment of physician work RVUs, since issues of intensity cannot truly be considered.

We believe that while imperfect, the best mechanism for reviewing relative values remains the Relative Value Update Committee (RUC). Since 2006, the RUC has focused more and more on examining values for existing codes to determine if they are appropriate. As CMS notes in the rule, this process was confined to the five year review process in the early years of the RBRVS. In recent years, the RUC has reviewed existing codes on an ongoing basis using a series of screens to identify services that could be potentially misvalued. Cardiology services have been among the most examined in this effort.

The ACC supports the CMS proposal to eliminate the formal and separate five year review in favor of an annual review. As CMS notes, this process has been ongoing for most of the past five years and an additional effort is redundant. However, we strongly urge that CMS include a proposal and comment period as part of this new annual process as was part of the 5 year review process. In 2009 and 2010, cardiologists have learned of substantial changes in payments for major services two months before implementation because of initiatives related to potentially misvalued services. The opportunity to review proposed changes to values for existing services is essential to ensure that all stakeholders who may be affected by the changes can comment. The Administrative Procedures Act (APA) requires government agencies to include a comment period for these changes unless doing so is “impracticable, unnecessary, or contrary to the public interest.” The review of existing codes does not meet this standard so therefore requires a notification of proposed rulemaking.

In 2010, there was a particularly strong example of why CMS should give stakeholders the opportunity to comment before implementing a value. SPECT myocardial perfusion imaging is one of the most commonly reported services in the Medicare population. In 2008, a joint workgroup of the CPT and RUC identified that the service was commonly reported using three codes – 78465 to report the perfusion imaging, 78478 to report a heart wall motion study and 78480 to report a study of ejection fraction. In October of 2008, the specialties that report these services presented a plan to the CPT editorial panel to eliminate separate reporting of these add-on services and instead require the reporting of a single code which included both of the services previously reported as add-on codes. The RUC made recommendations on the work value and practice expense input for these new codes in February of 2009.

It was not until November of 2009 that cardiologists learned of this change which was also associated with what at the time was a 36% cut in payment for the service. However, CMS made substantial number of errors in the practice expense calculations. These errors required the issuance of a correction notice on May 11, 2010. Because of the large volume of these services provided, this change, along with others related to a malpractice RVU miscalculation, resulted in a recalculation of every RVU. This action was completed more than a year ago and at the time of the submission of this letter, the problems related to this were still not resolved. Retroactive payment adjustments for the first third of 2010 have yet to be processed. CMS is still struggling with how to address this issue and millions of dollars of Medicare payments have not yet been made to those that provide this service.

If the proposed RVUs had been included in a notice of proposed rulemaking, commenters would have been given the opportunity to correct this mistake before it was finalized. While we understand the rationale for using the interim final rule with comment period for truly new services, it makes no sense for services that exist and are altered or have coding changes. Such changes may include a change in the description of the code, a renumbering or the creation of new codes to reflect what had previously been reported with multiple codes. All of these changes are merely made to better describe the services that physicians provide, which do not change substantially from one year to the next in many cases. CMS should allow stakeholders to comment on these changes to comply with the APA and avoid the mistakes and chaos of 2010.

We support the CMS proposal for a public nomination process to identify misvalued services. We agree that those recommending that a service be reviewed should be required to present some kind of documentation that meets standards similar to the RUC's rules established for compelling evidence to change the value of an existing service. We urge a strong CMS review to ensure that valuable resources are not wasted on the review of a family of services unnecessarily. Additionally, a review that encompasses a large number of similar codes creates obstacles for the RUC process when comparator codes are not available to make relativity comparisons. We also support the CMS notion to prioritize based on volume. We would also urge CMS to consider the primary specialty that provides these services in placing them forward for the review. Given the role of specialty societies within the RUC process, a large number of codes to

review for a single specialty may limit the number of physicians who may contribute and reduce the quality of the reviewed data.

We support the CMS proposal to include nominated codes in a proposed rule. As discussed above, CMS has a considerable duty to the public for notification of rulemaking and we believe that this is an essential element of the proposal.

