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AMERICAN COLLEGE  
OF CARDIOLOGY  
FOUNDATION

Helping Cardiovascular Professionals  
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May 15, 2009

Chairman Max Baucus  
Senate Finance Committee  
Washington, D.C. 20510

Ranking Member Charles Grassley  
Senate Finance Committee  
Washington, D.C. 20510

Dear Chairman Baucus and Ranking Member Grassley,

On behalf of the 37,000 members of the American College of Cardiology (ACC), I am pleased to offer the following comments on your paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs." I commend you for setting out many positive delivery system reform policy options that would take needed steps toward improving the coordination and quality of care. The ACC believes reform of our current health care delivery system is essential and stands ready to help you as you undertake system transformation.

### **Section 1: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems**

#### Linking Payment to Quality Outcomes

##### *Physician Quality Reporting Initiative (PQRI) Improvements and Requirement*

Performance measurement is critical to quality improvement, and the ACC has felt the physician quality reporting initiative (PQRI), while far from an ideal performance measurement system, constituted an important starting point for Medicare. Many cardiologists have participated in the PQRI, with mixed results. While some have had a positive PQRI experience, most have found it difficult to download and understand their feedback reports and receive their incentive payments. The College acknowledges the effort the Center for Medicare and Medicaid Services (CMS), with your input, is taking to address many of the administrative issues of the current program that have surfaced after its implementation. The ACC believes your proposed improvements to the PQRI, including an appeals process and more timely feedback, are necessary. The ACC urges you also to consider options to make the PQRI program more nimble, provide more education and technical support to participants, and provide more meaningful feedback to participants. The ACC supports maintenance of certification as an additional PQRI participation option. The proposed improvements and continued incentive payments will help maintain and accelerate physician participation.

The ACC is pleased that Congress and CMS allowed participation through clinical data registries for 2008 and 2009, realizing the superiority and value of clinical data captured in registries over augmented claims data. The ACC has invested considerable resources in an outpatient registry, IC<sup>3</sup> (Improving Continuous Cardiac Care), and hopes that the registry will be able to continue as a PQRI-qualified registry.

The ACC has serious concerns, however, with moving forward with penalties under the current PQRI program. As noted above, PQRI has considerable administrative issues that must be addressed to help physicians successfully participate. For instance, practices that were deemed unsuccessful participants for 2007 are still trying to determine why. In addition, participants are almost halfway through the 2009 reporting year, yet they will not receive feedback on their 2008 participation until the fall of this year. In order to drive real quality improvement, CMS must fix these administrative issues and functional health information technology (HIT) systems and registries must be in place to facilitate clinical data reporting.

### *Transparency and Evidence-Based Decision-Making for Imaging Services*

The ACC is proactively responding to the growth in cardiovascular imaging through the development of appropriate use criteria that define when and how often physicians should perform a given procedure or test. Appropriate use criteria may be used to assess patterns of care in an effort to understand and improve the rate of clinically appropriate imaging tests, while reducing clinically inappropriate tests, resulting in cost savings, fewer disparities, and a higher quality of health care.

The ACC strongly supported Congress' enactment of a Medicare demonstration project to test the use of appropriate use criteria and mandatory imaging laboratory accreditation in the Medicare Improvements for Patients and Providers Act (MIPPA) last year. The ACC believes the MIPPA provisions will have a positive impact on the quality and appropriateness of imaging services under Medicare.

While much attention is focused on the rapid growth of imaging from 2000 to 2006, the ACC notes that the rate of imaging volume growth in Medicare has been slowing since 2005 and imaging spending dropped significantly from 2006 to 2007. In fact, analysis of preliminary 2008 Medicare claims data shows that imaging growth was at or below overall growth in physician services.

The ACC has significant concerns with the proposal to use radiology benefit managers (RBMs) and prior authorization in the Medicare program. While projected as a modest savings in the Medicare program, the cost to Medicare for implementing prior authorization would be very expensive with no associated gains in imaging quality. In addition, the implementation of RBM programs would be an extraordinary administrative cost to ordering physicians, including the primary care physicians who order much of the imaging in Medicare and particularly for small practices.

More importantly, RBMs are bad for patients and are an intrusion in the physician-patient relationship. Under prior authorization, patients often have to wait to receive needed tests, causing delays in diagnosis and care. The ACC believes Medicare funds would be better spent on patient care and fostering participation in quality improvement programs, including the use of physician-designed appropriate use criteria and clinical decision support tools, as well as improved communication to lower utilization and improve quality.

