

Plan to Pay for Performance Looks Likely

BY MARY ELLEN SCHNEIDER
New York Bureau

SAN DIEGO — Within the next few years, Medicare is likely to move from a system of pay for reporting to pay for performance, Jeff Flick, a regional administrator for the Centers for Medicare and Medicaid Services, said at the annual meeting of the American College of Physicians.

Mr. Flick, who is based in San Francisco, predicted that Congress is likely to approve funds to continue the Medicare Physician Quality Reporting Initiative (PQRI) in 2008. However, in future years the program is likely to convert to a pay-for-performance system, he said, which could be similar to the system being developed for hospital value-based purchasing.

"I believe we're not going to move away from this," he said.

PQRI is a voluntary program that will let physicians earn a bonus of up to 1.5% of their total allowed Medicare charges during the last 6 months of 2007 for reporting on certain quality measures. Congress authorized the establishment of the 6-month pay-for-reporting program last December as part of the Tax Relief and Health Care Act of 2006. Changes to PQRI—and actual implementation of a pay-for-performance system—would require additional legislation from Congress.

Officials at the Centers for Medicare and Medicaid Services have selected 74 quality measures that can be used across specialties. If four or more measures apply, physicians must report on at least three for at least 80% of cases in which the measure was reportable. If no more than three measures apply, each must be reported for at least 80% of the cases in which a measure was reportable, according to CMS.

ACP has estimated that the typical internist will be able to earn about \$1,500 for reporting over the 6-month period. But the amount earned will depend on the case mix of the practice, said Robert Doherty, senior vice president for governmental affairs and public policy at ACP.

"If you look at this program, it's one that can teach us a lot for the future. It's not the answer," Mr. Doherty said. "But if you do participate, you'll learn a lot about the program."

ACP officials would rather see a "weighted" performance payment that would take into consideration the impact and the additional work related to measures for chronic diseases, he said.

But physicians who participate will have a chance to learn about the quality of care they provide and to get ready for pay for performance, Mr. Flick said. Physicians will also send a message to Congress that they are not afraid of quality, he said.

What is fundamentally driving the program is the need to move toward value, he said. CMS is currently receiving data on hospital, home health, and nursing home quality, but not on physicians. "We need data. We need to begin to understand information on quality of care," Mr. Flick said. ■

Cardiologist Shortage Anticipated

BY BRUCE JANCIN
Denver Bureau

NEW ORLEANS — Unless the training duration is shortened, the number of general cardiologists in practice in the year 2020 will be only two-thirds of the projected need, Dr. Jeffrey L. Williams predicted at the annual meeting of the American College of Cardiology.

By 2038—expected to be the peak year of the impending shortage—the number

of general cardiologists on hand will be only 47% of the anticipated need for more than 62,400 of the physicians, leaving the nation nearly 34,000 short, added Dr. Williams, a fellow in clinical electrophysiology at the University of Pittsburgh.

Shortening the duration of training required for general cardiologists—a key recommendation to address the coming cardiologist shortage proposed in the report of the 35th Bethesda Conference sponsored by the ACC—will help, but

not nearly enough, Dr. Williams added.

The Bethesda Conference report recommended fast tracking general cardiologists such that they would complete a 3-year cardiology fellowship after 2 years of general internal medicine residency instead of the conventional 3 years (*J. Am. Coll. Cardiol.* 2004;44:216-9 [doi:10.1016/j.jacc.2004.05.016]).

This would produce a greater number of general cardiologists with the same amount of funding.

Newly published data vs rosuvastatin

As an adjunct to diet when diet alone is not

What mean LDL-C reduction did and rosuvastatin did not?

- ▶ VYTORIN 10/40 mg was superior to atorvastatin 40 mg at lowering LDL-C (57% vs 48%, $P < 0.001$).¹
- ▶ VYTORIN 10/40 mg and 10/80 mg were both superior to atorvastatin 80 mg at lowering LDL-C (57% and 59% vs 53%, respectively, $P < 0.001$).¹

*Mean percent change in LDL-C from untreated baseline in a multicenter, double-blind, randomized, active-controlled, 8-arm, parallel-group study (6 weeks of active treatment) (N=1,902). Patients with hypercholesterolemia who had not met their LDL-C goal as defined by NCEP ATP III were randomized to VYTORIN 10/10, 10/20, 10/40, or 10/80 mg or atorvastatin 10, 20, 40, or 80 mg. Mean pooled baseline LDL-C values for VYTORIN and atorvastatin were 178 mg/dL and 179 mg/dL, respectively. VYTORIN 10/10 mg reduced LDL-C by 47% from baseline vs 36% with atorvastatin 10 mg ($P < 0.001$).¹

- ▶ The dosage should be individualized according to baseline LDL-C level, the recommended goal of therapy, and the patient's response.
- VYTORIN is indicated as adjunctive therapy to diet for the reduction of elevated TOTAL-C, LDL-C, Apo B, TG, and non-HDL-C, and to increase HDL-C in patients with primary (heterozygous familial and nonfamilial) hypercholesterolemia or mixed hyperlipidemia when diet alone is not enough.

