# Issues from the ACC

## ACC Members and Structure, MOC, MACRA, Governance, Accreditation

Rick Chazal, MD, MACC
Immediate Past President, ACC
Medical Director, Heart and Vascular Institute
Lee Health, Fort Myers FL
April 8, 2017

# Our Mission

## To Transform Cardiovascular Care and Improve Heart Health

# Disclosures

- none

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# "The Biggest Issues"

- ACC Status:  Institution and members
- External Environment: Transformation of Medicine Scientifically; Procedural Pressures
- MOC
- MACRA
- Governance
- Accreditation

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# ACC by the Numbers

**52,000+ members** across the entire cardiovascular care team

**More than 85 percent of U.S. cardiologists** are ACC members

**48 Domestic Chapters**

**36 International Chapters**

**10 NCDR Registries**

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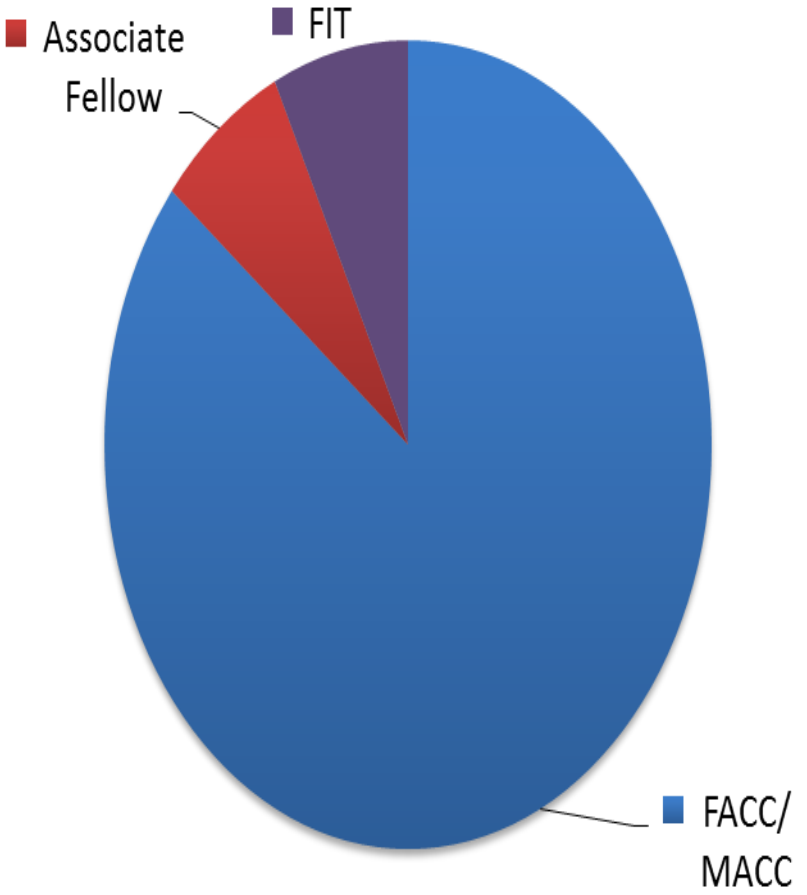
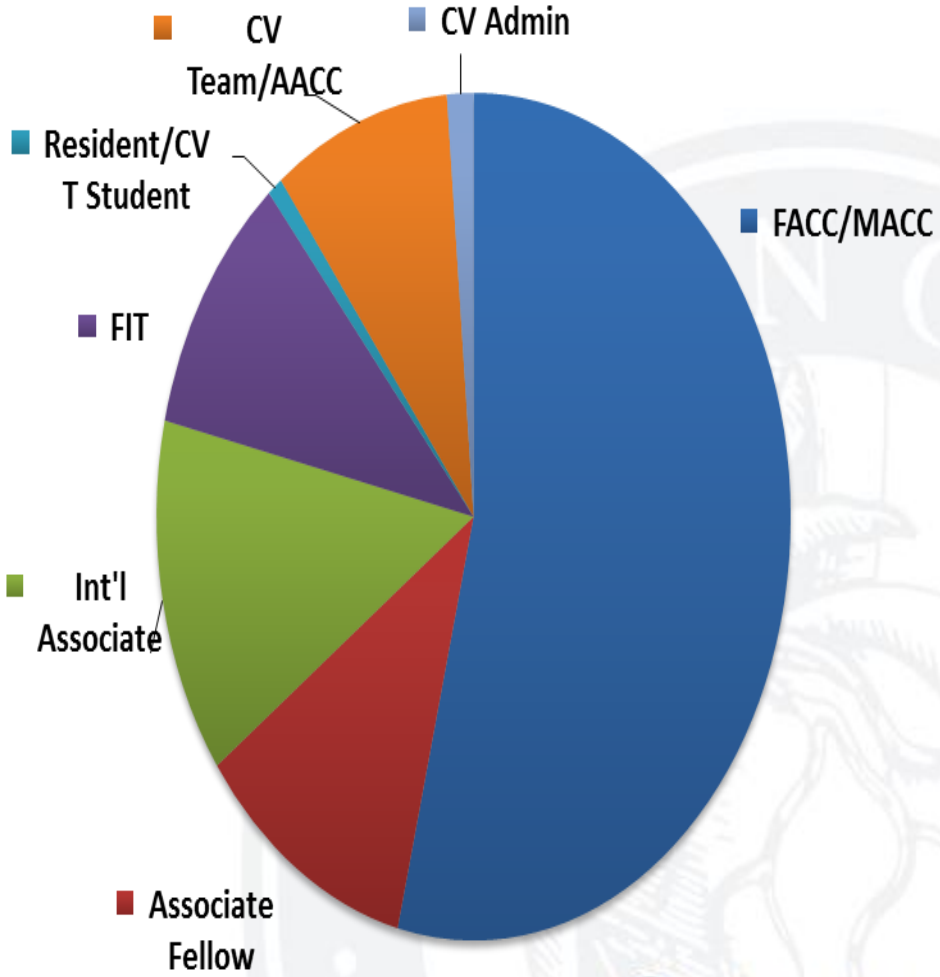
# ACC in 2000 (26,000 Members)




# ACC in 2016 (52,000+ Members)

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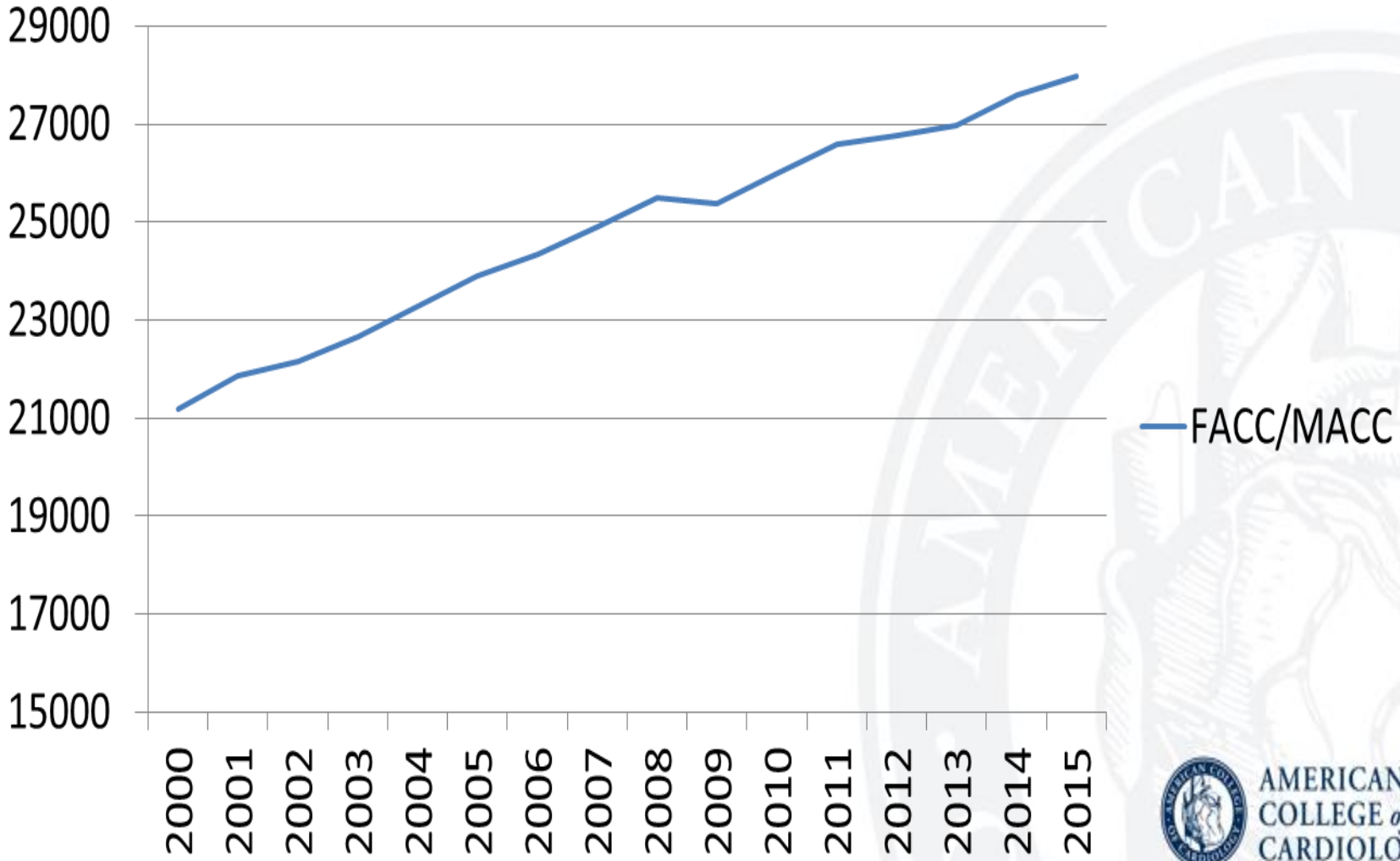
*Source (Right): Data compiled from 2015 Year End Official Member Count*