2012 Code Review

CMS notes in this rule that some specialties have had a disproportionate share of codes reviewed as part of this ongoing process. Cardiology is among those specialties. We are therefore supportive of the notion of ensuring that all specialties be reviewed. However, the screen CMS has selected to identify potentially misvalued codes—codes that have not been valued since the Third Five-Year Review of Work for CY 2006 is troubling. The majority of CPT codes have not been reviewed since CY 2006. Values assigned farther in the past should not automatically be viewed as potentially misvalued. CMS outlines in this proposed rule specific documentation it expects stakeholders to submit when nominating a potentially misvalued code during the 60-day public comment period. ACC respectfully suggests CMS itself use the compelling evidence standards it specifies in the proposed rule for other stakeholders to follow when it identifies potentially misvalued codes.

As part of this review, CMS identifies evaluation and management (E/M) services as among the most commonly reported for almost all specialties. CMS then proposes that all of these services be reviewed by the RUC over the next two years.

ACC opposes the review of E/M codes by the RUC at this time. As CMS notes, E/M services consistently appear in the top 20 high PFS expenditure services for each specialty. It appears that CMS wants to use this review—at least in part—to redress perceived inequities in primary care reimbursement. However, since each specialty uses these codes, adjustment of the E/M values up or down will affect all physicians. If CMS wishes to compensate primary care physicians for being, “the focus of managing the patient’s chronic conditions,” it should adopt some of the solutions already approved by CPT and RUC, such as payment for telephone and online E/M services or adoption of medical home recommendations. Finally, CMS indicates that it believes, “the focus of primary care has evolved to meet the challenges of preventing and managing chronic disease.” Cardiologists have also evolved to meet the challenges of managing and treating patients with chronic disease who find themselves in need of care for cardiovascular conditions that are only worsened by the graying of the population and increase of obesity-related illnesses. The College strongly supports improved payment for effective prevention and management of chronic disease. However, we believe that high quality provision of such services is not defined by the specialty of the provider and thus we cannot support policy options that focus on provider specialty rather than on the content and the quality of the service being provided.

CMS outlines in this proposed rule specific documentation it expects stakeholders to submit when nominating a potentially misvalued code during the 60-day public comment

period. Rather than addressing every E/M code, CMS could itself use the compelling evidence standards it specifies in the proposed rule for other stakeholders follow when it identifies potentially misvalued codes for E/M and other services.

Ultrasound Equipment

In this rule, CMS proposes to request that the RUC review all services that include ultrasound equipment as a practice expense input. CMS notes that there is considerable variation in the costs for these services that should be addressed. This equipment is used by many cardiologists for services such as echocardiography and vascular ultrasound. ACC looks forward to working with other societies at the RUC to address the inconsistencies and ensure that payment for all services properly covers the costs to practices.

Expanding the Multiple Procedure Payment Reduction Policy

CMS proposes to expand the multiple procedure payment reduction policy that had applied to the technical component of certain advanced imaging services to the professional component of these same services. For these services, CMS proposes to reduce payment for the professional component of second and subsequent services by 50% if performed on the same day by the same physician.

The ACC opposes this proposal to expand the multiple procedure payment reduction. CMS bases this proposed payment policy on a number of existing policies: the multiple procedure surgical payment reduction and the reduction associated with combination abdomen and pelvis CT codes. We believe there are considerable differences from all of these payment policies to make them poor proxies for this proposal for the professional component of advanced imaging.

The surgical payment reduction accounts for the fact that a surgical procedure includes significant work value for opening and closing a surgical site as well as 90 days of follow up care in the hospital or the office. The work values for imaging services primarily account for the review and analysis of the image and include negligible amounts of duplicated work.

As CMS notes in the rule, a new code for a combination of an abdominal and pelvis CT was recently created and the work value for that code was approximately equal to a 50% reduction for the lesser valued code. However, CMS does not indicate why it believes that the work value reduction for one commonly provided procedure using the same imaging modality on adjacent body parts should serve as the guide for a payment policy that applies to multiple modalities. CMS fails to note that there have been other combined codes created that did not reflect similar efficiencies in work values.

