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December 23, 2008

Michael Leavitt
Secretary, Department of Health and Human Services
200 Independence Ave SW
Washington DC 20201

Dear Secretary Leavitt:

The American College of Cardiology (ACC) is pleased to offer comments on the development of a plan to transition to a Medicare value-based purchasing program for physician and other professional services.

The ACC is a professional medical society and teaching institution made up of 37,000 cardiovascular professionals from around the world – including 90 percent of practicing cardiologists in the United States and a growing number of registered nurses, clinical nurse specialists, nurse practitioners, physician assistants, and clinical pharmacists. The ACC is committed to improving the health care of all Americans and is pleased to offer comments on the questions contained within the plan.

The ACC appreciates the expediency required of the Department of Health and Human Services (HHS) in developing these recommendations based on the requirements of the Medicare Improvements for Patients and Providers Act of 2008. However, given the depth of these issues and the important consideration that they require, ACC hopes that dialogue about a framework for moving to value-based purchasing can continue for some time after the delivery of the Congressionally-mandated report.

The ACC is committed to working towards health system reform that transforms today's system that too often rewards volume over quality. The ACC believes that a new payment system should include payment incentives for quality care and reward physicians and other providers for collaborating across settings of care. Such a system should also be transparent to both providers of care and to patients and should genuinely measure long-term health outcomes. Underlying all of this is the issue of access. We cannot achieve significant improvements in healthcare in the United States while so many do not have consistent or complete access to care.

ACC is committed to health system reform that involves carefully examining the many issues with the healthcare financing and delivery system and exploring alternative models that may begin to address these issues. Given the extraordinary complexity of the healthcare system, it seems unlikely that any one solution will be effective for all practice settings. However, as important as it is to accommodate various practice settings, it is far more important to recognize that the health of the patients is paramount. The ACC intends to explore health care delivery system innovations to support and reward the provision of evidence based care.

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.

In the plan, HHS asked commenters to address comments focusing on four areas as proposed in the plan:

1. Measures
2. Incentive Structure
3. Data Strategy and Infrastructure
4. Public Reporting

Measures

The issue of paying for value depends entirely on whether you can measure value. The ACC believes that patients receive value when they receive evidence-based care from their physicians. The ACC has worked diligently through its expert consensus process to identify measures that appropriately measure cardiovascular care. These measures have been further vetted through multispecialty discussions at the Physicians Consortium for Performance Improvement and other consensus-based organizations committed to quality. Only measures that meet this very high standard of review and consensus should be considered as part of a physician value-based purchasing plan (PVBP). Using proprietary or inconsistent measures leads to questions about the basis of measures and may not support the delivery of evidence-based care that is encouraged by these measures.

The ACC released a set of principles for performance measures in 2006 which it continues to standby.¹ All measures of valid comparison should have four characteristics:

- 1) Current – all measures should reflect current practice guidelines and take into account the latest evidence
- 2) Comparable – all measures should allow for physicians and other providers to be compared between one another in addition to longitudinal comparisons that allow physicians to demonstrate progress over time
- 3) Risk-adjusted – all outcome measures should have risk-adjustment so that physicians have the same incentive to provide care to difficult or very sick patients without risk of reductions on performance scores
- 4) Use standard data definitions – the performance measures used in PVBP should use recognizable data standards to measure clinical quality

The ACC has been a leader in creating measures of performance for its members, but recognizes that other specialties may not have as many robust measures as cardiology.

¹ Brush, John E., Jr, Krumholz, Harlan M., Wright, Janet S., Brindis, Ralph G., Cacchione, Joseph G., Drozda, Joseph P., Jr, Fasules, James W., Flood, Kathleen B., Garson, Arthur, Jr, Masoudi, Frederick A., McBride, Tilithia, McKay, Charles R., Messer, Joseph V., Mirro, Michael J., O'Toole, Michael F., Peterson, Eric D., Schaeffer, John W., Valentine, C. Michael
American College of Cardiology 2006 Principles to Guide Physician Pay-for-Performance Programs: A Report of the American College of Cardiology Work Group on Pay for Performance (A Joint Working Group of the ACC Quality Strategic Direction Committee and the ACC Advocacy Committee)

While a PVBP plan should endeavor to eventually include measures that are applicable to all professionals, it cannot be held back from implementation until every kind of health care provider has established quality measures based on evidence. The ACC believes that every facet of a PVBP should encourage professionals and other providers to work together to improve care.

The ACC has considered the issue of whether physicians or physician groups or some other kind of cohort should be measured. The ACC believes that the level of accountability for quality measures in the physician payment area should lie at the physician group level rather than the individual physician level in most cases. While physician groups may be very large or very small, they tend to have a structure that allows them to change to encourage quality care and for physicians to associate their own actions with the rewards and penalties that may be part of a value-based purchasing program. A well-functioning group practice has the opportunity to instill a culture of evidence-based medicine and performance measurement that can lead to excellent care for patients.