# Growth of FACC/MACC Members Since 2000

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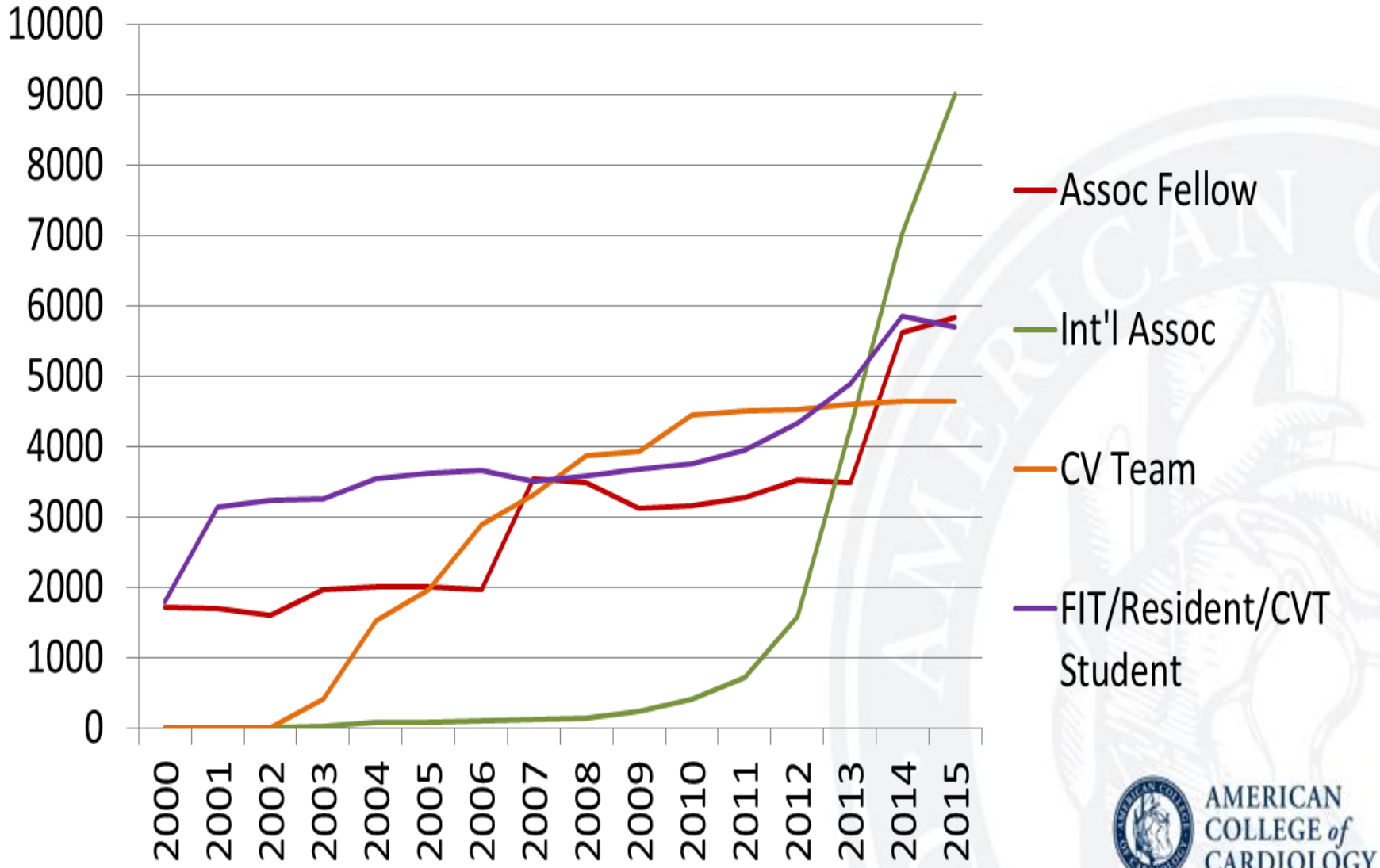
# Other Membership Category Growth Since 2000

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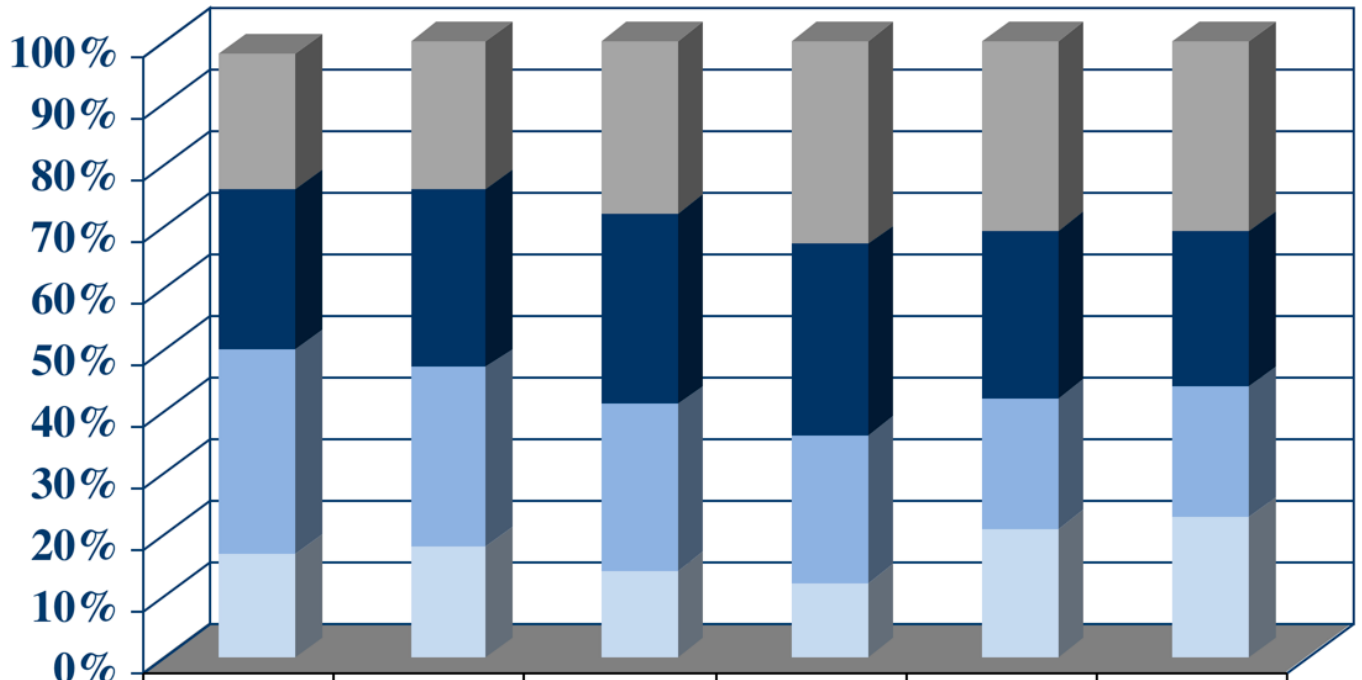
# Trends: Age Range of Membership – Overall




| | 2002 | 2006 | 2008 | 2012 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| 61 and Over | 22% | 24% | 28% | 33% | 31% | 31% |
| 51-60 | 26% | 29% | 31% | 31% | 27% | 25% |
| 41-50 | 33% | 29% | 27% | 24% | 21% | 21% |
| Under 40 | 17% | 18% | 14% | 12% | 21% | 23% |
| Median Age | | 51 | 53 | 55 | 54 | 53 |

Only captures data captured in Personify. Excludes FIT.

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# Old Cardiologists; *Really* old General Cardiologists!

TABLE 3

| | OVERALL | | 2013 BY SUBSPECIALTY | | | |
|---|---|---|---|---|---|---|
| CARDIOLOGY AGE QUARTILES | 2012 | 2013 | EP | INVASIVE | GENERAL | INT |
| Age 46 and below | 31% | 28% | 42% | 32% | 28% | 26% |
| Age 47 - 58 | 41% | 40% | 42% | 47% | 35% | 40% |
| Age 59 - 70 | 25% | 28% | 16% | 20% | 30% | 32% |
| Age 71 and over | 3% | 4% | 0% | 1% | 7% | 2% |

*Source: 2014 MedAxiom Annual Survey*


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# Domestic Chapter Growth

**1987:**
First Chapters Formed *FLORIDA (and Arizona)*

**1990:**
**16** Chapters

**2000:**
**39** Chapters

**2016:**
**48** Chapters
(Representing all 50 states plus Puerto Rico and DC)

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# Fiscal and Staff Growth in the Last Quarter Century (1990 – 2016)