In the rule, CMS asks for comments on potentially expanding this multiple procedure payment reduction even further in future rulemaking to include all diagnostic services or all professional services. The ACC would strongly oppose this expansion for the same

reasons. CMS should endeavor to pay for a service at a rate that reflects providing the service efficiently rather than attempting to continue to adjust for efficiency based on some kind of combination of services. This continual adjustment causes administrative complexity and fails to reward physicians and other providers for identifying efficient solutions for their patients.

Physician Quality Reporting

The ACC supports the continued efforts of CMS to move the Physician Quality Reporting System (PQRS) from a claims-based reporting system to one using registry and electronic health record (EHR) data. The administrative complexity of reporting through claims has led to fewer than half of physicians who attempt to participate being successful. In contrast, almost all of registry participants have been successful. The availability of registry reporting has substantially increased cardiology participation in the program and we strongly support these continuing efforts.

In 2007, the ACC began the development of the first outpatient cardiovascular registry called PINNACLE. ACC had considerable experience in developing registries for use in hospitals prior to creating this new outpatient registry. Physicians from across the country have used this registry to receive rapid feedback on their performance on many common measures of cardiovascular performance. This registry allows for physicians to report via the most appropriate method for their practice, whether it is paper-form submission, web data entry, or EHR integration.

ACC opposes the proposal to require entities to declare themselves as either a registry or an EHR data submission vendor. PINNACLE was not designed as a PQRS registry. Rather, it is a registry designed to drive quality improvement in practice and to provide a data repository for novel scientific research. As such, it relies on more than one data submission method. It accepts legacy paper forms, web based entry, EHR extracts from certified vendors, and back-end data mapping in EHR databases.

We believe that CMS should use the PQRS program to encourage further use of tools such as PINNACLE. Unfortunately, if this portion of the proposed rule were to be implemented, some portions of the practices that use PINNACLE would no longer be able to get credit for participating in PQRS.

We urge CMS to allow for entities to register as both EHR data submission vendors and as PQRS registries rather than requiring them to choose one or the other.

PQRS Core Measures

In this rule, CMS proposes that all family physicians, general internists, and cardiologists report on at least one of seven core measures of cardiovascular care. First, we appreciate that CMS has recognized the importance of measurement of cardiovascular care in both the primary care and specialty areas. CMS should focus early measurement and improvement efforts on those diseases which have the greatest cost and cardiovascular

disease has long been at the top of that list. However, we are unsure if the measures that CMS has proposed to include in this core set truly represent the core of cardiovascular care. It appears CMS selected these measures because they may be reported through claims, registry, and EHR methods. However, by doing so, CMS has excluded the coronary artery disease and heart failure measures that have been the core of cardiology participation in PQRS for many years. Three of the measures proposed to be included have not been approved by the National Quality Forum (NQF) process that CMS has typically used for measurement vetting. We would urge that CMS alter this list of quality measure to include at least one measure from either the coronary artery disease or heart failure measure group. We strongly support the inclusion of measures groups for coronary artery disease and heart failure for 2012 and beyond – these measure the most costly cardiovascular diseases and provide a helpful quality snapshot for physicians.

Maintenance of Certification Program Incentive

The ACA included a provision to allow physicians to receive an additional 0.5% bonus payment for participation in certain maintenance of certification (MOC) activities if also a successful PQRS participant. Unfortunately, CMS implemented this provision in 2011 in such a way that no physicians would be likely to participate. In 2011, a physician would have to complete all elements of maintenance of certification, including an exam, more frequently than is required in order to receive this additional bonus.

We are disappointed that CMS implemented this provision in this fashion in 2011, so we strongly support the proposed change in 2012 to align more closely with Congressional intent. We support the CMS proposal to allow physicians to receive an additional 0.5% bonus as long as they complete one element of MOC more frequently than required for MOC in addition to successful PQRS participation. This should provide an incentive, however small, for physicians to increase their participation in lifelong learning and increasing their knowledge base in their field.

