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*The mission of the American College of
Cardiology and the American College
of Cardiology Foundation is to transform
cardiovascular care and improve heart health.*

June 22, 2015

The Honorable Orrin G. Hatch
Chairman
Finance Committee
United States Senate
Washington, DC 20510

Senator Johnny Isakson
Co-Chair
Finance Committee
Chronic Care Working Group
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Finance Committee
United States Senate
Washington, DC 20510

Senator Mark Warner
Co-Chair
Finance Committee
Chronic Care Working Group
United States Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The American College of Cardiology (ACC) is pleased to respond to your letter from May 22, 2015 requesting feedback on how we might facilitate more efficient care for patients with chronic conditions. The ACC is a 49,000-member medical society that is the professional home for the entire cardiovascular care team. The mission of the College is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards, and guidelines. The College operates national registries to measure and improve care, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications. The ACC also produces the *Journal of the American College of Cardiology* (JACC), ranked number one among cardiovascular journals worldwide for its scientific impact.

The College commends you for convening the Senate Finance Committee Chronic Care Working Group to analyze current law, discuss alternative policy options, and develop a bipartisan legislative solution to the issue at hand. We support your efforts to improve the quality of care provided to individuals with multiple chronic conditions (MCC) and offer the ACC's engagement and assistance in working toward the goals and objectives outlined in the letter.

Many of the patients our members care for suffer from MCC; co-morbidities such as heart failure, hypertension, diabetes, dyslipidemia, obesity, and depression greatly complicate the care of the typical adult patient with cardiovascular disease. Consequently, a significant portion of cardiovascular professionals devote the majority of their practices to managing patients with multiple, complex chronic conditions. In addition, cardiologists whose practices focus on acute diagnostic and/or interventional services find their patients are frequently affected by ongoing co-morbid conditions.

The ACC is committed to improving systems of care for patients with cardiovascular disease. Our investment of expertise and resources in the development of clinical guidelines, performance measures, the National Cardiovascular Data Registry (NCDR), and quality improvement demonstrate the depth of the College's commitment to advancing science and improving the quality of cardiovascular care. These significant investments are already paying off through dramatic declines in cardiovascular morbidity and mortality. Further progress in reducing death and disability from cardiovascular disease will depend heavily on improvements in systems of care for patients with MCC.

Our comments and recommendations specific to the topics outlined in the letter are as follows:

Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures

The ACC supports models of care that emphasize interdisciplinary care, provider communication, and coordination, notably the patient-centered medical home (PCMH), community health teams, and accountable care organizations (ACOs). The College supports such models and their emphasis on strengthening the capacity of primary care. However, we strongly urge the working group to acknowledge the importance of specialty care and the critical role of specialty physicians in these models. We cannot emphasize enough that for a patient with MCC whose major condition is cardiovascular, the cardiologist is often best suited to manage the patient and coordinate care with other physicians. Given both the complexity of many patients with chronic conditions and the recognized scarcity of primary care physicians, the ACC recommends that legislation explicitly acknowledge the need for specialists such as cardiologists to be able to coordinate care in models like the PCMH or an ACO. Rigid adherence to exclusively primary care centered models risks providing sub-optimal care for complex patients with chronic conditions.

The workgroup's evaluation of APMs should consider the roles of advanced practice clinicians (nurse practitioners and physician assistants) who treat an expanding volume of chronic illnesses. Registered nurses and clinical pharmacists add a tremendous depth to the cardiovascular team and by their education and training should be empowered to practice at the top of their license. By integrating registered nurses and pharm-Ds to a care team, patients receive coordinated, valuable care. Integrated, coordinated care involving physicians, advanced practice nurses, physician assistants, and pharmacists can enhance access to services, improve quality of care, and lower overall health care expenditures.

Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

The fee-for-service payment system as it exists does little or nothing to encourage or reward the coordination of care necessary to provide optimal care to chronic care patients. The ACC applauds Congress for passing the *Medicare and CHIP Reauthorization Act (MACRA)* which is the first major step toward rewarding clinicians for outcomes as opposed to the number of patients they see. The ACC is working closely with HHS and CMS to develop the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs) and will look to Congress in the near future as we determine how this system will ultimately work in practice.

The effective use, coordination, and cost of prescription drugs

For both clinicians and their patients with chronic conditions, incentives need to be established for using generic medications while ensuring that the quality of generics is equal to brand names. An assessment of access to medications that includes affordability of medications and adherence potential, among other factors, would also be of great benefit. In recent years, [the cost of generic drugs has skyrocketed](#). ACC members have experienced this issue first-hand and strongly advocate that the Committee investigate the issue of generic drug price increases.

Patient access to generic medications should not be affected by an onerous preauthorization process from insurance companies. Preauthorization of generic medications is a recent trend that unnecessarily impacts access, adherence, and practice work load. In addition, patients whose medications are not preapproved are at higher risk of readmission.

Clinicians are increasingly feeling the pressure from insurance companies to prescribe drugs based on their cost rather than effectiveness. The College would advocate for legislative language to prevent insurance companies from suggesting that clinicians prescribe drugs based on their cost as opposed to their effectiveness. In Florida, for example, a measure was proposed that would allow clinicians to waive the “fail first” strategy of insurance companies that force them to use a less effective drug first before they will

approve the preferred drug. A similar approach at the federal level would further empower providers to act in the best interest of the patient when choosing which medications to use.

