



1949 - 2009

AMERICAN COLLEGE
OF CARDIOLOGY

*Helping Cardiovascular Professionals
Learn. Advance. Heal.*

Heart House

2400 N Street, NW
Washington, DC 20037-1153
USA

202.375.6000
800.253.4636
Fax: 202.375.7000
www.acc.org

President

Alfred A. Bove, M.D., Ph.D., F.A.C.C.

President-Elect

Ralph G. Brindis, M.D., M.P.H., F.A.C.C.

Immediate Past President

W. Douglas Weaver, M.D., M.A.C.C.

Vice President

David R. Holmes, Jr., M.D., F.A.C.C.

Secretary

John G. Harold, M.D., F.A.C.C.

Treasurer

Richard A. Chazal, M.D., F.A.C.C.

Chair, Board of Governors

John G. Harold, M.D., F.A.C.C.

Trustees

Elliott M. Antman, M.D., F.A.C.C.
Eric R. Bates, M.D., F.A.C.C.
Alfred A. Bove, M.D., Ph.D., F.A.C.C.
Ralph G. Brindis, M.D., M.P.H., F.A.C.C.
A. John Camm, M.D., F.A.C.C.
Richard A. Chazal, M.D., F.A.C.C.
Gregory J. Dehmer, M.D., F.A.C.C.
Paul L. Douglass, M.D., F.A.C.C.
James T. Dove, M.D., M.A.C.C.
Robert A. Guyton, M.D., F.A.C.C.
John G. Harold, M.D., F.A.C.C.*
Robert A. Harrington, M.D., F.A.C.C.
David R. Holmes, Jr., M.D., F.A.C.C.
Jerry D. Kennett, M.D., F.A.C.C.
Richard J. Kovacs, M.D., F.A.C.C.*
Gerard R. Martin, M.D., F.A.C.C.
Charles R. McKay, M.D., F.A.C.C.
Rick A. Nishimura, M.D., F.A.C.C.
Steven E. Nissen, M.D., M.A.C.C.
Patrick T. O'Gara, M.D., F.A.C.C.
George P. Rodgers, M.D., F.A.C.C.
John S. Rumsfeld, M.D., Ph.D., F.A.C.C.
Jane E. Schauer, M.D., Ph.D., F.A.C.C.*
James E. Udelson, M.D., F.A.C.C.
C. Michael Valentine, M.D., F.A.C.C.
Mary Norine Walsh, M.D., F.A.C.C.
Carol A. Warnes, M.D., F.A.C.C.
W. Douglas Weaver, M.D., M.A.C.C.
Kim Allan Williams, M.D., F.A.C.C.
Stuart A. Winston, D.O., F.A.C.C.

**ex officio*

Chief Executive Officer

John C. Lewin, M.D.

April 17, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Frizzera:

The American College of Cardiology (ACC) is pleased to offer suggestions for reporting methods for the Medicare Physician Quality Reporting Initiative (PQRI) program in 2010.

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 quality in medicine and the suggested changes should allow further participation of ACC members in the reporting of quality data.

CMS notes that there are many different mechanisms through which physicians can participate in PQRI, but those can be broken down into three major categories – claims-based reporting, registry-based reporting, and electronic health record (EHR) reporting. The ACC has suggestions for each of these mechanisms of reporting.

In the area of claims-based reporting, ACC would suggest that physicians be given the opportunity to report on a period that is less than a full year, perhaps six months. Physicians that wish to participate through a claims-based process now are forced to make that decision very close to the beginning of the year. With changes in CPT codes and regulations, and the very late introduction of PQRI measure specifications, practices might not feel that they are ready to participate on January 1 and give up on the program. Allowing a partial year of participation would open the opportunity for more physicians to participate, especially those who are not eligible to report measures groups. Given the year long commitment and the length of time between reporting and receiving a bonus payment and performance report, allowing physicians to try the program for a short period should increase participation. This would also make claims-based reporting consistent with registry-based reporting, for which a half year of reporting is allowed.

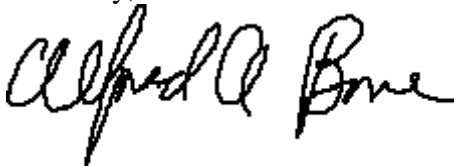
The mission of the American College of Cardiology is to advocate for quality cardiovascular care — through education, research promotion, development and application of standards and guidelines — and to influence health care policy.

The ACC strongly supported the addition of registry-based reporting to PQRI in 2008. The ACC has spent many years working on the development of registries that are commonly used in the facility setting and more recently developed a registry that may be used in the office setting known as IC³ (Improving Continuous Cardiac Care). The IC³ was selected as a participating PQRI registry for 2008. The ACC believes that participating in a registry is a very important step towards quality improvement in the outpatient setting and would like to continue to be able to report data on behalf of the participants to CMS for PQRI participation. However, the ACC believes that some improvements could be made. First, CMS should allow for registries to report data on all patients, regardless of the payer, for both measures groups and individual measures. The data that CMS receives reflecting all patients will be even more valuable than data which is restricted to Medicare patients and avoids unnecessary steps on the part of the registry to restrict data to Medicare patients. CMS may be concerned about having a minimum threshold of Medicare patients in the registry, which is understandable. To address this, CMS could require a certain minimum number of Medicare patients and require the registries to report the total number of Medicare patients in the practice.

The ACC is pleased to see the continued efforts to allow physicians to participate in PQRI through the use of electronic health records (EHR). The ACC will be interested in reviewing this kind of reporting as the results of testing are revealed by CMS. Giving physicians a number of different opportunities to participate in PQRI should increase participation. The ACC believes that CMS should announce in advance those registries and EHRs for which it will accept data for PQRI purposes. This would allow physicians who wish to participate in PQRI the opportunity to know that they do not have to participate in the claims-based process. If CMS wants to use the PQRI as an incentive for physicians to participate in registries or use EHRs, then it should announce that their data will be accepted before the reporting year begins.

Thank you for the opportunity to comment on reporting options for PQRI in 2010. The ACC looks forward to further work with CMS to improve the PQRI program. If you have any questions or wish to discuss this issue further, please contact Brian Whitman, Associate Director of Regulatory Affairs, at (202) 375-6396 or bwhitman@acc.org

Sincerely,



Alfred A. Bove, MD, PhD, FACC
President