



June 22, 2015

The Honorable Orin Hatch  
Chairman  
United States Senate  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
United States Senate  
Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Johnny Isakson  
United States Senate  
131 Russell Senate Office Building  
Washington, DC 20510

The Honorable Mark Warner  
United States Senate  
475 Russell Senate Office Building  
Washington, DC 20510

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

The [Alliance for Aging Research](#) is the leading non-profit organization dedicated to accelerating the pace of scientific discoveries and their application to improve the experience of aging and health. The Alliance believes that advances in research help people live longer, happier, more productive lives and reduce health care costs over the long term. We support policies that advance medical research and innovation and address the needs of aging Americans. On behalf of the Alliance, we applaud your commitment to improving care for people living with multiple chronic conditions (MCC) and appreciate the opportunity to assist the Senate Finance Committee in developing comprehensive MCC legislation.

As many as three out of four Americans age 65 and older have multiple chronic conditions. These conditions are associated with substantial costs totaling as much as 66 percent of total healthcare spending.<sup>i</sup> Multiple chronic conditions among older adults often leave them with poorer functioning and higher rates of mortality. The Alliance's comments are limited to three priority issues identified in your [May 22, 2015 stakeholder letter](#). We believe that incentivizing better MCC coordinated care under Medicare, improving the utilization of medications, and transforming outcomes for Medicare beneficiaries could significantly improve several costly challenges in care delivery. These challenges are low rates of adult immunization, high incidence of healthcare-associated infections across care settings, and high prevalence of preventable stroke among older adults.

### **Adult Immunization**

Vaccine preventable illnesses and diseases continue to cause significant sickness, hospitalization, pain, disability, and death in the United States. Pneumonia causes between 300,000 and 600,000 hospitalizations in older adults each year.<sup>ii</sup> More than 50 percent of flu-related hospitalizations are in people age 65 and older.<sup>iii</sup> Around 50 percent of the more than 1 million cases of shingles each year are in people age 60 and older. Many of those who suffer from shingles experience postherpetic neuralgia-induced pain that lasts for months or years.

These infections come at a significant cost. The annual direct and indirect medical cost of infectious diseases is \$120 billion.<sup>iv</sup> In the U.S. flu costs over \$87 billion<sup>v</sup> alone and shingles costs approximately \$1 billion.<sup>vi</sup> Medicare beneficiaries hospitalized for pneumonia have almost \$16,000 in higher expenses than those without this infection.<sup>vii</sup>

Despite the debilitating health outcomes and healthcare costs associated with influenza, pneumonia, and shingles not all older adults receive these ACIP-recommended vaccines. A recent analysis conducted by Bates White for the Alliance for Aging Research—to be released on July 9, 2015—found that all of the routinely-recommended vaccines for adults are cost-effective using standard economic metrics. This high degree of cost effectiveness suggests that both public health and economic well-being would be enhanced with higher levels of immunization among target populations, including population the elderly.

In order to rectify the trend of underutilization of recommended adult vaccines, we propose that the Senate Finance Committee’s MCC legislation require providers to ascertain and track beneficiaries’ vaccination history and discuss recommended vaccines during the Initial Preventive Physical Exam (also known as the “Welcome to Medicare Visit”) as well as the Annual Wellness Visit. Additionally as part of Medication Therapy Management, a requirement to undertake an immunization status assessment as part of the Comprehensive Medication Review would increase available information, likely resulting in more appropriate utilization of vaccines. We believe that making vaccination counseling an integral part of the Annual Wellness Visit and providing supplemental reimbursement to physicians for so doing could have additional positive benefit. We would further recommend evaluating the potential benefits of having seniors with multiple chronic conditions vaccinate with their medical homes.

Unlike pediatric vaccines, adult vaccines have not yet been incorporated into routine clinical workflow models. The use of electronic medical records and accountable care organizations could potentially facilitate their incorporation and incentivize systematic alerts that vaccines are due so that physicians do not have to keep track of eligibility requirements, contraindications, and vaccine history. Increased provider participation in the CDC’s Immunization Information System (IIS) would also improve the flow of information about utilization history and potentially increase appropriate vaccine utilization among older adults. Advancing the incorporation of vaccine utilization quality measures into the Medicare Star Rating program and in private quality metrics such as HEDIS should also be considered.