The ACC supports your proposals to create a Diagnostic Imaging Exchange Network (DIEN) and to promote adherence to physician-developed appropriate use criteria. The ACC would like to work with you to make the timeline and incentive structures for these programs more workable for the physician community.

Finally, the ACC is supportive of transparency in self referrals, and believes all providers should be included in the requirement, not just physician-owned facilities. The College is interested in more details on how the required list of other suppliers in the area would be created and kept current.

### Primary Care

#### *Primary Care and General Surgery Bonus*

The ACC supports efforts to bolster primary care, such as incentives to encourage physicians to choose primary care and remain in primary care, but does not support offsetting bonuses to primary care by implementing across-the-board reductions in payments for other critical physician services. Investments in primary care should be funded with system-wide savings stemming from more appropriate utilization of various services throughout Medicare and without regard to current payment silos.

The care coordination and office visits provided by general cardiologists who manage patients with complex heart disease needs to be recognized as having the same value as a similar service provided by a physician who is practicing as a primary care physician. The appropriate medical management of cardiovascular disease can save money and improve care by avoiding hospitalizations and more complex interventions.

#### *Payment for Transitional Care Activities*

The ACC strongly supports efforts to improve chronic care management and care coordination. Cardiovascular specialists, not just primary care practices, provide the services described under this option for patients with heart failure and other forms of advanced cardiovascular disease and should qualify for the management fees. The ACC believes that any physician who provides ongoing chronic care to a patient should be able to qualify regardless of specialty.

## **Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration**

### Chronic Care Management

#### *CMS Chronic Care Management Innovation Center*

The ACC supports the creation of a chronic care management innovation center as explained in the policy options. It is imperative that CMS have the administrative flexibility to test new methods of payment that may be implemented more broadly in the future. There is not yet sufficient evidence to change the entire Medicare program to a new model, but the experience gained by increased numbers of demonstrations should prove very valuable.

### Hospital Readmissions and Bundling

#### *Hospital Readmissions and Post-Acute Bundling Policy*

The ACC wants to be part of the solution to the high number of hospital readmissions for cardiovascular disease. This summer, the ACC is launching the “Hospital to Home” program with the Institute for Healthcare Improvement (IHI) with a goal of reducing preventable readmissions for heart failure and acute myocardial infarction (AMI) by 20 percent by the end of 2012.

## Moving from Fee-for-Service to Payment for Accountable Care

### *Sustainable Growth Rate (SGR)*

While the ACC is disappointed that your policy options do not include a permanent solution to the flawed sustainable growth rate (SGR) formula, the College acknowledges your commitment to working with the physician community on long-term reform of the formula. The ACC strongly supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system. The College urges you to establish a transition to a complete replacement of the flawed formula that provides stable, positive updates and covers the increase in the cost of care. The ACC encourages you to authorize voluntary demonstrations and pilots to test alternative payment models that improve quality and outcomes. Specifically for cardiovascular care, the ACC encourages you to test:

- The use of clinical data registries and adherence to guidelines and appropriate use criteria in improving patient care and reducing variations in spending among cardiology practices.
- Methods of reducing hospital readmissions and preventable emergency room visits for heart failure through better transition of care from the inpatient to outpatient setting, care coordination, physician integration and realignment of physician economic incentives.
- Methods of reducing geographic and regional variation in care by using appropriate use criteria to improve appropriate ordering of imaging studies and/or to reduce variation around coronary artery revascularization (heart attack prevention).

### *Medicare Shared Savings Program (i.e. Accountable Care Organizations)*

The ACC supports opportunities that allow entities to virtually integrate and share savings; however, the ACC believes much more discussion on the operational details is necessary before these concepts progress. The ACC is interested in more details on how accountable care organizations (ACOs) would function, including the legal changes necessary to allow such integration, the handling of patients as they move from one ACO to another, and the impact on traditional referral patterns. In addition, the ACC seeks clarity on the payment mechanism and governance. While many ACC members could readily participate through their larger medical groups, IPAs, and existing integrated systems, the ACC is interested in accountable care and shared savings models that will allow physicians in small independent practices—the vast majority of the practice environment—to participate. The ACC has begun development of a model for reducing avoidable cardiovascular hospital readmissions in which physicians in independent practices would participate in a quality network and share in savings achieved through reducing hospital readmissions – a virtual accountable care organization.