**1990 Highlights**

**Members: 18,700**

FTEs: 80+

Operations Revenue: $18.3M

Investments: $19.4M

Total Net Assets: $28.8M

Debt: $0

**2016 Highlights**

**Members: 52,000+**

FTEs: 525+

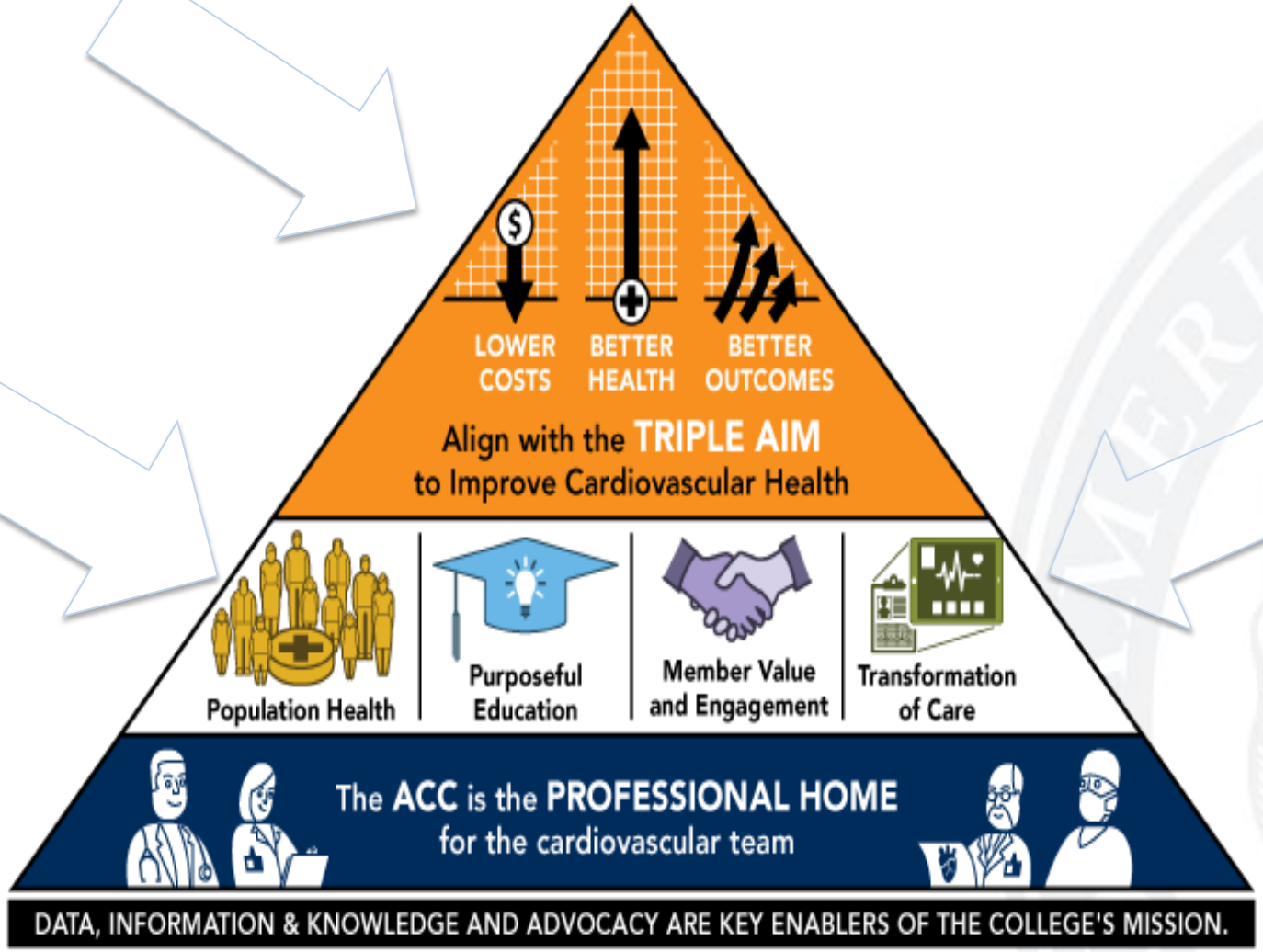
Operations Revenue: $140M

Investments: $102.4M

Total Net Assets: $87.3M

Debt: $60.9M

# The Strategic Plan positions the College and its members for success in meeting the Triple Aim of improving cardiovascular health through lower costs, better health and better outcomes

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# Maintenance of Certification and the ABIM

2016 STRATEGIC PRIORITY
Achieve Excellence as a Provider of Strategies to Maintain Professional Competency

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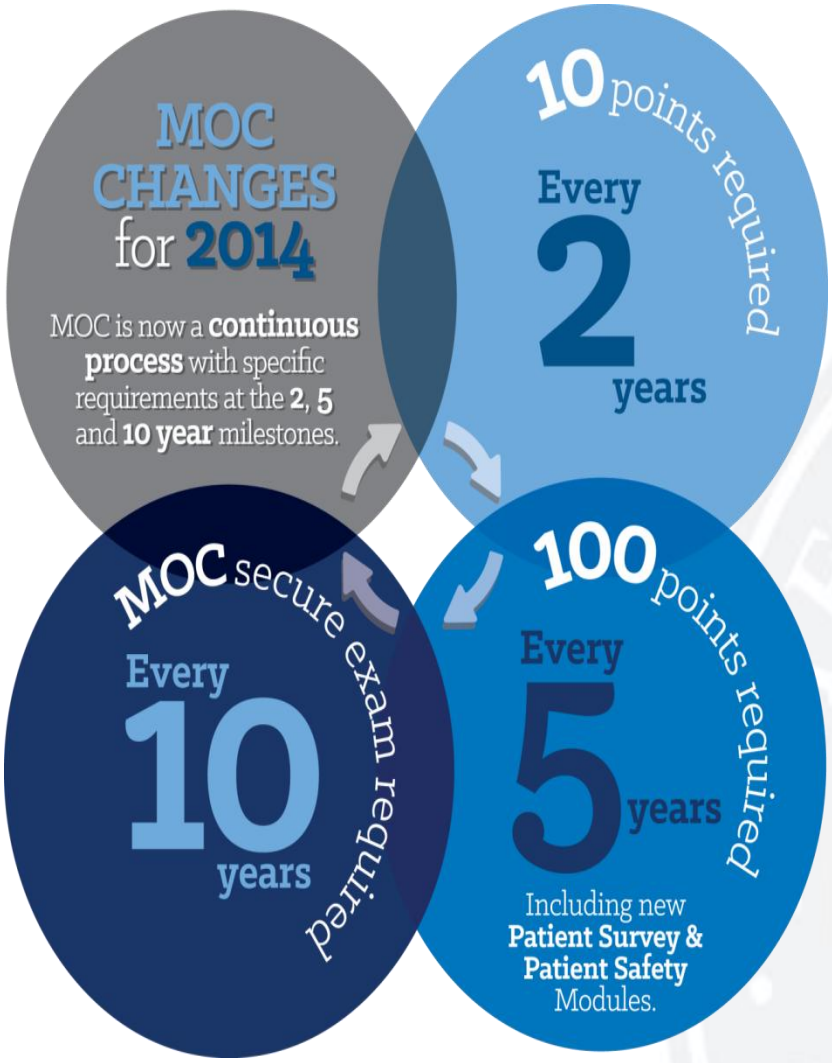
# What 2014 Brought…

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# ACC Listened …

## and developed a three-pronged approach focused on –

- Serving as a source of information about the changes for members
- Providing tools and resources to help members more easily meet the new requirements
- *Advocating on behalf of members for changes to the MOC process*

*Cardiology* Magazine, January 2015

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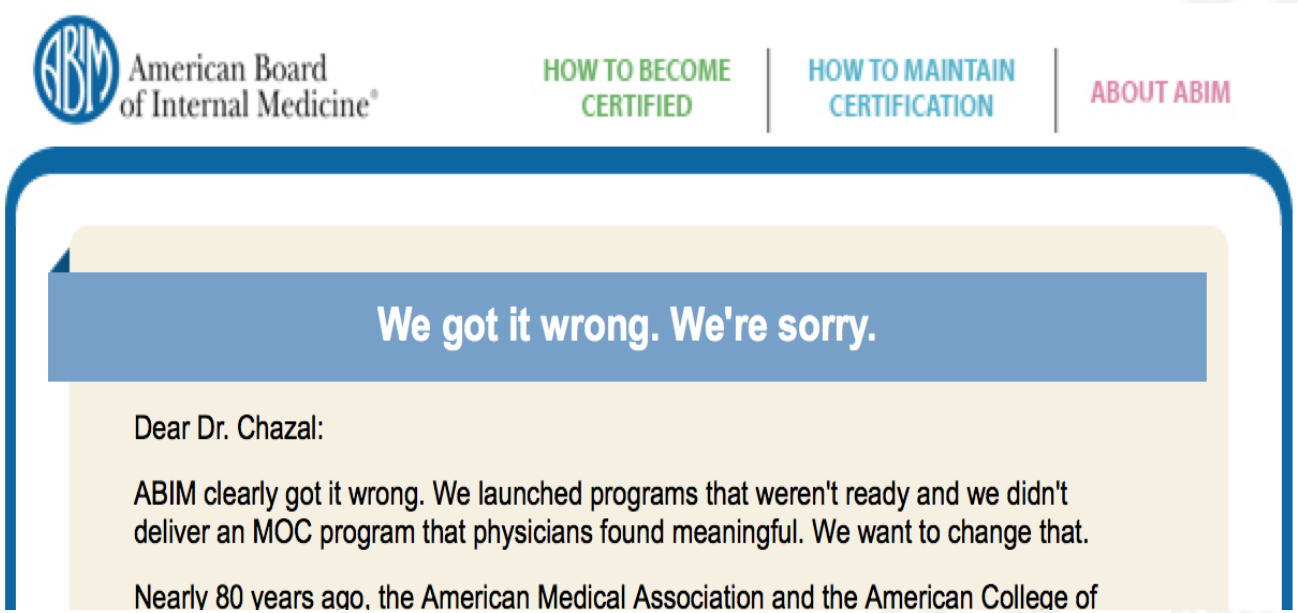
# ABIM Actions:
## The "We're Sorry" E-mail Heard 'Round Internal Medicine

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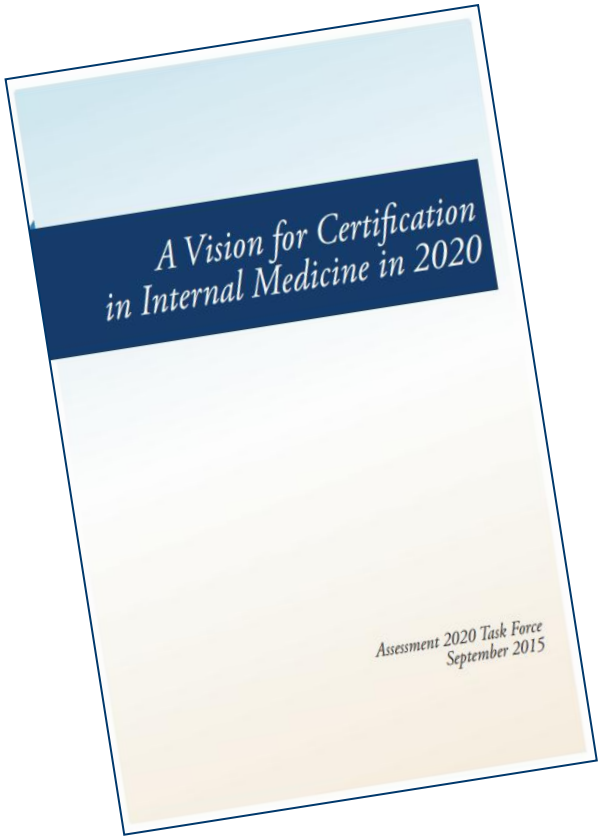
# ABIM's Assessment 2020 Task Force Report Developed to:




- Develop a vision for future of assessment
- Stimulate discussion among stakeholders

In line with many of the ACC's recommendations!