### **Healthcare-Associated Infections**

Nursing homes, skilled nursing facilities, and assisted living facilities provide a variety of services to people who are unable to independently manage their personal and medical care needs. More than 3 million Americans receive care in U.S. nursing homes and skilled nursing facilities each year and nearly 1 million people reside in assisted living facilities.<sup>viii</sup> Many of these individuals have multiple chronic conditions.

The most recent comprehensive data on healthcare-associated infection (HAI) rates in long-term care facilities was released more than a decade ago. Data on HAIs in other settings are also limited, but the CDC estimates that 1 to 3 million serious infections occur every year in these facilities. These infections include urinary tract infections, diarrheal diseases, and antibiotic-resistant staph infections, among

others. Healthcare-associated infections are a major cause of hospitalization and death. As many as 380,000 people die of infections in long-term care facilities each year.<sup>ix</sup> Despite these significant numbers, there are currently no federal requirements for surveillance and reporting of HAIs in long-term care facilities; no federally standardized HAI prevention efforts for these facilities; and sporadic, voluntary antibiotic stewardship programs.

The Alliance for Aging Research held a [policy roundtable](#) in September of 2014 to discuss the disproportionate impact of HAIs on older adults. The roundtable resulted in a number of recommendations to improve the prevention and treatment paradigm in this vulnerable population. One recommendation was to implement surveillance and reporting of HAIs in nursing homes and skilled nursing facilities. Infection data can give healthcare facilities and public health agencies information they need to design, implement, and evaluate prevention strategies. According to the CDC, research shows that when healthcare facilities and providers are aware of infection problems and take action to prevent them, rates of HAIs can decrease by more than 70 percent.<sup>x</sup>

We propose as part of the Senate Finance Committee's MCC legislation a requirement that nursing homes and skilled nursing facilities report HAIs to the CDC for inclusion in its' National Healthcare Safety Network (NHSN). This should be a required as a Condition of Participation for Medicare and Medicaid. In addition, this HAI data should be translated for use in CMS' Nursing Home Compare 5-star rating system to educate consumers about rates of infection by facility, as well as whether facilities implement a CDC-guided, evidence-based antibiotic stewardship program.

### **Stroke Prevention**

In 2010, Medicare spent on average \$9,738 per beneficiary. For beneficiaries with 6 or more chronic conditions, average Medicare spending was over 3 times greater. These beneficiaries were more likely to have heart failure, chronic kidney disease, COPD, atrial fibrillation (AFib), and stroke.<sup>xi</sup> AFib is the most common form of heart arrhythmia. An estimated 2 million Americans have AFib,<sup>xii</sup> which puts them at an elevated risk for a fatal or permanently debilitating stroke. With population aging, the prevalence of AFib is expected to double by 2050.<sup>xiii</sup>

FDA-approved oral anticoagulation treatments are available to help reduce the risk of stroke in AFib patients, but they are underutilized. Between 40 and 60 percent of AFib patients are not placed on an anticoagulant.<sup>xiv</sup> Elderly patients are often not put on an anticoagulant owing in part to under-appreciation of the stroke risk associated with AFib and the tendency of some health care professionals to prioritize bleeding risk from treatment over stroke prevention. In older AFib patients, concern over falls injury and bleeding risk plays a disproportionate role in treatment decision-making despite the fact that the bulk of clinical evidence shows a net benefit for anticoagulation. Broader implementation of existing stroke and bleeding risk stratification tools could lead to an increase in the number of anticoagulated elderly patients. While such risk assessments have been endorsed by medical societies, it will likely be many years before recommendations have been integrated into general clinical practice. In order to realize a meaningful reduction in AFib-related strokes in the nearer term, we recommend mandating the incorporation of risk scores into electronic health records to promote formal stroke and bleeding assessment and risk stratification.