### *Extension and Expansion of the Medicare Health Care Quality Demonstration Program*

The ACC supports demonstrations to test methods of improving the quality of care and reducing spending. The ACC particularly supports the establishment of pilot authority for Medicare Health Care Quality Demonstration Program, which will allow Medicare to expand those programs that are found to be successful in limited areas.

### **Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform**

#### Health IT

##### *Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals*

The ACC appreciates the incentives for health IT included in the American Recovery and Reinvestment Act. Health IT is a critical component of the infrastructure of a reformed delivery system. Interoperability, computer decision support, automatic data collection, and registry participation are necessary to achieve common goals of quality improvement, care coordination, and efficiency. The effective use of health IT and registries necessitates the ability to accurately link patient information across systems and track patients longitudinally.

##### *Improving Quality Measurement*

The ACC supports your proposal to provide more resources to the Department of Health and Human Services (HHS) to further strengthen and improve quality measurement and development processes. Coming from years of experience in performance measurement, the ACC believes physician involvement in the process is critical and we are encouraged that your proposal includes physicians in the multi-stakeholder group.

It is very important to have an established, trusted consensus-based process in place to develop, test and maintain performance measures. Performance measurement and reporting are critical elements in improving the quality of care delivered as well as providing a mechanism to promote transparency.

Currently, there are a number of consensus-based entities that provide a venue for various segments of the health care delivery system. The Quality Alliances such as the AQA, Hospital Quality Alliance, Pharmacy Quality Alliance, and the Surgical Quality Alliance provide a forum for various interests to convene and develop implementation strategies related to performance measurement, reporting, and improvement. While the National Quality Forum (NQF) is critical in its role of endorsing performance measures, the Quality Alliances play an equally vital role in providing an open forum for discussion and consensus related to implementation. AQA is open to large segments of the delivery system, including physicians, health plans, employers and other clinicians and has a track record of developing consensus-based principles related to public reporting, use of appropriate use criteria and performance measurement.

There is a need for strong coordination among the various quality organizations to ensure effective development and use of performance measures and reporting. The NQF can play a significant role. However, all of the Quality Alliances, through the Quality Alliance Steering Committee, must have a voice and a strong link with the NQF to ensure that physicians, hospitals, nurses and patients all have a venue for open and honest discussion.

#### Comparative Effectiveness Research

The ACC supports a well-funded, national commitment to comparative effectiveness research (CER) with the goal of providing the data necessary to better inform physician/patient decision making.

Through ACC's past 24 years of developing clinical guidelines, performance measures and clinical appropriateness criteria, we have found that comparative effectiveness research has proven to be a vital tool that helps translate clinical research into more informed medical decision making. Each time a guideline is issued, it spurs additional research to prove or disprove the conclusions reached in the guideline recommendations. Guidelines have also served as the basis for developing the ACC's National Cardiovascular Data Registry® (NCDR), which, in turn, helps to answer questions on whether recommendations based on clinical trials apply in real-world practice settings. The College strongly believes that guideline development is best done by medical specialty societies, like ACC, where the clinical expertise resides, to synthesize the information from multiple sources in ways that are actionable and where there is greater credibility among patients and providers.

Congress should commit financial resources to help physician organizations promote the development and implementation of tools such as clinical guidelines and data registries so important in meaningful comparative effectiveness research.

The ACC believes CER must be conducted in a scientific fashion and not be confused with cost effectiveness determinations. The College fully understands that cost effectiveness is important to society and to health care reform, and believes it is an important parallel process to clinical effectiveness. If we are to distribute scarce resources fairly to the most important clinical priorities and to all patients regardless of income, we must determine cost effectiveness of care options but only once the science is clear. We must recognize that marginal increases in clinical effectiveness with very large price tags will not be affordable in a sustainable health system.

### Transparency

#### *Physician Payment Sunshine*

The ACC supports efforts to set appropriate rules that allow for greater transparency in the relationship between health care professionals and industry. The ACC believes that legislation to increase transparency through public reporting of industry gifts to physicians should include a reportable aggregate annual amount of \$100 or more with annual adjustments for inflation. In addition to providing the opportunity to submit corrections after their information was publicly reported, health care professionals should have the opportunity to review any information prior to public reporting and disclosure to ensure accuracy. Exemptions should be provided for subsidies for participation in medical conferences, continuing medical education, unrestricted grants for research or medical specialty meetings.