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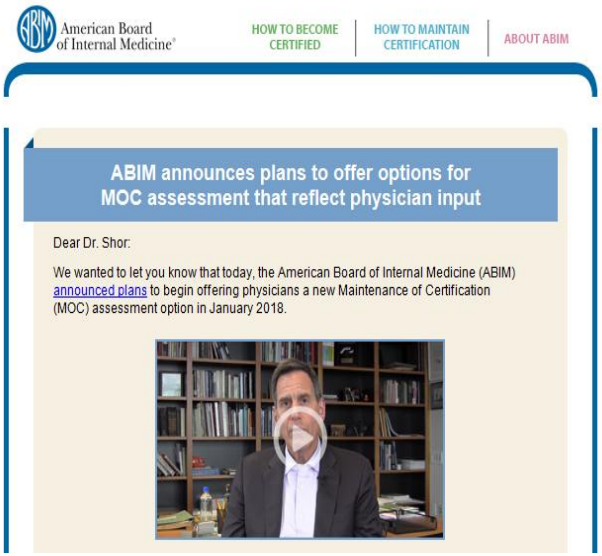
# "ABIM announces plans to offer options for MOC assessment that reflect physician input"




Email sent on May 5, 2016 from:

**Richard J. Baron, MD, MACP**

**Clarence H. Braddock III, MD**

and **Jeanne M. Marrazzo, MD**

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# The BIG Announcement:

The ABIM will begin offering physicians a new MOC assessment option

in **January 2018.**

**NOTE:** ABIM's current 10-year exam will remain available as a second assessment option.

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# ACC Input to ABIM Has Created Change:

- Reversal of the double jeopardy provision
- Decoupling of the initial board exam from MOC participation
- Streamlining the ability for practitioners to get both CME and MOC Part II credit
- Suspending MOC Part IV requirement

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# ACC Input to ABIM Has Created Change:

- Reversal of the double jeopardy provision
- Decoupling of the initial board exam from MOC participation
- Streamlining the ability for practitioners to get both CME and MOC Part II credit
- Suspending MOC Part IV requirement
- *Developing alternatives to ten year exam*

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# The ACC is seeking the following from ABIM:

- Model the new, more frequent, focused assessments of cognitive skills on the “SAP” model and use the “2016 ACC Lifelong Learning Clinical Competencies for General Cardiologists” as the basis for these assessments.

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# The ACC is seeking the following from ABIM:

- An open-book format for those members choosing to take the 10-year exam. Allow access to all resources during exam (I.e., not limited to Up-to-Date)

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# The ACC is seeking the following from ABIM:

- Allow the ACC, other professional societies and qualified entities to put forth standards-based processes that would be certified by the ABIM.

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# The ACC is seeking the following from ABIM:

- Enable diplomates to seamlessly receive credit for activities in which they lead and participate in on behalf of hospitals, health care systems, payers and state medical boards.

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# The ACC is seeking the following from ABIM:

- Permanently eliminate practice improvement (“Part-IV”) activities as a requirement for MOC. Practice improvement activities are important and will soon be required of all providers by Federal law (MACRA).

- Appropriate practice improvement activities should be acceptable for fulfillment of MOC participation, but a specific minimum level of Practice Improvement activities should not be returned to the list of MOC requirements.

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# The ACC is seeking the following from ABIM:

- Undertake research to test the outcome of MOC activities on the actual improvement in patient care and outcomes in order to provide an evidence-base for the value of MOC.

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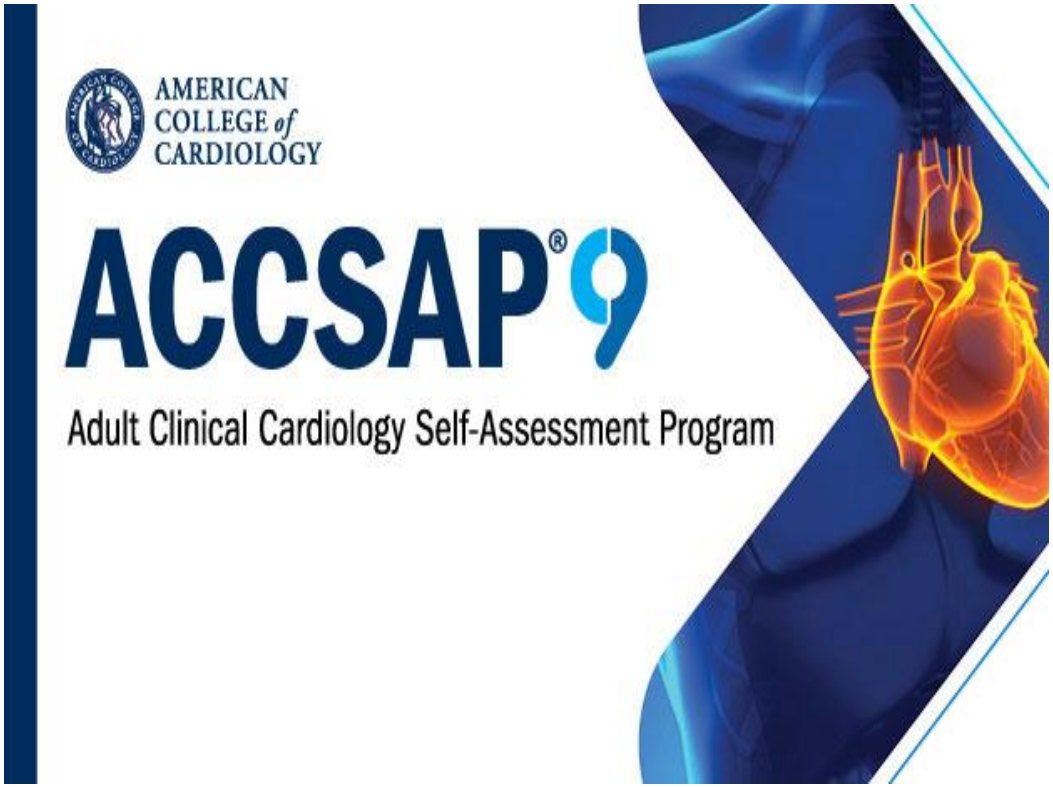
# MOC offered with self-paced digital learning




- In depth core cardiology knowledge covering all topics in the ABIM topic blueprint
- Learning from text, audio, video
- Practice knowledge comprehension with hundreds of rigorous case-based questions with rationale and references
- Simulated Board exam sessions to identify areas of needed study
- Offers up to 155 MOC points

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# MOC offered with journal-based CME


JACC
JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY


- As of September 1, 2016
- Read journal article
- Answer post-test questions
- Correctly answer 70% or better
- Self reflect in evaluation
- Claim CME and MOC

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# Future Plans

- "All CME is MOC eligible"
  - Virtually all of ACC.17
  - All live courses
  - All digital products


- Automated EBAC credit for European learners
- MOC eligibility for ABP and other boards

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# *ALSO…*

As a result of the ABIM changes in MOC the ACC convened 2 Task Forces:

TF1: To look at ways to work with ABIM to promote reforms to the MOC process

**TF2: To look at alternatives to ABIM and to provide lifelong learning and Maintenance of Competence.**

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# Maintenance of Certification and Recertification *(ACC/F)*
## *Task Force #2*

## Discussions with:

- ABIM
- Alternative Boards: Neurosurgery and Neurology
- Input from Key Stake Holders
- Independent Boards such as Nuc, echo

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# Maintenance of Certification and Recertification *(ACC/F)*
## *Task Force #2*

## Reviewed discussions with:

- NBPAS-Dr. Teirstein
- Patient Perspective
- Payers
- Cost
- Certificate of Continuing cardiovascular Development Program(C3DP)

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# Summary of Elements that TF #2 feels should be included in ongoing certification:

- The current ***initial*** certification process is felt to be acceptable
- Expansion of MOC part II to include elements from LifeLong Learning Clinical Competency Statement (completed in August 2015)
- Elimination of MOC III/Ten year test, allowing instead, credit for ongoing prescribed education/confirmation of successful completion

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# Task Force #2-BOT issues

- If recertification elements acceptable to ABIM, recommend not initiating new board
- If elements not accepted by ABIM, present same to ABMS for consideration of new board outside of ABIM…or use of C3DP as alternative

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# ACC Vision of ABIM Part-III MoC

- Recent MoC History
  - "Assessment 2020" – published, 9/16/2015
  - LCCR Meeting – Philadelphia, 9/18/15
  - IM Summit – Philadelphia, 11/2/2015
  - CV Board Meeting – Philadelphia, 1/29/2016
  - ACC/ABIM Leadership Meeting at ACC.16 – 4/4/2016
  - ACP/AAIM Leadership Planning Meeting at ACP – 7/22/16
  - ACP/AAIM Leadership Meeting at ACP – 9/15/2016
  - LCCR Meeting – Philadelphia, 9/16/2016

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# ACC Vision of ABIM Part-III MoC

- Recent MoC History
  - LCCR Meeting – Philadelphia, 9/16/2016
    - Multiple IM subspecialty societies expressed similar views to those expressed by ACP meeting attendees

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# ABIM Alternative Maintenance Pathway

| | Current MOC Pathway | 5-year Maintenance Pathway | 2-year Maintenance Pathway |
|---|---|---|---|
| | | | OR |
| *Assessment time* | About 8 hours | About 5 hours | About 2 hours |
| *Frequency* | Every 10 years | Every 5 years | Every 2 years |
| *Breadth of discipline* | Yes | Yes | Yes |
| *Location* | Testing center | At home or office | At home or office |
| *Security* | Proctored, face-to-face | Online proctored | Online proctored |
| *Scheduling availability* | Twice each year | Twice each year | Six times each year |
| *Immediate result* | No | Yes | Yes |
| *Open-book access* | No | Yes* | Yes* |

* Pending results of current pilot study exploring this feature.