Ideas to effectively use or improve the use of telehealth and remote monitoring technology; and strategies to increase chronic care coordination in rural and frontier areas

Members of the cardiovascular care team are using telehealth every day to care for patients. Depending on the status of the patient, the clinician will determine whether a phone call or in-person visit is most appropriate. The future of telehealth will focus on bundled payments and offering the same quality of service in a less costly package. Medical specialty societies can play a vital role in determining which patients are appropriate to be monitored by telemedicine and which are not. Heart failure and rhythm management are two areas in the cardiovascular space that are prime candidates for telehealth. Proper reimbursement for providing this service is essential in order to incentivize clinicians to use the technology. In order for all of this to be possible, particularly in rural areas, there is an urgent need for broadband availability.

Opinions for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

The ACC recognizes the crucial role an informed and motivated cardiovascular patient can play in implementing his or her own treatment, preventing complications, and slowing or preventing the progression of disease. Our patient-focused website, CardioSmart.org, contains patient education and self-management tools for a number of cardiovascular conditions.

There is a critical role for individual patient preferences in the decision-making process, from diagnostic testing to therapeutic intervention. While this factor is clearly important in all patients, it becomes increasingly crucial as complexities escalate due to age, MCC, polypharmacy, social context, and other factors. Therefore, in developing strategies to optimize health and quality of life for individuals with MCC, it is essential to recognize the fundamental role of the patient's perspective. The notion of patient preferences as a driver of decision making becomes complicated by the fact that many patients' choices reflect only limited awareness of treatment effects. Not only is medical science constantly changing, but questions of cognitive ability may arise for elderly patients. The complexity of MCC, the variability of patient health literacy, and the limitations of educational resources to disseminate accurate, current scientific information may work to confound successful implementation of self-care management strategies. Some elderly patients with chronic conditions do not own or have access to computers and prefer face-to-face interactions. Education and information must be provided to these patients in a format that is easily understandable and translatable, particularly in situations where there is shared decision making with medications. Empowering patients to measure and transmit their condition by creating ongoing feedback with the clinician is also very important. This could include remote sensors, home laboratory testing, even something as simple as managing anticoagulants with atrial fibrillation.

The College believes involving patients in an evidence-based decision-making process is the best way to improve outcomes while providing the highest value. In 2014, ACC Chapters in Florida and Wisconsin were awarded a \$15.8 million Center for Medicare & Medicaid Innovation (CMMI) grant to test the implementation of SMARTCare, which is a combination of clinical decision support, shared decision-making, patient engagement, and provider feedback tools designed to improve care for patients with stable ischemic heart disease. This type of grant gives the ACC an opportunity to demonstrate how data from clinical registries can be leveraged to enhance clinician/patient communication. The SMARTCare program has the potential to save hundreds of millions of dollars annually while improving the decision-making process to benefit patients. SMARTCare is focused on the treatment of coronary artery disease, but is a model that could be applied for other chronic conditions across medicine.

Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions

Clinicians are and should be having advanced planning conversations with their patients, and in turn should be properly reimbursed for doing so. This is an area in need of major improvement, however. CMS has created codes that are underutilized, whether from a lack of knowledge about the codes, or the fact that they are reimbursed at such a low rate that clinicians are not incentivized to use them. Appropriately designed and implemented advanced care planning components and a format for documentation both in the hospital and in the office record have the potential to improve patient quality of life during this stage, to conform with patient preferences, to enable transmission to multiple members of the health care team, and to substantially lessen the cost of inappropriate and undesired end-of-life care. These services should have a payment code, and provision of these services should be required in the hospital-based setting and encouraged in the office setting.

Training non-palliative care physicians and advanced practice clinicians in advanced care planning is another approach to alleviate this problem. Members of the cardiovascular care team should be able to provide their specific area of expertise to a patient, e.g. a patient with heart failure and/or at risk of sudden cardiac death. Providers of cardiac services can reduce costs by working closely with primary care physicians to define parameters. A mechanism needs to be developed to facilitate work in conjunction with the primary care physician.

Another possible solution to ensuring proper advanced care planning would be to develop a program for Medicare patients to answer thought provoking questions about their prior year of health, health goals, and wishes.

For clinicians caring specifically for geriatric patients, adding a collection of minimum core geriatric data including gait speed, functional status, and morbidity for Medicare patients would prove helpful. The goal would be to develop a broadly collected set to enable the description of elders beyond single variables, facilitate comparisons and provide normative geriatric data. This could be done at Medicare entry and at intervals to enable targeted approaches for care and reimbursement beyond a single disease focus.

The ACC applauds you and your respective staff for taking the initiative to accomplish specific goals related to more efficiently caring for patients with chronic conditions and commends you for your collaborative approach. On behalf of the entire cardiovascular care team and the patients we serve, the College appreciates the opportunity to provide input on these concepts. For additional information on the perspectives of the ACC, please contact Charles Cascio (ccascio@acc.org), Associate Director of Legislative Affairs.

Sincerely,



Kim Allan Williams, Sr., MD, FACC, FAHA, FASNC
President