Contraindications: hypersensitivity to any component of this medication; active liver disease; unexplained persistent elevations of serum transaminases; and women who are pregnant, nursing, or may become pregnant.

VYTORIN contains 2 active ingredients: ezetimibe and simvastatin.

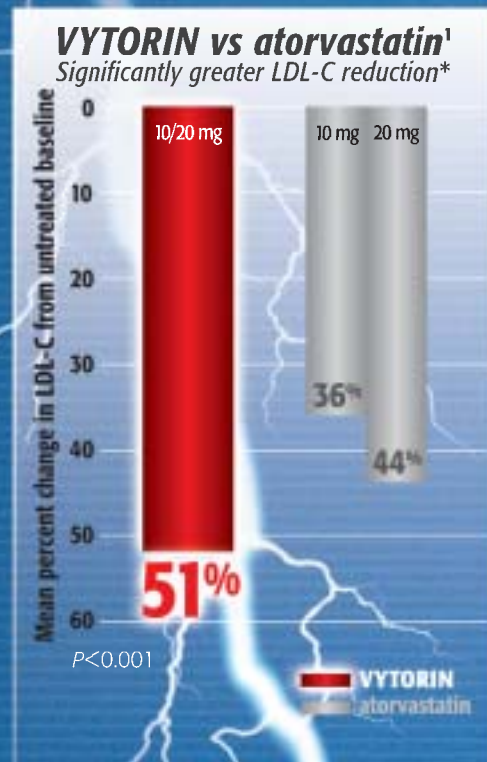
No incremental benefit of VYTORIN on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin has been established.

The clinical impact of comparative differences in lipid changes between products is not known.

SELECTED CAUTIONARY INFORMATION

Skeletal Muscle: Myopathy sometimes takes the form of rhabdomyolysis with or without acute renal failure secondary to myoglobinuria, and rare fatalities have occurred. The risk of myopathy/rhabdomyolysis is dose related. Tell patients to promptly report muscle pain, tenderness, or weakness. Discontinue drug if myopathy is suspected or CPK levels rise markedly.

Myopathy Caused by Drug Interactions: Use of VYTORIN with itraconazole, ketoconazole, erythromycin, clarithromycin, telithromycin, HIV protease inhibitors, nefazodone, or large quantities of grapefruit juice (>1 quart daily) should be avoided because of the increased risk of myopathy, particularly at higher doses.



But Dr. Williams calculated fast tracking would increase the number of general cardiologists practicing in 2020 from 22,365 to only 23,761—still well below the projected need for 33,459, based on the accepted ratio of 6 per 100,000 population.

The looming critical shortage of cardiologists is due to a confluence of factors. The number of U.S. medical school graduates matching in internal medicine residencies has declined dramatically over the last 20 years. Fewer cardiologists are being trained today than a decade ago. An estimated 10% will retire in the coming decade. The baby boomers are reaching the age when cardiovascular disease rates

climb sharply. The average patient load in cardiovascular medicine is declining, and maintaining those lower loads requires more physicians, Dr. Williams continued.

The Bethesda Conference didn't address the possibility of fast-tracking fellowships in electrophysiology (EP) and interventional cardiology. This would entail 2 years of general cardiology fellowship followed by 2 years of subspecialty training. Dr. Williams incorporated this concept into his modeling and concluded it would result in a further modest gain in the number of general cardiologists, because it would free up funds for close to 350 trainees who would no longer be tak-

ing a third year of general cardiology.

Doubling the number of cardiology fellows being trained and incorporating fast tracking for electrophysiology and interventional cardiology would essentially thwart the projected shortage of general cardiologists in 2020 but would produce a glut by 2050, according to Dr. Williams' projections.

Dr. JoAnne M. Foody called his study a useful first look at potential approaches to the looming shortage of cardiologists.

"The study shows we need to think more critically about the long-term implications of the workforce shortage and develop cogent approaches to address the

issue," said Dr. Foody of Yale University, New Haven, Conn.

