AMERICAN
COLLEGE *of*
CARDIOLOGY

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

202.375.6000
800.253.4636
Fax: 202.375.7000
www.CardioSource.org



December 08, 2014

Christine K, Cassel, MD
President and Chief Executive Officer
National Quality Forum
1030 15th St, NW
Suite 800
Washington, D.C. 20005

cc: Helen Darling, MA (Chair), NQF Board of Directors
Richard J. Umbdenstock, FACHE (Vice-Chair), NQF Board of Directors

Dear Dr. Cassel:

The American College of Cardiology (ACC) is writing to appeal the endorsement decision to conditionally approve measures #2431 and #2436 in the National Voluntary Consensus Standards for Cost and Resource Use Phase 2 Cardiovascular Measures:

- 2431: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for Acute Myocardial Infarction (AMI)
- 2436: Hospital-level, risk-standardized payment associated with a 30-day episode-of-care for heart failure (HF)

The ACC is dedicated to improving not only quality, but also the efficiency and value of health care for all Americans. We are also strongly committed to transparency and accountability for all health care professionals and recognize that evaluating cost of care is an important first step towards achieving greater insight into the efficiency of our healthcare system—if appropriate standards are applied. We recognize that the current trajectory of healthcare spending is not sustainable and we applaud the NQF for taking on this challenging work. We would also like to thank the Standing Committee and the Technical Expert Panel for their methodical, cautious and diligent work.

We understand that the results from the NQF voting period for these measures indicated a lack of consensus for the measures, with 40% approval by the councils. In fact, the ACC voted against endorsement for these measures and were reassured to see that fellow NQF members also carefully weighed the risks and benefits of placing measures in the marketplace that are not ready for widespread adoption.

We reviewed the materials made available since the voting period failed to net consensus and respectfully submitted our concerns in writing to the Consensus Standards Approval Committee (CSAC) on September 2, 2014. We echoed the concerns raised during the July 21 NQF Council Leader Call:

- **Attribution:** Those who believe holding the admitting hospital accountable for the costs related to an episode in order to motivate them to do a better job of "care coordination" are making a number of assumptions:
  1. The majority of hospitals can perform care coordination without being part of an integrated delivery system or accountable care organization (ACO) that has operational control over outpatient services; it is difficult to assign accountability to an individual or an entity that does not have such control.
  2. The elements of care coordination that are effective are known.
  3. Care coordination actually controls costs.

- **Stand-alone Cost Measures:** We are concerned that stand-alone cost measures like these will be used quickly by CMS and other organizations facing a cost crisis. In such circumstances, some quality measures might be applied, but it is not likely that sufficient emphasis will be placed on quality to counterbalance the motivation given providers to lower costs. Until we can fully integrate meaningful measures of quality with cost measures, we will face this danger, and more importantly, patients may be placed at risk.

- **Sociodemographic Variables:** We are concerned about the poor quality of the risk-adjustment methodology in the measures and prefer stratification by sociodemographic factors with reimbursement tied to performance taking into account each stratum. We urge you to consider placing a moratorium on your Cost and Resource Use efforts until your work on Sociodemographic Risk Adjustment is completed and used as part of the consensus development process.

The CSAC apparently voted to approve the measures despite reaching only 40% approval by councils and 62% approval by the Standing Committee on its second vote after 52% approval on its first vote. The results of the CSAC vote do not appear to be available on the NQF website.

The November Board of Directors agenda indicated that "The Board will discuss a proposal from the Executive Committee to defer action on the cardiovascular cost and resource use measures until there is an opportunity for cross-stakeholder dialogue on concerns that have been raised about the measures." The Board discussion on the measures revealed an understanding of how difficult it has been to develop a consensus around these measures. Several comments were raised regarding the challenge of appropriate attribution of events thirty days post-discharge. Despite recommendations to defer the measure until additional research and review could be performed, the Board passed a motion to approve measures 2431 and 2436 as conditional, with a 1 year review period for unintended consequences. We are appealing this decision and request that NQF post the transcript of this discussion and results on the NQF website.

NQF continues to be a leader in the quality enterprise and the ACC remains a strong supporter of your mission. We recognize your efforts to continually evolve and refine your processes to maintain high standards for member engagement, consensus and transparency. It is clear that evaluating cost and resource use measures is a complex and challenging undertaking. If you have any questions or wish to discuss these comments, please contact Eileen Hagan, Director, Payer and Value Solutions at ehagan@acc.org or 202-375-6475.

Sincerely,

Patrick J. O'Gara, MD, FACC
President