Statement of

W. Douglas Weaver, MD, MACC

On behalf of the

American College of Cardiology

Presented to the

SENATE FINANCE COMMITTEE

Roundtable on Medicare Physician Payments: Perspectives from Physicians

July 11, 2012

Chairman Baucus and Ranking Member Hatch, I am Dr. Douglas Weaver, Past President of the American College of Cardiology (ACC) and Vice President and Systems Medical Director of Heart and Vascular Services at Henry Ford Health System in Detroit, MI. On behalf of the ACC, I am pleased to participate in the Senate Finance Committee roundtable discussion on reforming the Medicare physician payment system. ACC members, including cardiologists, nurses and other members of the cardiovascular care team, have made a commitment to improving both the quality and value of the care provided in this country.

The ACC is a 40,000-member nonprofit medical society serving the needs of both providers and patients in this country and internationally. The College has been a leader in producing guidelines of care, professional and patient education, and operating national registries for assessing process measures and outcomes of cardiovascular procedures and everyday outpatient care.

Rewarding Quality and Efficiency

The College urges Congress to avert scheduled reimbursement cuts, repeal the sustainable growth rate (SGR) and provide stable payments for several years to allow the development of new delivery and payment models. The current uncertainty in the future stifle both our practices and our hospitals in making real investments aimed at improving integration and reducing the current fragmentation of care and reducing waste. The ACC supports moving the current Medicare physician payment system away from a volume-based system and toward a value-driven system that better aligns compensation with performance of evidence-based medicine and higher value, appropriate healthcare.

The College supports the testing of new payment models of delivering and reimbursing for care through the Center for Medicare and Medicaid Innovation, private payers, and other initiatives. The College believes there is no "one-size-fits-all" replacement and models are needed that work for a variety of settings, including small, independent practices and rural areas as well as large single specialty and multispecialty groups. One size will not fit all and there needs to be the ability to have local solutions.

The ACC has learned that efforts to improve quality and efficiency use the best scientific evidence when available, plus the routine collection of robust clinical data that can then be used to provide feedback on performance. A fundamental challenge of health care in the past was a lack of available and reliable data. The practice of medicine generates a great deal of data but it often goes no further than the instrument on which it was recorded or a paper record in a physician's office. Physicians must believe the data and trust it in order to act on it. In general they are very skeptical of administrative claims data knowing the careless way in which it is often collected and often deficient of clinical nuances that affect both physician choices and patients outcomes.

Through the creation of practice guidelines and appropriate use criteria for the performance of diagnostic tests and therapeutic procedures, and the use of clinical data registries and quality improvement programs, connecting data to practice will both improve care and reduce unnecessary care. If Medicare promotes these activities by incentivizing their use and helping pay for the efforts, we believe the current improvements that we are witnessing will accelerate.

Evidence-Based Guidelines and Performance Measures

The current clinical practice guidelines serve a role in providing a diagnosis and treatment plan for common conditions for the "typical "patient. These will be even more effective as health information technology (HIT) improves and incorporates clinical decision support tools.

The National Cardiovascular Data Registry

Clinical data registries can help medical professionals and participating facilities identify and close gaps in quality of care; reduce wasteful and inefficient care variations; and implement effective, continuous

quality improvement processes. Clinical data registries capture clinical information that is evidence based and derived from clinical guidelines, performance measures and appropriate use criteria in order to accurately measure patient outcomes and clinical practice.

Today, the ACC supports six hospital-based registries and one outpatient physician office-based registry representing over 20 million patient records, operational in over 2500 U.S. hospitals and in over 500 physician offices across the US.

WellPoint, Inc, United Healthcare Services, and Blue Cross Blue Shield of Michigan formally require participation in NCDR® as part of reimbursement or recognition programs. These efforts have galvanized physicians to work together on areas where there is either low or uneven quality. The Blue Cross Blue Shield Association includes NCDR® participation as part of their national Blue Distinction Centers for Cardiac Care Program. Many states, including California, Florida, Maryland, Michigan, Missouri, Washington, and West Virginia, are aligning regional monitoring efforts with NCDR®. Health systems such as Hospital Corporation of America (HCA) and Kaiser Foundation Hospitals (of Kaiser Permanente) leverage NCDR® to support quality improvement efforts within their networks, as does the Veterans Administration.

Decision Support Tools

The ACC has developed appropriate use criteria (AUC) that define when and how often physicians should perform a given procedure or test in the context of scientific evidence, the health care environment, the patient's profile and the physician's judgment. The College has created point of order tools through which physicians can access the AUCs during a patient encounter with minimal workflow disruption.