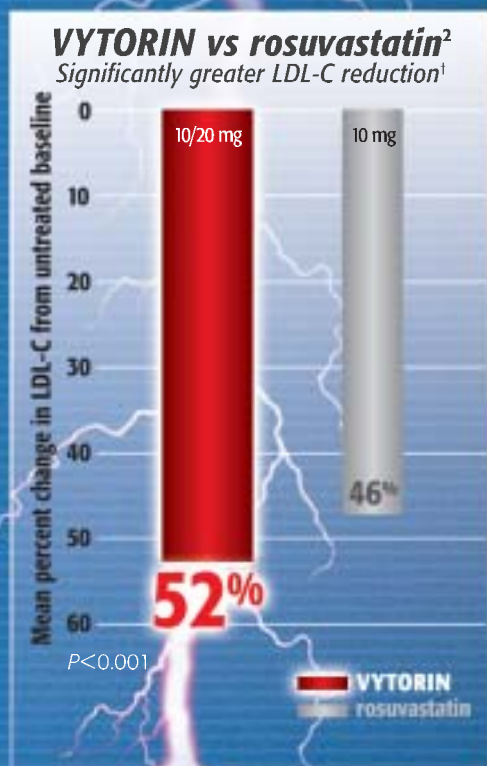
If anything, Dr. Williams' projections as to future need for cardiologists are conservative, because they don't fully incorporate the effects of rising rates of obesity, metabolic syndrome, and type 2 diabetes.

Dr. Foody said fast tracking electrophysiology training is tricky because the subspecialty is currently reinventing itself.

"[Electrophysiology] is really changing rapidly. It's hard to sort out what it will look like in 10 years. Will it be a composite that includes components of heart failure? I predict that we're likely to see multiple different tracks within EP," she said. ■

enough, in 2 separate head-to-head studies

VYTORIN provide that atorvastatin 50%^{1,2,3} mean LDL-C reduction at a usual starting dose



- ▶ VYTORIN 10/40 mg lowered LDL-C more than rosuvastatin 20 mg (55% vs 52%, P=0.001).²
- ▶ VYTORIN 10/80 mg lowered LDL-C more than rosuvastatin 40 mg (61% vs 57%, P<0.001).²

[†] Data from a multicenter, randomized, double-blind, active-controlled, 6-arm, parallel-group study designed to evaluate the efficacy and safety of VYTORIN vs rosuvastatin over a 6-week period. Patients with hypercholesterolemia (N=2,959) were randomized to 1 of 6 treatment groups: VYTORIN 10/20, 10/40, or 10/80 mg or rosuvastatin 10, 20, or 40 mg. Mean baseline LDL-C level for both VYTORIN 10/20 mg and rosuvastatin 10 mg was 172 mg/dL.²

SELECTED CAUTIONARY INFORMATION (cont)

The concomitant use of VYTORIN and fibrates (especially gemfibrozil) should be avoided. Although not recommended, the dose of VYTORIN should not exceed 10/10 mg if used with gemfibrozil. The benefit of further alterations in lipid levels by the combined use of VYTORIN with niacin should be carefully weighed against the potential risks of myopathy. The dose of VYTORIN should not exceed 10/10 mg daily in patients receiving cyclosporine or danazol, and 10/20 mg daily in patients receiving amiodarone or verapamil.

Liver: It is recommended that liver function tests be performed before the initiation of treatment and thereafter when clinically indicated. Additional tests are recommended prior to and 3 months after titration to the 10/80-mg dose, and semiannually for the first year thereafter.

VYTORIN is not recommended in patients with moderate or severe hepatic insufficiency.

In clinical trials, the most commonly reported side effects, regardless of cause, included headache (6.8%), upper respiratory tract infection (3.9%), myalgia (3.5%), influenza (2.6%), and extremity pain (2.3%).

Please read the brief summary of Prescribing Information on the adjacent page.

References: 1. Ballantyne CM, Abate N, Yuan Z, King TR, Palmisano J. Dose-comparison study of the combination of ezetimibe and simvastatin (Vytorin) versus atorvastatin in patients with hypercholesterolemia: the Vytorin Versus Atorvastatin (VVA) Study. *Am Heart J*. 2005;149:464-473. 2. Catapano AL, Davidson MH, Ballantyne CM, et al. Lipid-altering efficacy of the ezetimibe/simvastatin single tablet versus rosuvastatin in hypercholesterolemic patients. *Curr Med Res Opin*. 2006;22:2041-2053. 3. IMS HEALTH, NPA PlusSM, NRx, July 2006.

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