While the accountability for payment may most properly rest at the physician group level, aggregation of data to a regional level or disaggregation of data to an individual physician level is also likely to be very helpful in improving care so that we can further identify the barriers to providing evidence-based care in the United States. While there are beliefs about what those barriers are, having the ability to manipulate the data could reveal even more information and greatly improve our health care system.

The ACC would be interested in exploring payment incentive programs that reward health care systems that are larger, such as accountable care organizations, or physician-hospital partnerships, or other methodologies. However, the ACC believes that it may be difficult to establish such systems throughout the country because of the extraordinary variation in availability and structure of health care. Regardless of the distribution of incentives, a PVBP should encourage different providers of care to work together. One of the most unfortunate legacies of the Medicare legislation is the absolute split between Part A and Part B spending and funding and further splits between fee schedules within those various parts. Since different providers of care are paid through different formulas, there may be a financial incentive to treat patients in the venue that provides the most payment rather than that which is most appropriate for the care of the patient. Such incentives are contrary to the development of a value-based purchasing program.

Incentive Structure

The payment system for health care in the United States creates a number of different incentives, few of which are related to quality of care. While it is fortunate that physicians are able to provide quality care in many cases, rewarding them financially for those efforts would be a significant improvement over today's system that largely rewards volume of services provided.

The payment incentive for providing quality care must be high enough to make it more worthwhile to provide quality care to fewer patients rather than low-quality care to many

patients. The ACC does not believe that the volume of service provided should be completely disregarded as new payment systems develop, nor should the technical skill and relative risk be disregarded. These elements are considered as part of the system used to pay physicians for Medicare services since 1992 - the Resource-Based Relative Value Scale (RBRVS). While the RBRVS is far from perfect, it does recognize that there are differences in the technical difficulty and relative risk of different procedures and services. While arguments can be made about the relative accuracy of RVUs in the current system, the ACC continues to believe that the intensity of work accounted for in the RBRVS should be maintained in some form in a future value-based purchasing system.

The ACC is aware of significant regional variations in the cost and quality of medical care in the United States. While some review these studies and make recommendations of gross and unfocused payment changes, the ACC recommends a more nuanced approach. The ACC believes that future payment systems must continue to have some kind of fee-for-service component as a base with significant incentives for quality care. In pursuit of this quality goal, ACC has invested considerable resources in creating a process to gather clinical data from its members in a variety of clinical settings. The National Cardiovascular Data Registry (NCDR) has become commonplace in inpatient settings throughout the United States. The ACC would like to further expand the use of registries, particularly in the outpatient setting, but physicians that participate in these registries need to be compensated for their important contribution to quality care. If physicians are paid better for seeing a high volume of patients regardless of the quality of care provided, it is difficult to convince them to take the time to participate in those registries. A significant bonus payment for participating in a registry of, for example, greater than 10%, would be likely to increase participation in these registries, particularly in outpatient arenas.

While not all physicians will initially have access to registries, transitional bonus payments could be made for reporting quality data through claims-based efforts such as the Physician Quality Reporting Initiative (PQRI). The use of augmented claims data has the disadvantage of being administratively burdensome on physicians and not capturing the same amount of information as a registry. However, it is an appropriate intermediate step that serves to move physicians in the direction of quality reporting. Financial incentives should be structured to encourage physicians to use registries by giving them a greater financial incentive for registry reporting than reporting through augmented claims.

There are many different ways in which performance may theoretically be measured. The ACC believes that the use of process measures is the best way to measure and reward performance at this time. By rewarding physicians for behaviors that have been shown by evidence to lead to better outcomes, the system avoids many of the issues of risk adjustment and adverse selection that may impact other measurement systems. The ACC also believes that physicians should receive an incentive for using more efficient systems such as electronic health records. Electronic health records, properly implemented, have enormous potential to increase efficiency and reduce the issues of the transition of care.

The ACC urges caution in attempting to measure outcomes as a part of a value-based purchasing plan. The goal of the healthcare system should be to get the best possible outcomes using the fewest necessary resources. Unfortunately, judging outcomes is difficult in some spheres of care. While the outcome of a surgical procedure or a hospital stay might be relatively easy to determine over a short period of time, it is far more difficult to judge the quality of five years of care for a congestive heart failure patient who may be seen by multiple physicians in a variety of settings and receive a number of different treatment options. Outcomes are also very much based on patient behavior. While physicians strive to counsel patients to change behaviors in order to improve their healthcare, patient compliance remains a difficult issue. Any system that would further discourage physicians from treating patients who are non-compliant or sicker than average would be a system that would not encourage quality care, as these patients would be more likely to receive fractured and costly care when not managed.

