American Heart Association | American Stroke Association
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June 19, 2015

Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Medicare Chronic Care Policy Recommendations

Dear Chairman Hatch, Ranking Member Wyden, Sen. Isakson, and Sen. Warner:

On behalf of the American Heart Association (AHA), including the American Stroke Association (ASA) and over 30 million volunteers and supporters across the country, we appreciate the opportunity to recommend policies that would improve the health and quality of life for patients with chronic conditions, particularly those with cardiovascular diseases.

The AHA/ASA is dedicated to building healthier lives, free of cardiovascular disease and stroke. While we have made significant progress in the United States in reducing death rates from heart disease and stroke, much work remains to address these leading causes of death and disability and ensuring patients suffering from these diseases receive high quality, coordinated care. This goal is especially important for Medicare beneficiaries as the top three chronic conditions that this population faces include high blood pressure, high cholesterol, and ischemic heart disease, with heart failure and stroke also among the most prevalent conditions in this patient population. As you know, it is also likely that many Medicare beneficiaries suffer from multiple chronic conditions.[1]

Almost one year ago, your Committee heard first hand from an AHA volunteer, Stephanie Dempsey, about the personal toll of chronic diseases. Stephanie suffered from multiple chronic conditions, underwent a number of surgical operations, and took over a dozen medications a day throughout her life. Her chronic conditions not only affected her health, but the strain caused by her conditions led to the loss of her independence, financial security, and family.

Sadly, we mourned the loss of Stephanie late last year, but her call to action to develop policies to help patients like her live long, healthy, and productive lives remains just as important today as it did a year ago. We are grateful that you have acknowledged the challenges she faced and are committed to finding solutions by convening the chronic care working group. This is a critical step to improving the care and health outcomes of patients like Stephanie.

[1] MedPAC. Report to the Congress: Medicare Payment Policy. March 2015. Accessed online at: http://www.medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0

Below, we have outlined a number of specific policies that we believe address the goals your workgroup seeks to achieve and will lead to improved health outcomes for patients with cardiovascular diseases. We strongly encourage the Committee to include these recommendations as part of a legislative solution to improving chronic disease care for Medicare patients.

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

We agree that Medicare should incentivize and encourage the coordination of care across specialties, providers, and facilities. To accomplish this goal, we strongly encourage the Committee to include reforms to Medicare that incentivize patient access to advance care planning discussions and palliative care. Advance care planning can play an important part in providing patients with information about the role of palliative care, especially since many patients and families are often unaware of the existence or availability of palliative care services. Advance care planning also offers patients the opportunity to define their preferences and expectations for the medical care that they want to receive throughout the progression of their condition. Specifically, we urge the Committee to include in its chronic care proposal the Care Planning Act of 2015 (S. 1549), recently introduced by Senators Isakson and Warner. This bill would create a voluntary Medicare benefit to allow eligible individuals, such as those with late stage heart and neuromuscular diseases, to engage in a team-based planning process to align care with a patient's goals, allow a care team to work together to meet a patient's needs, and ensure patients receive information on palliative care.

Palliative care is defined as medical and supportive care for people with serious illness that is routinely integrated into care by all practitioners and focused on providing patients and their families with relief from illness and suffering burden regardless of diagnosis.[2] The care is provided by an interdisciplinary team which can include practitioners from a number of fields, including nursing, medicine, social work, physical and occupational therapy, spiritual care, and psychiatry. This team also helps ensure coordination along the care continuum and across settings, as well as assists in care transitions, by helping patients clearly communicate their care goals so that transitions are well organized and the receiving care team understands the patient's needs.

Research demonstrates that patients living with serious illness identify elements of palliative care, such as pain and symptom management, among their top priority needs from the healthcare system.[3] This is especially critical for patients who suffer from acute cardiovascular events or stroke who were previously highly functional but are now living longer, need additional support for coping, and adjusting to the illness and complex decision making. Palliative care helps integrate medically appropriate and supportive care practices to help these patients achieve goals of improved functioning and prolonging life, when possible, and with comfort and the preservation of hope at the end of life.

Palliative care also improves patient outcomes. For example, research that examined outcomes for patients receiving palliative care-focused case management while receiving care for chronic pulmonary disease or heart failure found significantly better outcomes on self-management of illness, awareness of illness-related resources and legal preparation for end of

[2] Center to Advance Palliative Care, 2011 Public Opinion Research on Palliative Care: A Report Based on Research by Public Opinion Strategies.
[3] Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. JAMA. 1999;281:163–168.

life. Patients also reported lower symptom distress, greater vitality, better physical functioning and higher self-rated health than randomized controls.[4]

As shown above, we strongly believe that incentives to encourage expanded access to, and more comprehensive delivery of, advance care planning and palliative care services meet the Committee's goals of increasing care coordination, ensuring the appropriate level of care, and improving outcomes for patients with chronic diseases.