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# ACC Vision of ABIM Part-III MoC

- Use ACCSAP as the learning/testing model that fulfils Part III requirement
- "Formative assessment" – this is the main negotiating point with ABIM
  - ID verification
  - Security of questions
  - Psychometric validity

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# ACC Recommendation for Part IV

Allow all MACRA-MIPS practice improvement activity to count as MoC credit

Do not reinstate a stand-alone Part-IV requirement

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The ACC's accounting staff have **reviewed and discussed the ABIM's publically available financial statements** with an outside accounting firm and have found the statements to be in compliance with **Generally Accepted Accounting Principles** (GAAP), as utilized by not-for-profit organizations in the United States.

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The ACC's online MOC hub at *www.ACC.org/MOC* and ACC in Touch Blog at *blog.acc.org* contain the latest MOC resources and updates, including free MOC activities.

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# Transformation of Medicine: Data and Data Science

| | Yesterday | Today | Tomorrow |
|---|---|---|---|
| Data: | Symptom Based | Population Pattern Based | Individual Algorithm Based |
| | Intuitive Medicine | Evidence-based Medicine | Precision Medicine |
| | 5000 BCE | Mid 20th century | Now!? |

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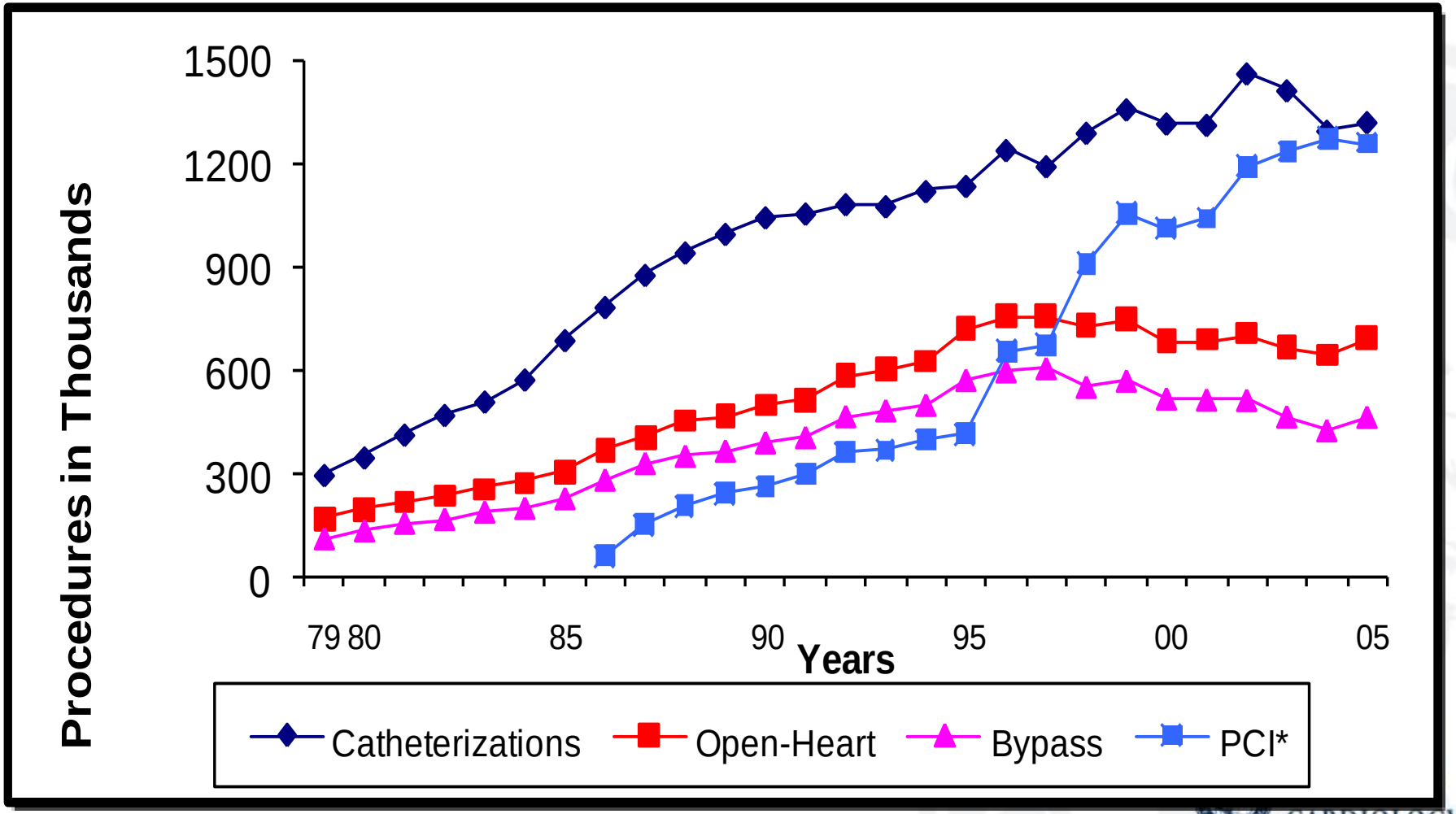
# CORONARY REVASCULARIZATION PROCEDURES: *Growth of PCI*




Trends in Cardiovascular Operations and Procedures. Source: NCHS and NHLBI.

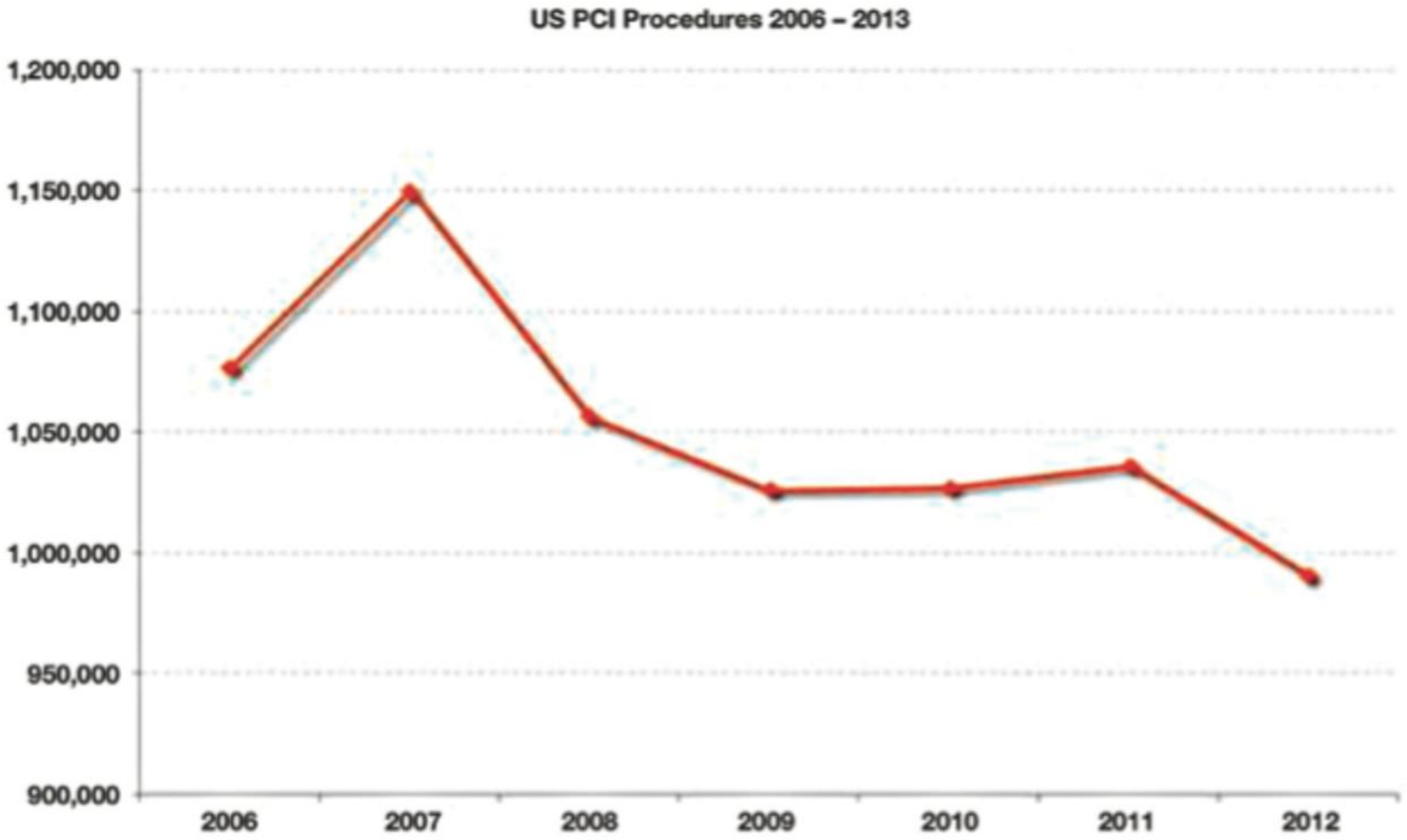
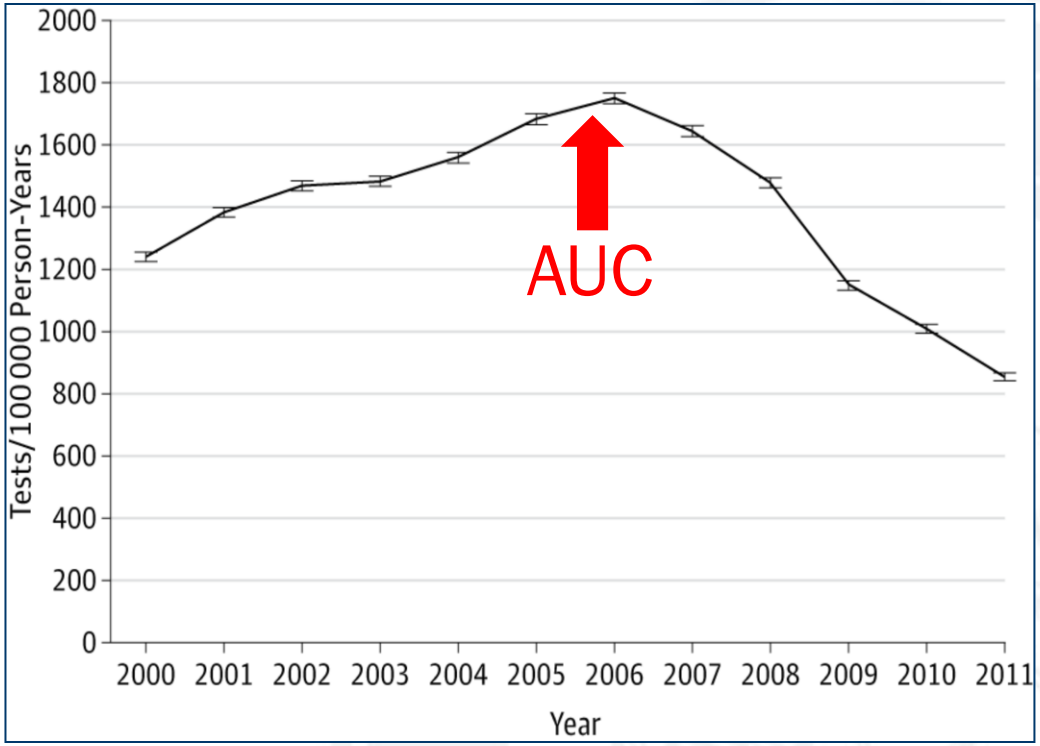