Blue Cross Blue Shield of Delaware (BCBSD) is requiring the use of our tools that help physicians choose the best imaging test for a patient instead of insurance benefit managers who have at times limited patients' access to appropriate cardiovascular diagnostics. The program provides feedback reports on the patterns of appropriate use to physician practices and health plans. Participants then use the reports to complete action plans and share best practices. We believe that such efforts are the right way to move forward.

The Door to Balloon Initiative

D2B: An Alliance for Quality™ illustrates how data collection and feedback can improve quality and outcomes. The Door to Balloon Initiative, or D2B, challenged cardiovascular specialists to meet the national guidelines developed by the ACC and the AHA that state that hospitals treating heart attack patients with emergency PCI should reliably achieve a door-to-balloon time of 90 minutes or less. "Door-to-balloon time" means the time it takes to diagnose a heart attack and restore blood flow to the heart by placing a stent in a blood vessel. Studies demonstrate strong associations between time to primary PCI and in-hospital mortality risk; however, accomplishing this level of performance was an organizational challenge. In 2006, the ACC partnered with many other organizations to address the challenge by sharing the key evidence-based strategies and supporting tools needed to reduce D2B times nationally. The program was very successful, with widely published studies showing that D2B times dropped to under 90 minutes in over 90 percent of US hospitals, with many now having D2B times under one hour. This initiative significantly improved patient outcomes.

Hospital to Home

The Hospital to Home (H2H) Initiative, led by the ACC and the Institute for Healthcare Improvement, is an important resource for hospitals and cardiovascular care providers to improve transitions from hospital to "home" and, equally important, to avoid any federal penalties associated with high readmissions rates. H2H is an online learning community of individuals and facilities committed to reducing readmissions

and improving patient care. The H2H initiative challenges communities to better understand and tackle readmission problems through the use of simple, targeted, and actionable strategies in three core concept areas: Early Follow-up, Post Discharge Medication Management, and Patient Recognition of Signs and Symptoms.

Alternative Payment Models

SMARTCare

The ACC combined many of its tools into a project to address documented clinical quality, resource use and cost variation in the treatment of stable ischemic heart disease (SIHD) called SMARTCare. In Wisconsin, the project is driven by the ACC State Chapter in collaboration with integrated health care systems, statewide, multi-stakeholder collaborative groups, including business coalitions, measurement and data collaborative groups, and a payment reform partnership. A parallel effort in Florida is led by the ACC State Chapter in collaboration with 6 provider organizations across the state.

The goal is to reduce complications, procedures not meeting current appropriate use standards, and episode cost; achieve high levels of patient engagement; improve quality of life; and increase the number of patients at risk reduction goals. The project seeks to accomplish these changes by improving appropriateness of noninvasive cardiac imaging; treatment decision between medical therapy, stenting, and bypass surgery; and optimizing medication and lifestyle interventions. Combining these tools would provide customized patient benefit and risk information based on evidence and registry data in real time. Information provided in these tools and registries would then be used to assess patterns of care. Feedback about impact on overall clinical care and cost would be made available through an interactive dashboard and analysis tool. Ongoing tracking using longitudinal outpatient registries would allow sites to modify use of their tools over time to better outcomes and increase efficiency. The information is intended to be used to support an episode of care shared savings/bundled payment model and quality incentive payments.

Patient Involvement and Regulatory Relief

Shared Decision Making

Health care decisions are not black and white. ACC believes engaging patients in decision making is crucial to achieving the best outcome for a patient, as determined by the clinical situation and the patient's preferences and values. More emphasis must be placed on shared decision making, the process by which a health care provider communicates to the patient personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options and the patient communicates his or her values and the relative importance he or she places on benefits and harms. Through CardioSmart.org and partnership with the Choosing Wisely Initiative, ACC is providing content and tools to achieve this goal.

Conclusion

Providing physicians and other health care providers with longitudinal data on their performance and tools to improve their performance results in improved quality and efficiency and lower costs. To establish the infrastructure and data necessary, Medicare and private payers should encourage the development and widespread use of clinical data registries that allow the tracking, reporting, and improvement of healthcare quality in concert with payment programs that encourage higher quality. This will form the foundation for meaningful payment reform based on the best clinical evidence.

The pathway to reducing the rate of growth of US health care spending and its alarming contribution to the national deficit will require that we align payment incentives with improved data-driven outcomes---the task requires improving rather than cutting care. Physician leadership, working together with other

clinicians, hospitals, insurers, and Medicare, will be necessary to effect these needed improvements in our health care system. Thank you for the opportunity to speak today about several of the exciting quality improvement collaborations underway in cardiology and what lessons can be applied to improve quality and lower costs across the health care system. The College offers itself as a resource to you as you work with your colleagues to permanently repeal the SGR and transform the Medicare physician payment system.