The effective use, coordination, and cost of prescription drugs

We also strongly encourage the Committee to include in its proposal policy changes in Medicare that would improve medication adherence – or taking medication as directed – among patients with chronic illnesses. We believe the Committee should include in its proposal language to expand eligibility for medication therapy management (MTM) programs under Medicare to include beneficiaries with only a single chronic condition that has been proven to respond positively to improved medication adherence, like cardiovascular disease. Specifically, we encourage the Committee to include in its proposal the bipartisan Medication Therapy Management Empowerment Act of 2015 (S. 776) to make this critical change to the MTM program. This bill would expand MTM services to certain individuals with only a single chronic disease, including individuals with cardiovascular disease, in order to ensure optimal medication outcomes through improved medication use.

For a variety of reasons, an estimated three out of four Americans do not take their medication as directed.[5] Unfortunately, poor medication adherence is particularly an issue for patients with heart disease. 24% of patients who suffer a heart attack do not fill their medications within seven days of discharge[6] and 34% of heart attack patients with multiple prescriptions stop taking at least one of them within one month of discharge.[7] These non-adherent patients are more likely than their medication adherent counterparts to have adverse health events that incur additional costs to them and the health care system.[8] For example, the risk of hospitalization, re-hospitalization, and premature death among non-adherent hypertension patients is more than five times higher compared to hypertension patients who adhere to taking their medicine.[9] We also know that patients with high cholesterol who do not adhere to their medications have a 26% greater likelihood of a cardiovascular-related hospitalization compared to patients who adhere to their prescriptions.[10]

Put simply, when patients with cardiovascular diseases do not take their medications as prescribed they put their health at risk while adding unnecessary costs to our health care system. This is why we strongly believe that current MTM eligibility criteria should be updated so that current law does not continue to restrict patient access to valuable medication

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[4] Aiken, LS, et al. Outcome Evaluation of a Randomized Control Trial of the PhoenixCare Intervention: Program of Case Management and Coordinated Care for the Seriously Chronically Ill. Journal of Palliative Medicine. Volume 9, Number 1, 2006.

[5] American Heart Association. (2013). Medication Adherence – Taking Your Meds as Directed. Retrieved from https://www.heart.org/HEARTORG/Conditions/More/ConsumerHealthCare/Medication-Adherence---Taking-Your-Meds-as-Directed_UCM_453329_Article.jsp.

[6] Jackevicius, CA, Li, P, & Tu, JV. (2008). Prevalence, predictors, and outcomes of primary nonadherence after acute myocardial infarction. Circulation, 117(8), 1028-1036.

[7] Ho, PM, Spertus, JA, Masoudi, FA, Reid, KJ, Peterson, ED, Magid, DJ,... & Rumsfeld, JS. (2006). Impact of medication therapy discontinuation on mortality after myocardial infarction. Archives of Internal Medicine, 166(17), 1842-1847.

[8] Ho, PM, Bryson, CL, & Rumsfeld, JS. (2009). Medication adherence its importance in cardiovascular outcomes. Circulation, 119(23), 3028-3035.

[9] Gwadry-Sridhar, FH, Manias, E, Zhang, Y, Roy, A, Yu-Isenberg, K, Hughes, DA, & Nichol, MB. (2009). A framework for planning and critiquing medication compliance and persistence research using prospective study designs. Clinical Therapeutics, 31(2), 421-435.

[10] Pittman, DG, Chen, W, Bowlin, SJ, & Foody, JM. (2011). Adherence to statins, subsequent healthcare costs, and cardiovascular hospitalizations. The American Journal of Cardiology, 107(11), 1662-1666.

management services that are designed to increase coordination between pharmacists and physicians and improve the use of prescription drugs.

Ideas to effectively use or improve the use of telehealth

Finally, we strongly encourage the Committee to address the Medicare reimbursement barrier that would help make telestroke care more widely available by allowing Medicare to reimburse for telestroke services that originate in urban and suburban areas, as well as in rural areas. This policy would help meet each of the bipartisan goals set out for the chronic care reform legislation: It would increase stroke care coordination among providers, incentivize the appropriate level of care for stroke patients, and facilitate the delivery of high quality care, improve patient outcomes, and reduce Medicare and Medicaid spending. It is for these reasons that we strongly urge the Committee to include in its chronic care proposal Senator Kirk's legislation that would expand access to stroke telehealth services under Medicare, the Furthering Access to Stroke Telemedicine Act – or the FAST Act (S. 1465).

