June 20, 2016

Lew Sandy, MD
Chair, Clinical Episode Payment Workgroup
Health Care Payment Learning and Action Network
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Dr. Sandy:

Thank you for the opportunity to comment on your draft white paper from the Clinical Episode Payment (CEP) Work Group, entitled, Accelerating and Aligning Clinical Episode Payment Models: Cardiac Care. Copies are available at: http://hcp-lan.org/workproducts/cad-whitepaper-draft.pdf. We also appreciate that you had a webinar with all interested parties on June 1, 2016.

The Society for Cardiovascular Angiography and Interventions (SCAI) is a non-profit professional association with over 4,500 members representing the majority of practicing interventional cardiologists and cardiac cath teams in the United States. SCAI promotes excellence in interventional cardiovascular medicine through education, representation and the advancement of quality standards to enhance patient care.

In SCAI’s opinion, bundling payments for all different types of coronary artery disease (CAD) into one payment group is simply unworkable. The severity of the disease is too diverse, and proper treatments are too diverse as well. These bundles are being developed because policy makers felt that patients were being over-treated because of financial incentives to physicians to provide excessive care. If that was true, do policy makers now think that financial incentives to undertreat patients may not have the same affect?

The quality measures that are suggested for this bundle do not at this time exist, nor does the bundle propose a mechanism for funding the development and use of such measures. Patients would simply be subject to too much of a risk of under-treatment if this large of a bundle were implemented. Before this can be properly be implemented, the quality measurement tools and mechanisms to use them must be developed.
A first step toward a workable bundle might be to differentiate among different types of CAD. The dividing lines could be between acute myocardial infarctions and others, or it could be between STEMI and non-STEMI but there are other options. HCP-LAN should also be aware that there is not complete agreement within the profession on how some outcomes should be measured (see for example: http://www.scai.org/Assets/46375d8b-bd61-47c7-91f9-680df5c498c4/635168437330170000/2013-10-14-myocardial-infarction-pdf)

We would be happy to work with the HCP-LAN as that finalize this document. We think it could benefit from more input from experts in this field.

A second step toward more workable bundles would be to differentiate between patients treated medically, surgically and percutaneously. While the patient’s condition play a large part in deciding the appropriate treatment, patient preferences also matter (i.e. a middle-aged long distance runner probably would be less likely to accept medical therapy for a moderate blockage than a sedentary senior citizen). Additionally, there are costs that fall outside of a bundle that would not be captured in this bundle. For example, some types of stents (usually the more expensive ones) are reported to require fewer repeat procedures in the long run…but the possible benefits of these more expensive stents would not be factored into these bundles.

MACRA was enacted to not only reduce costs but to improve quality. While there are legitimate concerns about overuse of revascularization, it should be noted that revascularization rates are going down, but meanwhile there continues to be under-use of PCI in some patients with acute myocardial infections (AMIs), particularly in rural areas. If this bundle is really focused on improving quality of care, some effort to decrease the rate of AMI patients inappropriately being treated only with thrombolytics. Their outcomes are worse.

This bundle places no responsibility on those with the most to gain from improved outcomes, the patients themselves play a major…maybe the most important role in improving their health status. A well-engineered bundle would incentivize patients as well.

Another concern with this proposal is that it doesn’t seem to recognize that those with more training in cardiovascular disease are more likely to effectively treat the disease. More highly trained physicians should not be considered as interchangeable with those who have less training.

Anytime financial incentives exist they may influence behavior. We don’t see how this bundle would discourage providers from treating and/or enrolling higher risk patients or enrolling very low risk patients into this bundle. A discussion of how this could be achieved would be quite helpful.

Patients with more severe CAD are frequently referred to more sophisticated diagnosis and treatment options. It isn’t clear how these situations will be handled and what steps can be taken to avoid incentives to over or under refer severe CAD patients elsewhere.
A bundle for CAD care or some portion of it is an intriguing idea. It’s something that we encourage but the vagueness in this proposal shows that it is not ready for implementation or even testing. If the bundled concept does move forward, we suggest that it do so as a demonstration project with voluntary inclusion. That is the best way for the providers, insurers and patients to work together for the best outcomes.

The paper also seems to infer that specialists and subspecialists simply act at the direction of primary care physicians who decide what care should be rendered. In fact most cardiologist and many interventional cardiologists are heavily involved in or in charge of the care of a patient with CAD.

Finally, patients with CAD frequently have significant comorbidities that affect their care and differentiation of the treatments for CAD from treatments for other problems such as congestive heart failure can be nearly impossible to separate without reviewing a patient’s medical charts. A bundle for all CHD patients simply isn’t workable in our opinion.

If you would be willing to work with us in refining this bundling concept, we would welcome the opportunity to do so. Our comments on this proposal should not be construed as an endorsement of the proposal. We all share the goals of improving care while reducing costs. If you would like to continue this dialogue contact, Wayne Powell, our Senior Director for Advocacy and Government Relations at 202.741.9869 or wpowell@scai.org

Sincerely,

Kenneth Rosenfield, MD, MHCDS, MScAI
President