In order for physicians to connect their performance with payment incentives, there must be a clear link. One of the limitations of the current PQRI program is the substantial delay between the reporting of quality measures and the release of the information and the payment to physicians. By the time that physicians are made aware of their actions and receive or do not receive their payments, six months have passed and it is hard to connect the reward with the behavior. It would be far more effective to have the reward closely follow the action to give the physicians incentive to quickly change behavior. The ACC believes that feedback and payments for quality measures should be quick but should reflect patterns of care rather than isolated cases. Such an approach would likely result in a periodic bonus for quality measures, but the opportunity for physicians to review the data on a nearly real-time basis.

Incentives for these process measures should be distributed at the same level of measurement, which ACC believes is most properly at the physician group level. If incentives were distributed in a different manner from the measurement system, it would be difficult for physicians and other healthcare providers to connect the measurement with payment.

ACC is aware that there are considerable issues of geographic variation that may manifest themselves in PVBP. There are considerable access issues in many parts of the country. A patient without access to any care has no ability to benefit from value-based purchasing, no matter how well it is designed. Any PVBP system that is created should aim to give patients who live in rural areas the same access to high quality care as those in urban areas. Specific incentives may be needed to ensure the highest level of care for patients throughout the country. Such incentives, however, should be considered on the basis of patient needs. . There should be the same expectation of quality in rural and urban areas based on appropriate incentives.

Data Strategy and Infrastructure

Ideally, data reporting should be seamless with the care process. Most of the data that is needed to measure the performance of a physician is the data that is needed to care for the

patient. A system of truly integrated electronic medical records would be the most seamless method of reporting quality data. However, the implementation rates for electronic medical records in settings such as physician offices continue to be low due to the significant cost of implementation and the uncertain future payment landscape.

A registry is a good intermediate step for reporting data. Pertinent clinical information is reported on all patients, allowing practices to participate in their own quality improvement projects. That data can then be reported as appropriate to both private and public payers. The ACC has invested considerable resources in developing registries for use by cardiologists and believes that physicians that participate in these registry programs are improving the care for their patients through the measurement of quality in their own practice.

The most burdensome method of reporting quality data is requiring physicians and other providers to re-document or resubmit information on select patients using a cumbersome coding system, such as in the current PQRI program. While this current program aims to pay physicians for the burden of this reporting, the low participation rates for that program seem to indicate that most physicians are not finding it worthwhile. In addition, because this system is limited to Medicare patients, it does not provide the full benefit of a registry for a practice.

CMS would be far better served to provide a more robust incentive for physicians to report quality data through a registry or electronic medical record, rather than investing significant resources in a program that is little used and does not provide as much meaningful data.

Public Reporting

The ACC has been carefully considering the issue of public reporting of quality and efficiency information in recent years and has released two policy statements on the issue this year. Those two statements: *Principles for Public Reporting of Physician Performance Data* and *Standards for Measures Used for Public Reporting of Efficiency in Health Care* form the core of our statement on this issue. The papers are attached to this submission as a reference.

The ACC supports a transparent healthcare system but continues to have long term concerns about the opportunity cost of focusing on public reporting over using performance measures as a feedback to provider organizations to improve the quality of care. However, if measures are to be reported, they should be reported at the physician group level. The ACC has significant concerns about the statistical validity of reporting on quality at the individual physician level. It is often difficult for physicians to see enough patients with a certain disease that is measured through an evidence-based measure to make a meaningful comparison.

The ACC does not believe that resource use measures should be publicly reported as these measures only reflect cost and do not reflect efficiency. A physician or other health

care provider is not merely a provider of resources and reporting on such a gross measure could lead to perverse incentives to reduce provided care inappropriately.

It may be appropriate to report a combination of resource use and quality information that may be considered to be efficiency measures. There is less consensus around the measurement of efficiency than there is in measurement of quality, so this is a difficult path to start down. However, if efficiency measures are reported to the public, the ACC believes that any such measures should:

- include valid and transparent cost measurement and analysis;
- avoid creating an incentive to provide poor quality care; and
- attribute resource use appropriately.

The ACC looks forward to continuing to work with HHS, the Congress, and the public to develop a plan for broad-based health system reform in the future. Our commitment to quality cardiovascular care demands a better system where value is rewarded over volume. If you have any questions about these comments, please contact Brian Whitman, Associate Director of Regulatory Affairs at (202) 375-6396 or bwhitman@acc.org. Thank you for the opportunity to comment.

Sincerely,



W. Douglas Weaver, MD, FACC
President