Stroke is a leading cause of serious long-term disability and the second leading cause of dementia, with nearly 800,000 strokes occurring per year.[11] About two-thirds of the total hospitalizations for stroke occur among adults age 65 and older,[12] and approximately 94 percent of strokes occur in an urban or suburban area.[13] Unfortunately, a number of barriers prevent or slow treatment for a large number of patients, including the lack of availability of stroke specialists who can evaluate the patient and determine if he or she is a candidate for treatment. In the treatment of stroke, it is frequently said that "time is brain." Timely access to a neurologist who can oversee administration of the latest therapies through expanded use of telestroke greatly improves the number of patients who receive the evidence-based treatment for stroke and reduces disability from stroke.[14]

Tissue Plasminogen Activator (tPA) is a clot-busting drug that helps reverse disability from the most common type of stroke if given within the first 3 to 4-1/2 hours of symptom onset. The faster a patient receives treatment for stroke, the better the chances for recovery with minimal or no disability. However, about one-third of Americans live more than an hour from a primary stroke center,[15] and only about 27 percent of stroke patients arrive at the hospital within 3.5 hours of symptom onset.[16] Additionally, there are currently only 4 neurologists per 100,000 persons in the US,[17] meaning that even emergency departments in urban and suburban areas are not able to have stroke neurologists readily available. As a result of these barriers, only 3 to 6 percent of patients receive tPA.

Telestroke can help fill this void, and evidence-based research supports its use and effectiveness. For instance, evidence shows that telestroke has proven to be very effective in

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[11] Go, Alan S., et al. Heart disease and stroke statistics--2014 update: a report from the American Heart Association. Circulation.2014.129.3: e28.
[12] Hall MJ, et al. National Center for Health Statistics Data Brief: Hospitalization for Stroke in U.S. Hospitals, 1989-2009. May 2012. Accessed online at: http://www.cdc.gov/nchs/data/databriefs/db95.pdf.
[13] Based on 2013 CDC survey data which reported the prevalence of stroke was 2.4% for adults living within a MSA and 3.2% for adults living outside a MSA. Using US Census Bureau estimates of the population living in MSAs and non-MSAs, we estimated the total number of strokes occurring in MSAs and non-MSAs.
[14] Schwamm, LH., et al. A review of the evidence for the use of telemedicine within stroke systems of care: A scientific statement from the American Heart Association/American Stroke Association. Stroke. 2009. 40. 7: 2616-2634.
[15] Adeoye O., et al. Geographic Access to Acute Stroke Care in the United States. Stroke. 2014; 45. Published online Aug. 26, 2014.
[16] Tong D, et al. Times from symptom onset to hospital arrival in the Get With The Guidelines-Stroke Program 2002 to 2009: temporal trends and implications. Stroke. 2012; 43: 1912-1917.
[17] Freeman, WD., et al. The workforce task force report clinical implications for neurology. Neurology.2013.81.5: 479-486.

increasing the use of tPA and reducing the amount of time it takes to get treatment to patients, in both urban and rural areas.[18] Another recent study of 4 urban hospitals in Illinois found that their utilization of tPA increased by two to six times after telestroke was implemented.[19]

Finally, telestroke can save Medicare money by reducing stroke-related disability and the need for costly inpatient rehabilitation or long-term care. Stroke is currently the leading cause of Medicare admissions to inpatient rehabilitation facilities, accounting for nearly 20 percent of all such admissions.[20] According to one study, patients receiving tPA were more likely to be discharged to home than to inpatient rehabilitation or nursing homes and the study projected savings in rehabilitation and nursing home costs of $10.2 million (in 2013 dollars) per 1,000 additional patients treated with tPA.[21] In addition, a similar study published in the *New England Journal of Medicine* showed patients receiving clot-busting therapy were at least 30 percent more likely to have minimal or no disability at three months when compared to patients who did not receive this treatment. The study also found that these patients have shorter hospital stays and are more frequently discharged to their homes rather than to more costly nursing homes. An analysis conducted by the AHA/ASA of the impact of lifting the rural site requirement specifically for telestroke evaluations found that the FAST Act could result in $1.2 billion in *net* savings to Medicare and Medicaid over 10 years.

Conclusion

We strongly believe that the policies outlined above should be included in any legislative solution brought forth to the full Committee. Expanding access to palliative care and advance care planning, medication therapy management programs, and telestroke in the Medicare program are important ways to achieve the Committee's goals. These policies would increase care coordination, allow for the most appropriate level of care for patients with cardiovascular disease, and improve patient health outcomes while reducing the growth in Medicare spending. If you have any questions or would like to discuss any of these proposals further, please contact Kevin Kaiser at kevin.kaiser@heart.org or 202-785-7931.

Again, we thank the Committee for convening a working group to address the challenging issues related to caring for Medicare patients with chronic conditions, and we thank you for your consideration of these proposals. We look forward to working with Committee and future opportunities to provide input on this initiative

Sincerely,

Elliott M. Antman, MD, FAHA
President
American Heart Association

[18] Schwamm, LM, et al., 2009.
[19] Cutting S, et al.. Telestroke in an urban setting. Telemed JE Health. 2014; 20 (9):855-7.
[20] MedPAC, 2015..
[21] Fagan SC, et al. Cost-effectiveness of tissue plasminogen activator for acute ischemic stroke. Neurology. 1998; 50: 883-890. The original numbers in 1996 dollars have been updated for inflation.