Future Payment Adjustments for the Physician Quality Reporting System

As CMS notes in the rule, the ACA included provisions that moved the PQRS from a bonus program to a penalty program starting in 2015. The ACC strongly opposes the CMS proposal to penalize physicians in 2015 for PQRS participation in 2013. As written, the legislation intends to penalize physicians for failure to participate in 2015, not to require the penalty to be implemented in 2015. CMS states that they are doing this for administrative simplicity. CMS used similar logic in implementing provisions related to payment reductions for not using electronic prescribing in 2012. Physicians who began using electronic prescribing on July 1 of 2011 will be penalized throughout 2012 despite meeting the requirements of the law. Similarly, a physician who reports through PQRS in 2015 will be penalized for not participating in 2013. While we understand the CMS interest in administrative simplicity, we do not believe that this allows the undermining of legislative intent. We urge CMS to discard this portion of the regulation and propose a method that allows physicians to avoid a penalty by reporting during 2015. There are numerous alternatives that could be considered, particularly if CMS takes

advantage of its intention to move more physicians towards registry and EHR based measures. The long lag time between data collection and payment adjustment is largely a result of the claims-based system. We urge CMS to follow the intent of Congress and use innovative solutions for this matter.

E-prescribing Incentive Program

E-prescribing payment adjustment reporting period

The ACC continues to oppose CMS's position that the reporting period for the e-prescribing payment adjustment must begin and end prior to the year to which it applies. As we have stated previously, the College believes the statutory language supports the interpretation that the payment adjustment should be based on 2012 data and implemented accordingly. Additionally, defining the reporting period in this manner is contrary to the manner in which CMS has implemented the bonus component of both the Medicare E-Prescribing Incentive Program and the Physician Quality Reporting System. To date, CMS has defined the reporting period as the current year and paid the bonus in the following year. CMS has opted to upend this process and define the reporting period as the year preceding that which is listed in the statute with the intention of applying the penalty in the year listed in the statute.

While we oppose the early reporting period deadline for the payment adjustment, we do support CMS's proposal to at least provide an additional opportunity for practitioners to report e-prescribing in order to avoid the 2013 payment adjustment, as well as the two reporting periods for 2014. This will allow additional time for educating practitioners regarding the 2013 payment adjustment, especially those who did not learn about the 2012 payment adjustment reporting period early enough to prevent the decrease to their 2012 Medicare payments.

E-prescribing measure

Cardiovascular specialists prescribe various medications for their patients. However, these prescriptions are not always written in conjunction with a particular service. Sometimes, a refill may be required and a visit unnecessary. An unnecessary visit is a waste of both time and money for all involved. Thus, the ACC supports the CMS proposal to remove the requirement that the e-prescription be written at the time of an office visit for the six-month reporting periods associated with the 2013 and 2014 payment adjustments. We would also urge that CMS do the same for the 2012 and 2013 E-Prescribing Incentive Program, as well as for the 12-month reporting periods for the 2013 and 2014 payment adjustments. This will allow for consistency throughout the program, as well as avoid confusion for practitioners regarding differences between the e-prescribing incentive and the e-prescribing payment adjustment.

E-prescribing requirements

There are now multiple Medicare programs that require the reporting of information pertaining to e-prescribing. To reduce the administrative burden on practices, the ACC believes that these requirements should be harmonized and discrepancies should be carefully considered to ensure a real need for them. The ACC supports initiatives to ensure that practitioners investing in certified electronic health record (EHR) technology in order to participate in the EHR Incentive do not have to purchase separate e-prescribing systems simply to comply with the requirements of the e-prescribing program.