We believe that health care professionals also need to be educated on evidence-based practices related to falls. The National Institute on Aging (NIA) has undertaken an important [national initiative](#) focused on preventing injury from falls in older adults. The Department of Health and Human Services also recently released study results from a comprehensive falls prevention program that effectively reduced falls among older adults. The study found that the program led to significantly lower rates of falls over a one-year period. Those patients who received the intervention had a 13 percent lower rate of falls, and an 11 percent reduction in risk of falling. Patients also had a significantly lower rate of injurious falls.<sup>xv</sup> The results of this initiatives could be instructive for specialists who provide care to older AFIB patients.

However, rates of fall-related injuries remain stubbornly high despite research pointing to effective interventions. Among other challenges, many older patients are reluctant to disclose previous falls and only a third are screened for this problem during primary care visits. The Alliance encourages the Committee to identify ways in which the specialty care community can be engaged in falls prevention for people with MCC. Many health conditions frequently treated by specialists can increase the risk of falls among older adults, including: urinary tract infections, orthopedic and foot problems, vision issues, cognitive impairment, and others—and polypharmacy from multiple conditions may further increase the risk. Specialists should be incentivized to ask about fall history and to educate older AFib patients and family caregivers about falls risk reduction.

The Alliance for Aging Research leads the AFib Optimal Treatment Task Force which convened a [symposium](#) in October of 2014. This program highlighted several areas for improvement in reimbursement of anticoagulation therapy testing and monitoring. These included reimbursement for patient self-testing (PST) of warfarin and routine monitoring of direct-acting oral anticoagulants (DOAC). We urge you to consider these examples as the Senate Finance Committee formulates its MCC provisions related to medication utilization.

Warfarin is an anticoagulant commonly prescribed for stroke prevention in AFib. Nearly half of patients taking warfarin do not spend sufficient time in therapeutic range, which means that patients are not appropriately anticoagulated. PST is one method of testing an AFib patient's level of anticoagulation. Research has shown that PST can reduce thromboembolic complications and all-cause mortality without increased bleeding events. Unfortunately, the use of PST is largely restricted to patients who do not live close to a coagulation clinic or diagnostic laboratory. Reimbursement for PST is approximately \$9 a month per patient, making it economically unfeasible for most healthcare professionals to incorporate it into their clinical practice. According to some estimates, providers would have to limit PST use to 20 percent of their Medicare beneficiaries to make the service economically feasible. In order to establish adequate reimbursement for PST, federal health agencies' priorities and budgets need better alignment since one agency would incur the cost of the PST device and testing strips but another would see the cost "benefit" in terms of fewer hospitalizations for major adverse events.

DOACs are newer, alternative treatments to warfarin. There is a misperception that once treatment with a DOAC has started, there is no need, or little need, for patient management or clinical oversight. Some healthcare professionals assume the patient does not need regular follow-up lab tests. However, renal function declines with age and should be assessed with some frequency so that dose adjustments can be made. A patient's renal function can even affect whether certain drugs are contraindicated. Additionally, medication adherence may be negatively affected without regular treatment monitoring and patient

feedback. Monitoring of DOACS should be implemented and adequately reimbursed in order to improve patient outcomes adherence.

Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner, the Alliance for Aging Research applauds your leadership of this effort to improve MCC care delivery. The health challenges of older adults with multiple chronic conditions are substantial human and financial burdens. These burdens are expected to increase as our population continues to age at an unprecedented rate. We would be happy to offer ongoing assistance to you and the Senate Finance Committee staff as you draft legislation. Please do not hesitate to contact us with any questions. Inquiries can be directed to the Alliance's Public Policy Assistant, Ryne Carney, at (202) 293-2856 or by email at [rcarney@agingresearch.org](mailto:rcarney@agingresearch.org).

Sincerely,



Susan Peschin, MHS  
President and CEO



Cynthia Bens  
Vice President, Public Policy

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<sup>i</sup>Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Woods Johnson Foundation, 2010.