**Figure 1. PCI procedures in the United States, 2006-2012.**
With permission from Boston Scientific, Source: Medical Device Industry Estimates, 2012. (Referred to by Gregg W. Stone, MD).

# POPULATION TRENDS FROM 2000-2011 IN NUCLEAR MYOCARDIAL PERFUSION IMAGING USE

- Adjusted for age and gender
- No concomitant increase in stress echo, with negligible increase in CCTA
- Performed in system without direct financial incentives
- AUC may be involved in reduction of volume and health care costs

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McNulty EJ et al, 2014 JAMA 311:1248-1249

# Understanding the Medicare Access and CHIP Reauthorization Act of 2015

*(MACRA)*


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# ~~Understanding~~ *trying to understand* the Medicare Access and CHIP Reauthorization Act of 2015

*(MACRA)*

2016 STRATEGIC PRIORITY
Achieve Excellence as a Provider of **Strategies to Maintain Professional Competency**

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# What Did MACRA Do?

- Repealed the flawed

  **Sustainable Growth Rate (SGR)**

- Established framework for moving Medicare from a **VOLUME** to a **VALUE-BASED** system

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# Background: Creation of the SGR

- The sustainable growth rate (SGR) was created by the *Balanced Budget Act of 1997* as a means to control Medicare spending by tying Medicare clinician payments to increases in the gross domestic product (GDP).
- When health spending outpaced GDP, negative payment updates were threatened as a result.
- Due to the inability to find sufficient offsets, the SGR was unable to be repealed for nearly two decades.

Congress passed 17 patches to avoid cuts
(implementing cuts twice)

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# Elimination of the SGR

- **Early 2014**: Congressional leaders from the House and Senate, in close collaboration with the physician community, drafted legislation which would repeal the SGR and reward physicians for the value of the services they provided.
- **Spring 2015**: Speaker of the House John Boehner and Minority Leader Pelosi struck a deal on the offsets and the *Medicare and CHIP Reauthorization Act of 2015* (MACRA) was born.

Virtually the entire House of Representatives united to pass MACRA, followed by the Senate.
President Obama signed the now-law on **April 16, 2015.**

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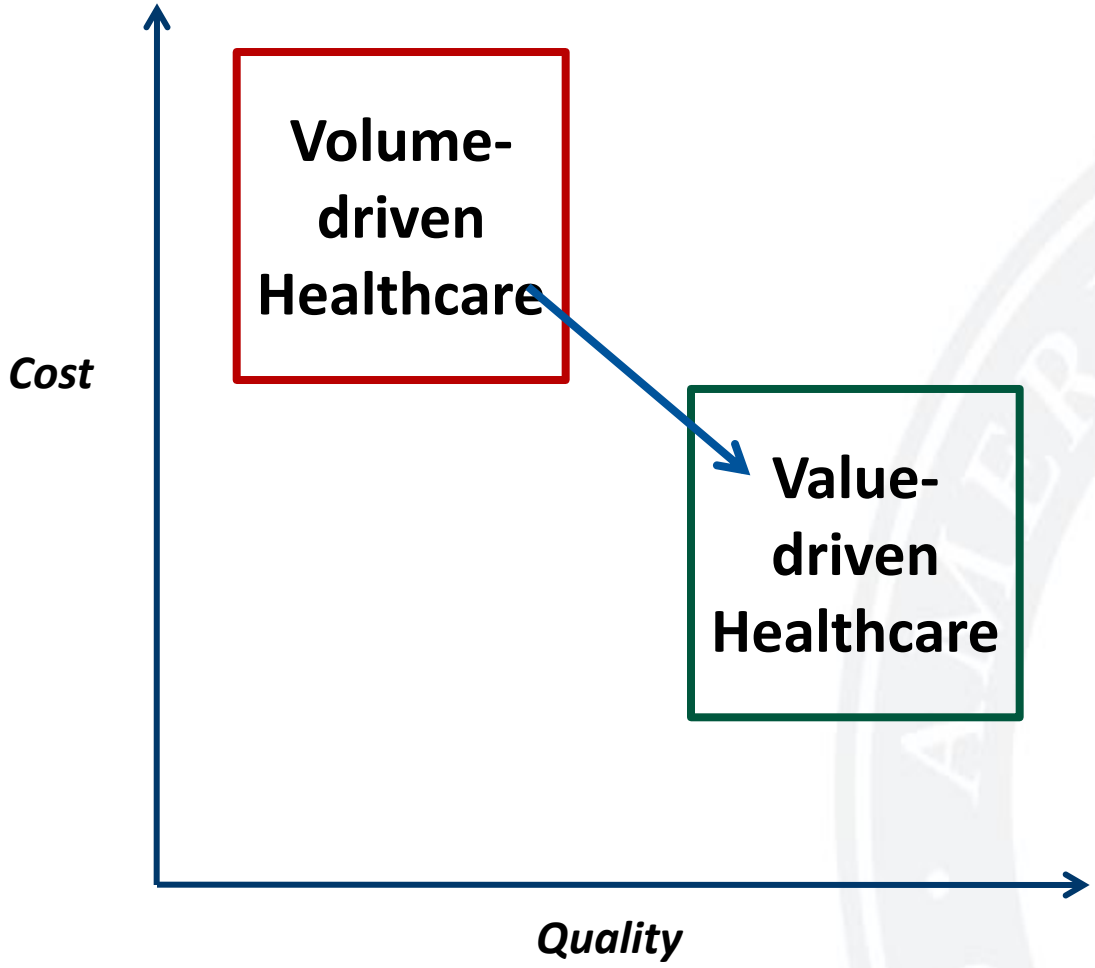
# Payment is Transitioning From Volume-Driven to Value-Driven

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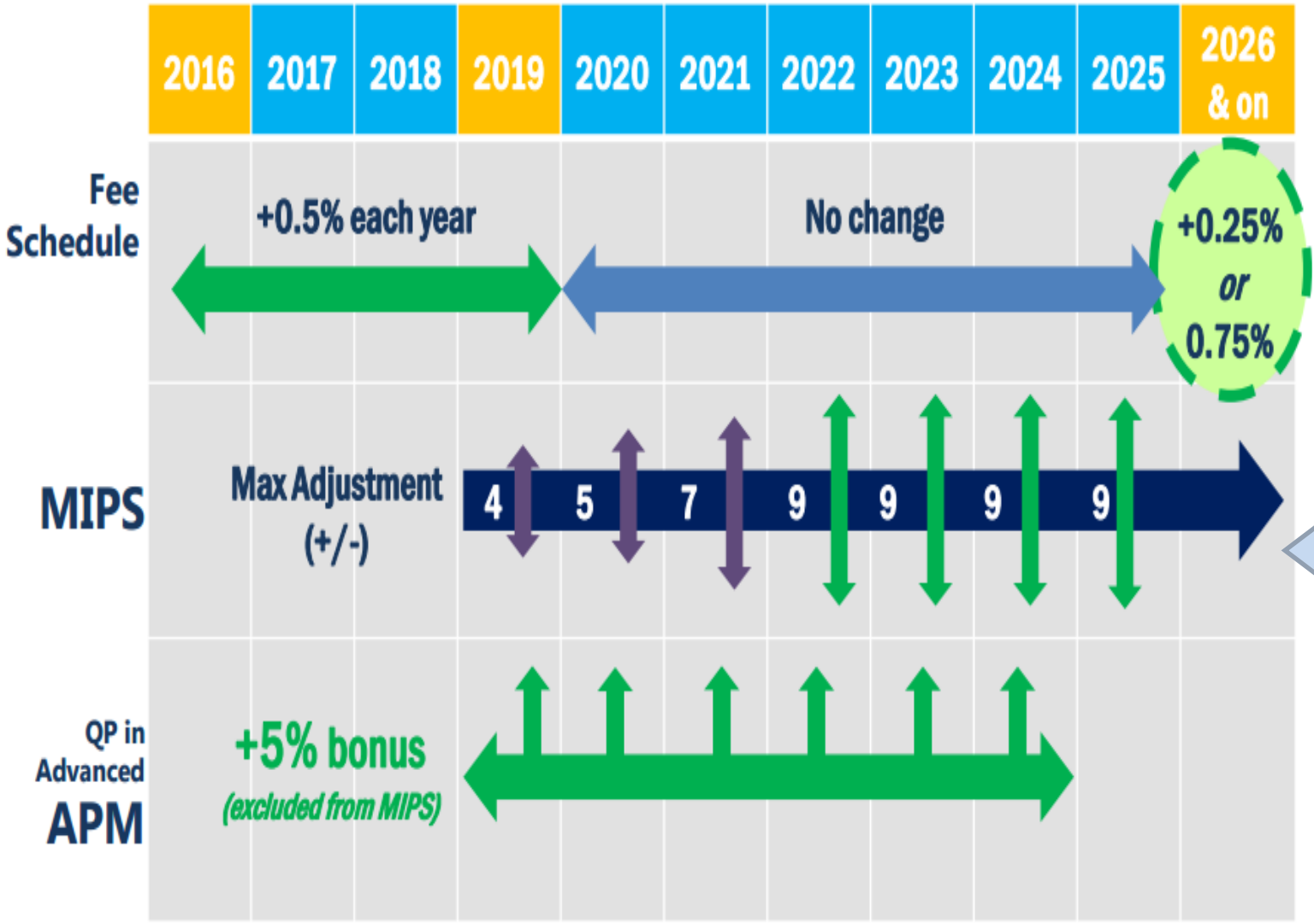
# Summary: MACRA Payment