Registry reporting of e-prescribing

The ACC is a strong supporter of participating in clinical databases. The National Cardiovascular Data Registry® (NCDR®) suite includes the nation's first cardiovascular outpatient registry, PINNACLE. PINNACLE has been a qualified registry for purposes of PQRS and the E-Prescribing Incentive Program for the last number of years and aims to continue as such. Participants in PINNACLE have repeatedly questioned why they were unable to use the registry to demonstrate that they had successfully fulfilled the requirements to avoid the e-prescribing payment adjustment. Rather than being able to report all of their PQRS and e-prescribing data through one mechanism, they have had to use multiple, creating an unnecessary administrative burden for cardiovascular practices.

Exemptions from 2013 and 2014 e-prescribing payment adjustments

CMS recently released a proposal to add exemptions from the 2012 e-prescribing payment adjustment. The ACC urges CMS to include all of those proposed in that regulation for 2013 and 2014. The College strongly recommends that the clarifications requested in the ACC's comments on that rule be adopted for the exemptions for 2013 and 2014, as well. The four exemptions proposed by CMS should be adopted, and the ACC urges that CMS create an additional exemption for employed practitioners who do not have the opportunity to e-prescribe because their employer has elected not to adopt an e-prescribing system. This exemption would cover those physicians who have the capability of prescribing during their residencies and/or fellowships during the reporting period but do not have access to an e-prescribing system. These individuals complete their residencies and fellowships and move to new practices that do have e-prescribing systems. However, because they did not e-prescribe during the reporting period through no fault of their own, these new highly qualified cardiovascular specialists and their new employers will experience payment reductions. The hosting entities are not penalized for their failure to adopt e-prescribing; rather, it is other practices that suffer the consequences of the non-action. Thus, CMS should include an exemption that addresses these concerns.

The ACC supports the development of a web-based tool to allow for easy assessment of requests, as well as timely determination of those requests. Individuals who believe they will not be able to meet the six or 12-month reporting requirements and are eligible for an exemption should be able to request those exemptions as soon as the need becomes apparent. They should not have to wait until the six-month reporting period for that

payment adjustment year. This will enable CMS to process the requests in a more timely fashion.

CMS does not propose any timeline for issuing decisions regarding hardship exemptions. The ACC believes that CMS should be required to issue determinations within 15 days of a request for a hardship exemption. Issuing the request in 15 days will allow practitioners to determine their options in the event of a denial and to create and implement plans that allow them to avoid the payment adjustment.

Additionally, the College firmly supports the need to allow for and develop an appeals process for denials of requests for hardship exemptions. The requirements for some of the hardship exemptions are subjective and review of those decisions would assist in providing some degree of objectivity to the process.

Physician Compare Website

In this rule, CMS proposes to continue to expand the Physician Compare website as required by the ACA. The Physician Compare site today is limited to physician contact information as well as whether he or she was a successful participant in PQRS in the preceding year. In this rule, CMS proposes a limited expansion of the performance measurement information available on this website to include the group performance information for those large practices that participated in PQRS using the group practice reporting option (GPRO). These large groups reported on a fixed group of measures and had large numbers of physicians participating. The ACC has long maintained that performance measurement for physicians should take place at the group practice level. This allows for large enough sample sizes to avoid data anomalies but also allows for changes made by individual physicians to have a significant impact on quality. We appreciate CMS's proposal to move slowly into public reporting, recognizing the power that this data can have if it is not properly presented. We are encouraged by the staged development of public reporting in this arena and look forward to working with CMS on further developments in this area.

Improvements to the Physician Feedback Program and Establishment of the Value-Based Payment Modifier

In this rule, CMS makes some significant steps toward the implementation of the physician feedback and value-based purchasing program provisions contained within the ACA. The ACC is supportive of the efforts to provide physicians with more data about their performance and resource use as well as to move the payment system towards one more focused on quality and less focused on volume. However, we are concerned by the enormous difficulty that CMS will have in implementing this program. The science of performance measurement is still very young and issues related to attribution and comparison, if not considered properly, will sink any program if not very carefully considered in collaboration with physicians. While CMS offers some hints of its plans in the future for this program within this rule, we urge CMS to work carefully in the coming year to develop plans on how to implement the value-based purchasing provisions. We

urge individual discussions with specialty societies as well as broad and open town hall meetings to make sure that CMS gets this right. The timeline for this work is short and the task is extraordinarily difficult.