<sup>ii</sup> Martson et al. 1997, Incidence of Community-Acquired Pneumonia Requiring Hospitalization AND Kaplan et al. 2002, Hospitalized Community-Acquired Pneumonia in the Elderly.

<sup>iii</sup> Centers for Disease Control and Prevention. January 2013. CDC Influenza Update for Geriatricians and Other Clinicians Caring for People 65 and Older. Available at [www.cdc.gov/flu/professionals/2012-2013-guidance-geriatricians.htm](http://www.cdc.gov/flu/professionals/2012-2013-guidance-geriatricians.htm). Last Accessed on June 19, 2015.

<sup>iv</sup> National Institute of Allergy and Infectious Diseases. 2000. NIAID: Planning for the 21<sup>st</sup> Century. Available at [www.niaid.nih.gov/about/whoweare/Documents/niaidstrategicplan2008.pdf](http://www.niaid.nih.gov/about/whoweare/Documents/niaidstrategicplan2008.pdf). Last accessed on June 19, 2015.

<sup>v</sup> Molinari, NM, Ortega-Sanchez IR, Messonnier ML, et al. 2007. The Annual Impact of Seasonal Influenza in the U.S.: Measuring disease burden and costs. *Vaccine* 25:5086-96.

<sup>vi</sup> Centers for Disease Control and Prevention. October 2012. Herpes Zoster Vaccination Information for Healthcare Professionals. Available at [www.cdc.gov/vaccines/vpd-vac/shingles-hcp-vaccination.htm](http://www.cdc.gov/vaccines/vpd-vac/shingles-hcp-vaccination.htm). Last accessed on June 19, 2015.

<sup>vii</sup> Thomas CP, Ryan M, Chapman JD, et al. 2012. Incidence and Cost of Pneumonia in Medicare Beneficiaries. *Chest* 142(4):973-81.

<sup>viii</sup> Centers for Disease Control and Prevention. January 2015. National Center for Emerging and Zoonotic Infectious Disease and Division of Healthcare Quality Promotion. Available at: <http://www.cdc.gov/longtermcare/>. Last accessed on June 20, 2015.

<sup>ix</sup> Centers for Disease Control and Prevention. January 2015. National Center for Emerging and Zoonotic Infectious Disease and Division of Healthcare Quality Promotion. Available at: <http://www.cdc.gov/longtermcare/>. Last accessed on June 20, 2015.

<sup>x</sup> Centers for Disease Control and Prevention. January 2015. National Center for Emerging and Zoonotic Infectious Disease and Division of Healthcare Quality Promotion. Available at: [http://www.cdc.gov/HAI/surveillance/OA\\_stateSummary.html](http://www.cdc.gov/HAI/surveillance/OA_stateSummary.html). Last accessed on June 20, 2015.

<sup>xi</sup> Centers for Medicare and Medicaid Services Chronic Conditions among Medicare Beneficiaries, Chartbook: 2012 Edition. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>. Last Accessed on June 20, 2015

<sup>xii</sup> Miyasaka Y, Barnes ME, Gersh BJ, Cha SS, et al. Secular trends in the incidence of atrial fibrillation in Olmsted County, Minnesota, 1980-2000, and implications on the projects for future prevalence. *Circ*. 2006;114:199-25.

<sup>xiii</sup> Kannel WB, Benjamin EJ. Final Draft Status of the Epidemiology of Atrial Fibrillation. *Med Clin North Am*. 2008 Jan; 92(1): 17-ix.

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<sup>xiv</sup> Ogilvie, I, Newton N, Weiner S, Cowell W, Lip G.. Underuse of Oral Anticoagulants in Atrial Fibrillation: A systematic review. *Am J Med.* 2010 123(7):938-45.

<sup>xv</sup> Cohen MA, Miller J, Shi X, Sandhu J, Lipsitz LA. Prevention Program Lowered The Risk Of Falls And Decreased Claims For Long-Term Services Among Elder Participants. *Health Aff.* June 2015. 34:6971-977.