Potential for higher MIPS bonuses based on budget-neutrality factor and exceptional performance

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

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# ACC Priorities for CMS Action

- **CMS Needs To:**
  - **Engage with clinicians and practice administrators** to ensure they **understand what reporting requirements apply and the thresholds they are being scored against** (i.e., whether they are in MIPS, a MIPS APM, or Advanced APM)
  - Continue exploring options , either through changes to the scoring methodology or the ability to **accept more than one data file per practice** , that would allow cardiology performance to be better reflected in **group-level MIPS reporting** .
  - Work with societies to ensure that there are opportunities for specialists to participate in APMs.
  - Support **reduced MIPS reporting thresholds for small practices**. However, in the absence of virtual groups in 2017, CMS should monitor policies and provide practice assistance to these practices.

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# Final Rule

- Released Oct. 14, 2016
- 2017 performance year/2019 payment year
- 2000+ pages
  - 400+ public comments
- 60 day comment period

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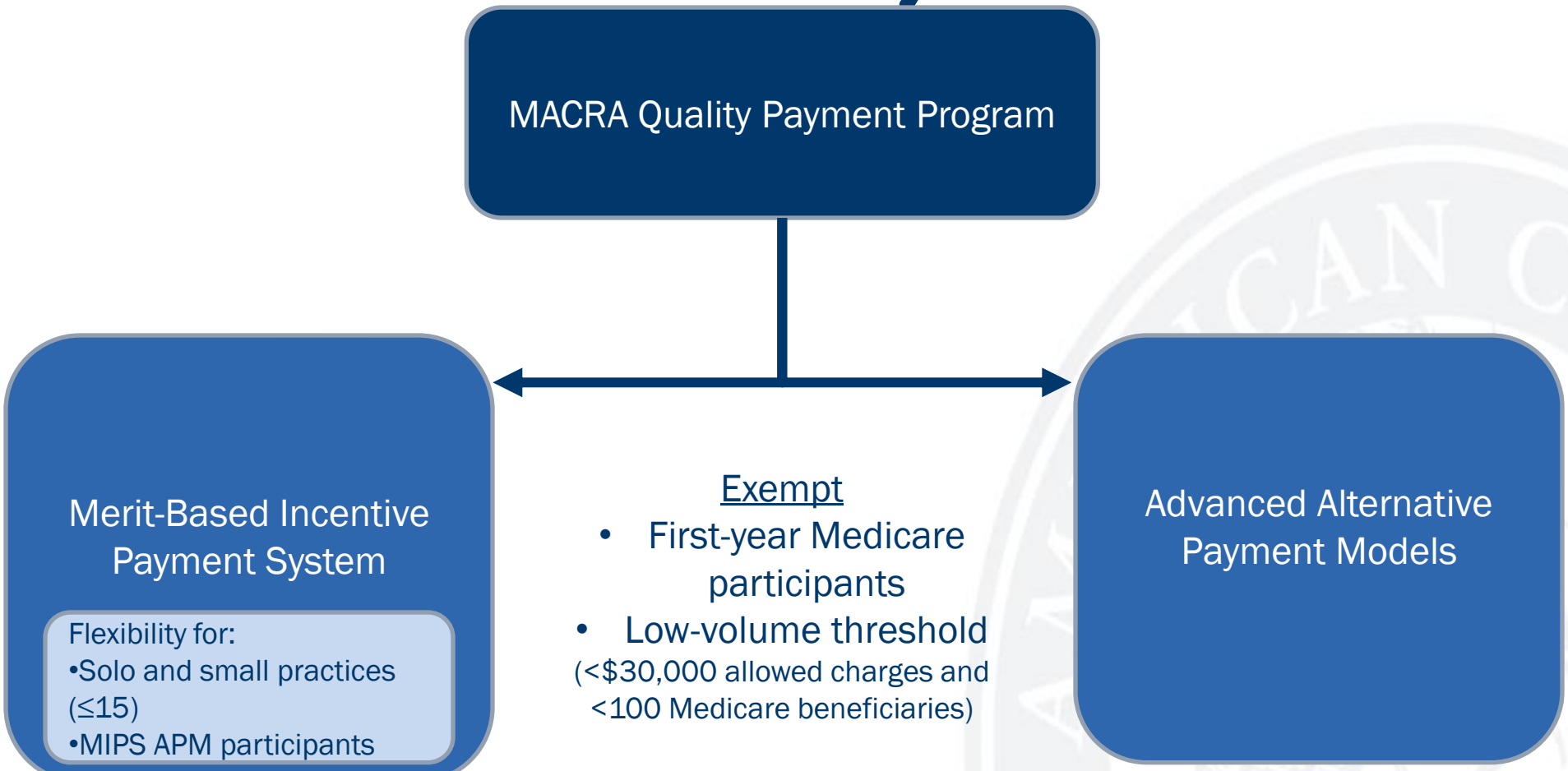
# Quality Payment Program Pathways

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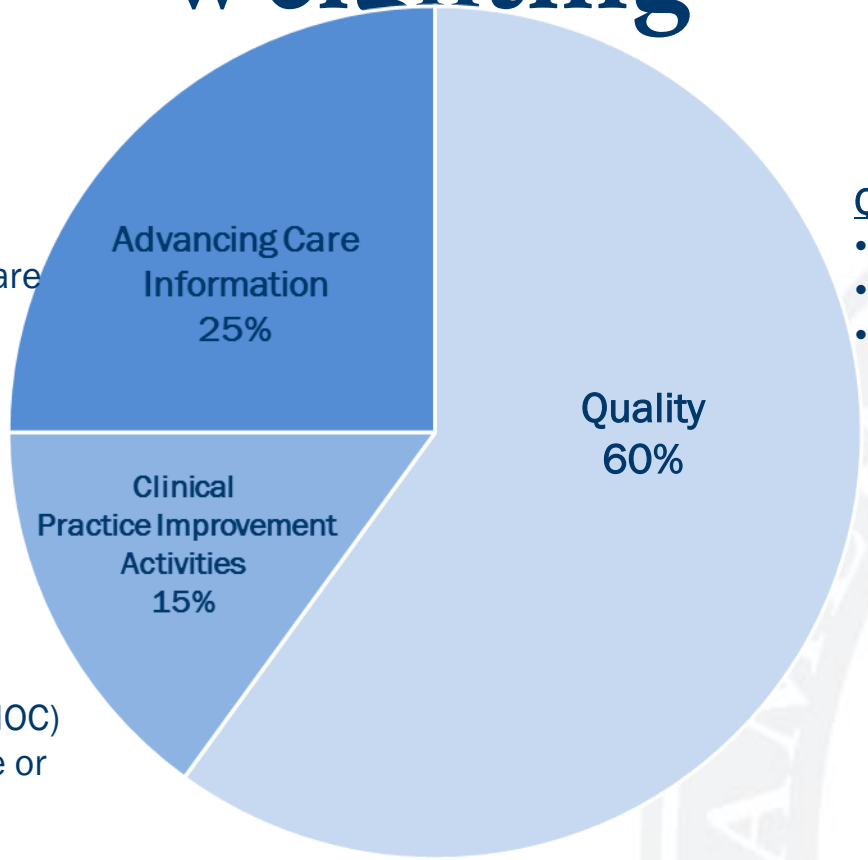
# 2019 MIPS Composite Weighting

**Advancing Care Information**
- Security Risk Analysis
- E-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care
- Bonus: Registry Reporting

**Clinical Practice Improvement**
- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM




**Quality**
- Most PQRS measures
- QCDR (non-MIPS) measures
- Bonus: "High-priority measures"
  - Outcome, appropriate use, patient safety, efficiency, patient experience, care coordination

**Resource Use** (0%) will be incorporated into the MIPS score starting with the 2018 performance period

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# Pick Your Pace in 2017

## Test the Quality Payment Program

- Report a minimum amount of data in at least one of the categories (for example, one quality measure, one CPIA, or all five required ACI measures)
- Avoid a negative payment adjustment in 2019

## Participate for part of the calendar year

- Submit MIPS data across all categories for at least 90 days, which could begin anytime between Jan 1, and Oct 2, 2017
- Potential for a small positive payment adjustment in 2019

## Participate for the full calendar year

- Submit data across all MIPS categories covering the full year reporting period, starting Jan 1, 2017
- Potential for a modest positive payment adjustment in 2019

## Participate in an Advanced Alternative Payment Model

- Participate in an recognized Advanced APM and meet the patient or payment threshold in 2017
- 5 percent incentive payment on Medicare Part B payments in 2019

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# Role of Registries

- QCDRs maintained as a MIPS reporting mechanism
  - Can report across all categories
- Pathway for reporting non-PQRS/non-MIPS measures
- Contribute to ACI and CPIA credit
- What role will they play in Advanced APMs?