Physician Feedback Reports

CMS announces plans to greatly expand the testing of physician feedback reports, indicating that reports will be sent to all physicians in four states (Iowa, Kansas, Missouri, and Nebraska) in the latter part of 2011. We support CMS testing these reports in this fashion. We believe that these reports should include a mix of quality and resource use information. We are disappointed that the quality data is limited to either PQRS reporting information or claims-based measures. We would be very interested in exploring the opportunity to integrate registry data that includes clinical information. We are encouraged by the CMS plan to incorporate those quality measures required for participation in the Electronic Health Record incentive program but believe that the inclusion of registry data would further add into the understanding of quality care.

We are particularly concerned with the use of claims-based performance measures in these reports. We believe that the systems of physician feedback, physician public reporting, and physician value-based purchasing should work together seamlessly, measuring the same performance and all furthering the goal of improving performance. Claims-based measures do not typically reflect the acuity of the patient nor do they capture all the information needed from a clinical report. In addition, the claims system does not always capture the information intended. Some of the measures that are proposed to be included track the use of drugs – the data on the drugs comes from Part D information. However, some patients are able to receive drugs without this transaction through patient assistance programs or through free generics available from some stores.

We would strongly oppose the use of these measures in public reporting or for payment adjustment so we do not believe that they should be included in the feedback reports. CMS will also report resource use on these reports for patients with heart failure, chronic obstructive pulmonary disease, diabetes, and coronary artery disease. We understand that CMS is working on the development of a Medicare-specific episode grouper through a competition of four contractors that will likely be used in future versions of this report.

We support the use of per-capita costs in confidential physician feedback reports until such time as that Medicare episode grouper has been fully developed. We believe that CMS recognizes the limitations of the per-capita methods and we support the work to identify an episode grouper that takes into account the multiple chronic conditions that are common in Medicare patients.

Attribution

Attribution of patients and their costs and quality is a very important element of physician performance improvement. CMS proposes to expand their attribution methodology to ensure that more physicians can have patients assigned to them. We support the CMS

proposal to expand this attribution methodology as we believe that there should be shared accountability across the care team. We support the CMS proposal to develop these attribution methods slowly and deliberately.

The ACC supports shared accountability but believes that comparisons among physicians should be made based on specialty designation. While primary care physicians may see patients with the same diagnosis code as cardiologist, the patient acuity and difficulty for those seen by specialists is often higher. We believe the proper comparison group for a cardiologist is other cardiologists. An even better comparison method would compare cardiology groups to one another. This allows for the capture of the broad subspecialties of cardiology that are often housed within a single group and increases the sample size and likely the confidence in the performance reports.

Value-Based Payment Modifier

The ACA requires Medicare to begin to adjust payment for quality and resource use to physicians in 2015. In this rule, CMS proposes to make these adjustments based on data from 2013 due to the length of time required for filing of claims. We support the CMS goal of using this program to improve quality for all Medicare patients and want to ensure that goal remains at the core of this initiative-

As Medicare begins to implement the value-based payment modifier, we would like to reiterate some important policies that should be guiding the implementation of this program, building from our 2006 Principles to Guide Pay for Performance Programs. First, we believe that the program should use performance measures that have been created by physicians and developed by multi-stakeholder bodies. We would oppose the implementation of new measures for value-based purchasing that have not had this level of scrutiny.

We believe that the value-based purchasing program should use a mix of process, outcome, and patient experience measures. We support the CMS goal of moving to a system that focuses on outcome measures, but we do not believe that the risk adjustment associated with outcomes measures is yet perfected to the point that well-selected process measures should be ignored. We have seen great improvement in performance on evidence-based process measures in the hospital setting and we believe that has helped to improve the quality of care in that environment.