#### *Physician-Owned Hospitals*

The ACC opposes any restrictions placed on physician-owned facilities that are not placed on all hospitals. The ACC supports physician ownership in facilities, equipment or services that benefit patients through the delivery of appropriate, high quality medical care.

The ACC believes any facilities, whether or not owned in whole or in part by physicians, should strive to enhance quality of care, efficiency and patient access, while ensuring that ownership interests are directed to improving the delivery of care through implementation of quality systems and measures. This dedication to clinical excellence should be demonstrated by adherence to guidelines, quality standards and appropriate use criteria, as well as participation in quality reporting initiatives such as the NCDR® and Society of Thoracic Surgeons (STS) National Database. The ACC believes physician ownership must also be clearly disclosed and transparent

to all patients using these facilities. Physician-owned entities should adhere to all state and federal regulations and abide by the American Medical Association Code of Medical Ethics and the ACC's ethical guidelines.

### Workforce

The ACC appreciates your recognition of physician workforce concerns and commends you for outlining steps the federal government can take to address workforce shortages.

In cardiology, there is a current shortage of 1,700 general cardiologists and more than 40 percent of general cardiologists are over age 55 and nearing retirement. A recent report estimates that the cardiology workforce will need to double to keep up with demand in the next 20 years. To help meet future cardiology workforce needs, the ACC recommends an expansion in the number of fellowship positions, opportunities for part-time work, and training for mid-level cardiovascular professionals, as well as incentives for services in underserved communities.

The ACC also is concerned with the workforce shortages of our colleagues in thoracic surgery. A recent Government Accountability Office (GAO) study found that in 2008, 40 percent fewer physicians applied for thoracic surgery fellowship positions than those applying for 2004 positions. Less than 67 percent of positions were filled in 2008, down from 94 percent in 2004. In 2009, there were 101 applicants for 118 cardiothoracic residency training positions, and ultimately, 24 training positions went unfilled. In addition, research indicates that the average age of practicing cardiothoracic surgeons is 55 and more than 50 percent plan to retire within the next 10 years. The ACC echoes the Society of Thoracic Surgeons (STS) request that you examine policies that would serve to incentivize medical students to pursue training in cardiothoracic surgery, such as improved reimbursement rates, improved loan forgiveness programs and a longer loan deferment period for repayment.

In addition to making sure sufficient physicians are trained, attention must also be paid to ensuring physicians serve in shortage areas since simply training more physicians will not solve this problem. The College encourages you and your colleagues on the Health Education Labor and Pensions (HELP) Committee to further explore options that would help incentivize physicians to build their careers in rural and underserved areas.

### **Section V: Public Program Integrity – Options to Combat Fraud, Waste and Abuse**

The ACC understands how important it is to prevent fraud, abuse and neglect in the Medicare system and understands that fraud in Medicare has cost the taxpayers a considerable amount of money. However, there is little evidence of fraudulent billing behavior among physicians. The ACC does not support the establishment of an enrollment fee for physicians enrolling in the Medicare program. Such a fee is completely inappropriate and could have the result of physicians deciding not to enroll as Medicare providers.

The proposed creation of the "One PI" database raises some concerns, in particular the suggestion that quality of care data would be combined with program integrity functions. If such a database is created, it is essential that the safeguards that are part of the current National Practitioner Database with respect to individuals' right to review and correct information be retained.

## **Policy Options Proposed by ACC**

### Medical Liability Reform

The ACC believes the current medical liability system is in serious need of reform and strongly encourages you to address it in health reform legislation. The ACC urges you to test approaches to reducing the cost of defensive medicine such as health courts, arbitration, and providing protection to physicians who participate in Medicare quality incentive programs and have followed guidelines or practiced according to appropriate use criteria.

### **Conclusion**

The College applauds you for your leadership on transforming the health care system and offers the ACC as a resource to you and your colleagues as you work to enact many of the positive reforms you have outlined. The ACC believes medical profession engagement is an essential aspect of actually reforming the delivery and payment systems. ACC's CEO John C. (Jack) Lewin, M.D., and Senior VP for Advocacy James (Jim) Fasules, M.D., F.A.C.C., are prepared to assist your staff and Committee in any way to further these worthy goals, or to elaborate on any of the preceding.

Sincerely,



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

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