# Preparing for 2017

- Final Rule review
  - Comments to CMS by Dec 2016
- Evaluating trends in 2015 PQRS and Value Modifier Results
- QCDR self-nomination
- Education and communication

# Bundled Payments

Notice of Proposed Rule Making – July 25, 2016
- Shift from Quantity to Quality
- Incentives for Better Care at a Lower Cost
- Reward Hospitals that work with physicians *and other providers* to avoid complications, prevent readmissions, and speed recovery.

Episode Payment Models For:
- Heart Attack
- Bypass Surgery
- Surgical Hip/Femur Fracture

Fixed Target Price for Each Episode (Quality Adjusted)

Retrospective Adjustment at End of Performance Year
- Care Provided for Less than Target Price = Hospital is Paid Savings
- Care Provided Exceeds Target Price = Hospital Repays Medicare

Will Impact Hospitals in 98 Metropolitan Statistical Areas (MSAs) effective July 2017

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# Challenges Ahead, Engagement Necessary

- Early years of implementation will post challenges to those accustomed to the current system

- ACC working with HHS and CMS to minimize these challenges to support **evidence-based, cost-effective, high quality care.**

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# There Will Be Opportunities for ACC to *Provide Input* Into *How* the Law Will Function


We will be at the table!

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# ACC in Action

## ACC sent 17 Congressional Letters in 2016

### Comment Letters

- Senate Finance Committee - Improving Care for Individuals with Chronic Disease (1/16)
- Senate Finance Committee - Stark Law Principles (1/16)
- Senate HELP Committee - Bipartisan Health IT Discussion Draft (1/16)
- House Energy and Commerce Committee – Site-Neutral Payment Policy Clarification (2/16)

### Letters of Support

- H.R. 3355/S. 488 – A bill that would allow PAs, NPs, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs (2/15)
- H.R. 3952/S. 2248 – Congenital Heart Futures Act (11/15)
- H.R. 546/S. 298 – Advancing Care for Exceptional (ACE) Kids Act (1/15)
- S. 2141 – TRUST IT Act of 2015 (1/16)
- H.R. 5001/S.2822 – Flexibility in EHR Reporting Act (4/16)

### Letter of Opposition

- H.R. 5088 – Promoting Integrity in Medicare Act – (bill opposing removing the IOASE exception to the Stark law) – (5/16)

### Coalition Letters

- Supporting increased funding for the NIH, FDA, and CDC – (3/16)
- Opposing an appropriations measure that would weaken the FDA's authority over several tobacco products including e-cigarettes and cigars (4/16)
- Supporting level funding for the Agency for Health Research Quality (AHRQ) – (5/16)
- Supporting level funding for the CDC Office of Smoking and Health (OSH) – (7/16)
- Opposing all appropriations policy riders that would weaken FDA's authority to regulate tobacco products – (9/16)
- American Academy of Pediatrics coalition letter concerning provisions in the Senate's 2017 National Defense Authorization Act (S. 2943) threatening pediatric subspecialist networks and GME
- American Academy of Pediatrics support letter for the Ensuring Children's Access to Specialty Care Act, allowing pediatric medical and surgical subspecialists and pediatric mental health specialists to participate in the National Health Service Corps loan repayment program

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# ACC in Action

## ACC sent 31 Regulatory Letters in 2016

- Letter requesting that CMS implement a shortened reporting period in 2016 for the Meaningful Use EHR program.
- MIPS-APM proposed rule
- Physician Fee Schedule Proposed Rule (AUC, global services data collection, moderate sedation unbundling policy, specific codes, other items)
- Hospital Outpatient Proposed Rule (EHR reporting period, Section 603 site-neutral implementation, imaging APC assignments)
- Hospital Inpatient Proposed Rule (facility performance measures, new technology add-on payments, MS-DRG assignments)
- VA APRN proposed rule
- LAA NCD
- Leadless Pacemaker NCD
- Episode Grouper comments and nominations to clinical workgroup
- Venous Ischemic Limb Disease Medicare Evidence Development & Coverage Advisory Committee Meeting
- Part B Medication Demonstration Project Proposed Rule
- Update to UNOS/OPTN heart transplant criteria
- Medicare provider enrollment
- Ability of ACC to obtain Medicare claims data for research purposes
- Certification of EHRs for electronic measure reporting
- Draft PDUFA goals letter
- First proposed revisions to the Common Rule (the regulations governing research involving human subjects) in more than 20 years
- PDUFA & MDUFA stakeholder meetings as the FDA worked with industry to reach agreement. The results are borne out in the draft PDUFA agreement released last month (which we did comment on) and we think they are represented in the MDUFA agreement from what we know of it at this time (which we will comment on when released).
- Letter to FDA on sodium reduction targets
- Nominated Dr. Sherman to AHRQ National Advisory Council
- Medicare Shared Savings Program Benchmarking Rule Comments
- Comments to the LAN Cardiac Bundle White Paper
- Letter on the episode groups summary, patient encounter codes, supplemental episodes, and the clinical committee sign on
- Comments to the CMS measure development plan under MACRA
- JACC supplement on the population health summit, 2015
- First Lady Message for Opening Ceremony at ACC.16
- Letter to NHBLI on their website content
- Sign on letter to FDA on track and trace system for tobacco
- Sign on letter to FDA on new tobacco products
- Sign on letter to MLB on “knocking tobacco out of the park”
- Statement to USDA on Dietary Guidelines

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# HHS Advisory Committee on MACRA Physician Payment Models

- Jeffrey Bailet, MD
- Robert Berenson, MD
- Paul Casale, MD (ACC Nominee)
- Tim Ferris, MD
- Rhonda M. Medows, MD
- Harold D. Miller
- Elizabeth Mitchell
- Len Nichols, PhD
- Kavita Patel, MD
- Bruce Steinwald, MBA
- Grace Terrell, MD

**Technical Advisory Committee for Assessing Physician Focused Payment Model (PFPM)**

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More information is available on the ACC's online MACRA hub at *www.ACC.org/MACRA*

Updates are provided via the hub and through the ACC's *Advocate* newsletter.

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# What do I need to do about MACRA?

- Be aware
- Identify champion/expert in practice
- Look at your data
- Begin to move from volume to value

# The Need for Change

The ACC has experienced **significant growth** and **change institutionally and in member demographics** over the last decade, in the context of changes in the outside environment.

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# Vision for Change

Needed improvements will **strengthen** the ability of ACC leaders to **focus on the College's mission** in a manner that is ***nimble, strategic, accountable*** *and* ***inclusive*** of the diverse needs of the global CV community…while providing *increased/more diverse member participation*.

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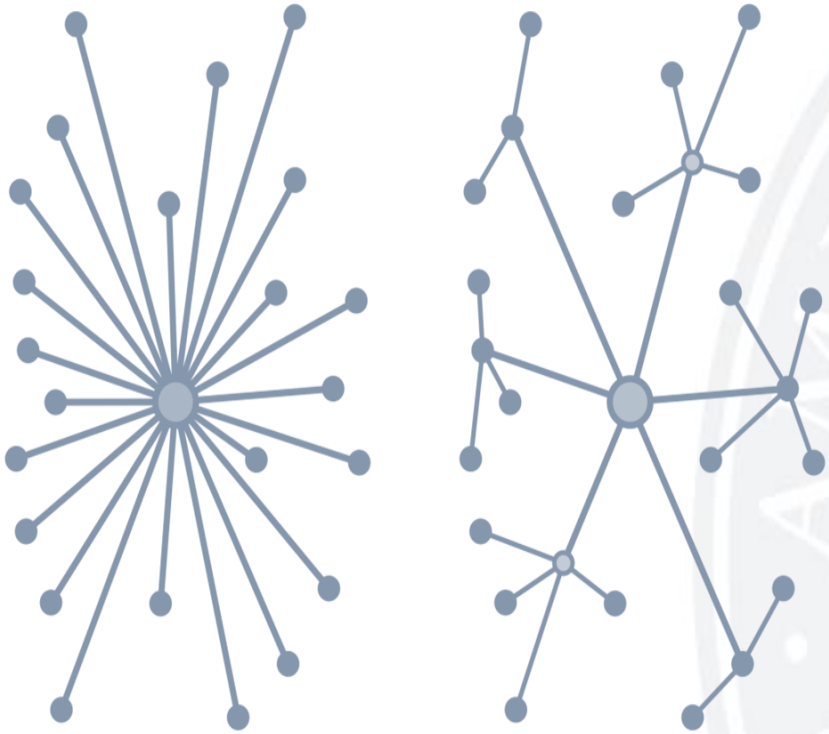
# Implementing the Principles

- A reduction in Board size from 31 to 13 members between now and 2018
- The creation of six Board standing committees
- Reduction in BOT officers to president, president-elect, secretary and treasurer
- Leadership appointments made by a newly formed Nominating Committee

# Centralized Authority *and* Decentralized Decision Making



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# ACC's Health System Strategy and Accreditation

2016 STRATEGIC PRIORITY

Further **Develop and Grow** the Health Systems Strategy

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# Critical need:

To provide hospitals, health systems and other facilities with an *integrated*, *holistic* approach to *quality improvement* across the cardiovascular care spectrum.

Most systems have the data…without the infrastructure to operationalize it into quality improvement.

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# Our Shared Goal


Establish a comprehensive quality improvement solution for hospitals and other facilities that combines SCPC accreditation and ACC's registry services, quality initiatives and education.

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# "The Biggest Issues"

- ACC Status:  Institution and members
- External Environment: Transformation of Medicine Scientifically; Procedural Pressures
- MOC
- MACRA
- Governance
- Accreditation

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