We strongly support the CMS initiative to minimize administrative burden associated with performance measurement. Claims-based measures have been attractive primarily because they do not require additional burden on physicians and other providers. However, there are new opportunities in an electronic environment. In particular, the ACC has developed the outpatient PINNACLE registry to capture performance measurement information. This registry has the benefits of capturing detailed clinical data without additional chart abstraction by integrating into existing electronic health record programs. We believe that CMS should take advantage of data collection like this and use data from outpatient registries to measure quality for physicians.

Proposed Measures

CMS proposes the inclusion of a series of measures for the value-based purchasing program composed of the core measures from the EHR meaningful use program, the measures in the group practice reporting option of PQRS, and the core measures for PQRS for cardiologists, family physicians, and general internists proposed in this rule. This long list of measures shows a focus on cardiovascular disease, diabetes, and pulmonary care. We support the CMS proposal to focus on the most common conditions in the Medicare population in the initial year of review. As noted above, we do not support the inclusion of claims-based measures in the value-based modifier.

Transition of Care Measures

Although CMS does not propose any measures of transition of care, it requests opinions on the issue of including transition of care measures in the value-based purchasing program. The ACC has a strong interest in improving the transition of patients from the hospital into the community. For the past two years, the ACC has convened a volunteer community to share best practices on this subject called Hospital to Home. Patients discharged with diseases such as congestive heart failure are at very high risk for a quick return to the hospital. We believe that a focus on transition of care is appropriate to include in the value-based purchasing program, however, the risk-adjustment methodology must be more robust than what is used in some current measures. In some cases, patients returning for planned procedures or unrelated illnesses are considered to be readmissions and this is not appropriate.

Cost of Care Measures

As with the physician feedback reports, CMS proposes to use per-capita costs for patients with certain conditions to measure resource costs. We do not support the inclusion of per-capita costs as the resource measures. Per-capita costs assign all physicians the same level of accountability for patients. As discussed earlier in this comment letter, we are looking forward to the further development of the episode groupers that are more appropriate for patients with multiple chronic conditions. It is unclear to us why that grouper may not be used in the first year of the value-based purchasing program given the CMS intention to select one of the contractors at the end of 2011. If properly designed, this would provide a better framework for comparing costs on both chronic and acute care episodes.

Assessing Physician Performance and Applying the Value Modifier

The establishment of the performance and resource use measures is an important step towards implementing value-based purchasing but far from the most difficult. Far more difficult will be creating composites of these measures in order to adjust payment as required by the ACA. We are particularly interested in how the measures will be created into a single composite. Many measures will not be as meaningful to some specialties as

others. Measures will need to be weighted according to patient volume in order to ensure that a physician such as a cardiologist is measured for cardiovascular more than for pulmonary care. We look forward to working with CMS in the coming year to develop a composite methodology to improve the value-based payment initiative.

We encourage CMS to implement a system that rewards both improvement and overall performance, similar to how it has implemented the hospital value-based purchasing program. If CMS were to reward only high performance, low performers would have little incentive to improve. If CMS were to reward only improvement, the high performers would receive no recognition for established high quality.

We encourage CMS to compare physicians who treat similar patients to one another rather than comparing all physicians on a single scale. While the hospital program compares all hospitals using the same measures, there are a relatively small number of hospitals in this country, and they are relatively homogenous compared to physicians. We are not aware of any method that would allow CMS to meaningfully compare a cardiologist with a pathologist or an otolaryngologist. The appropriate peer group for cardiologists is other cardiologists. We also urge CMS to adjust payment at the group level to the extent possible. As we have stated elsewhere in this comment letter, the group level is large enough to draw a sufficient sample but small enough to change quickly.

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 the hospital's 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 appreciates the opportunity to comment on the many policies proposed in this year's rule. We expect to take the coming year to increase our collaboration opportunities with CMS in forming the future of payment systems through the implementation of value-based purchasing. If you have any questions about this letter, please contact Brian Whitman, Associate Director of Regulatory Affairs at bwhitman@acc.org or (202) 375-6396.

Sincerely,



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President