



January 26, 2016

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](http://www.agingresearch.org) 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 provide feedback on the Senate Finance Committee MCC Working Group's recent policy options white paper. Many of the policy options included in this white paper warrant the Alliance's support. We also feel that there are recommendations from the comments we provided to the committee on June 23, 2015 that warrant further consideration.

Stroke Prevention in Atrial Fibrillation

Atrial fibrillation (AFib) is the most common form of heart arrhythmia. An estimated 2 million Americans have AFib.ⁱ With population aging, the prevalence of AFib is expected to double by 2050.ⁱⁱ AFib increases stroke risk by five-fold and doubles the risk that a stroke will result in permanent disability. Despite its prevalence and tremendous human burden, 40 percent to 60 percent of AFib patients are not placed on an anticoagulant to reduce their risk of stroke.ⁱⁱⁱ Elderly patients who have AFib are most often under-anticoagulated. This is driven by many factors including an under-appreciation of stroke risk, the tendency of some healthcare providers to prioritize bleeding risk over the net benefit of anticoagulants in preventing stroke, a perception that an elderly patient may be at a higher risk of falls, a lack of incentives to perform multiple risk assessments for stroke and bleeding risk, and time constraints in a standard office visit that are not conducive to shared-decision making between patients, caregivers and their healthcare providers.

The working group proposal to require the Centers for Medicare and Medicaid Services (CMS) to implement a one-time payment code for physicians to facilitate additional conversations with patients who have a serious and life-threatening illness would allow for several important improvements in the process for diagnosis and treating AFib in older patients. First, it would compensate providers for the critical process of assessing both stroke and bleeding risk to inform treatment decision making. 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 is taking several years for the recommendations to be integrated into general clinical practice. Proper incentives may aid this necessary integration.

Second, the code would allow for more time between patients and physicians to engage in shared decision making about the actual risk of stroke and net benefit of anticoagulation. If fall risk is a concern, the visit code would allow providers to share evidence-based information with patients and their caregivers on reducing falls risk and injury. This information is available through a partnership between the National Institute on Aging and the Patient-Centered Outcomes Research Institute as well as a large-scale study supported by the Department of Health and Human Services. The HHS-sponsored intervention study found significantly lower rates of falls over a one-year period and lower rate of injurious falls.^{iv}

Finally, after a treatment choice has been made, the visit code would allow for a dialogue to begin between patients, providers and their caregivers on options for monitoring anticoagulant use (warfarin and direct-acting oral anticoagulants) and how this could change over the course of treatment. Activities related to testing and monitoring would integrate with the second priority we identified in the policy options white paper - establishing a new high-severity chronic care management code.

While we understand that the proposed one-time visit code for a serious or life-threatening illnesses is intended primarily for use in diagnosing Alzheimer's disease, we appreciate your willingness to explore the applicability of the proposed code to other diseases and conditions. **The Alliance urges you to include AFib in the list of diseases that would be eligible for the one-time visit code for a serious or life-threatening illnesses because it could make a meaningful difference in the lives of many older adults living with AFib who are currently undertreated and at risk of having a stroke.**

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 frail and vulnerable beneficiaries were more likely to have heart failure, chronic kidney disease, COPD, atrial fibrillation (AFib), and stroke.^v A symposium convened by the AFib Optimal Treatment Task Force in October of 2014 highlighted several challenges with anticoagulation therapy testing and monitoring for patients with AFib including frail older adults. One challenge identified was a lack of incentives for patient self-testing (PST) of warfarin and routine monitoring of direct-acting oral anticoagulants (DOAC).

Warfarin is an anticoagulant commonly prescribed for stroke prevention in AFib. Patients are required to undergo routine blood monitoring to ensure they are in sufficient therapeutic range to prevent a stroke. 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 to test an AFib patient's level of anticoagulation that can reduce thromboembolic complications and all-cause mortality without increased bleeding events. Unfortunately, the use of PST is largely restricted because it is not

economically feasible for most healthcare professionals to incorporate it into their clinical practice. DOACs are alternative treatments to warfarin. There is a misperception that once treatment with a DOAC has started, there is no need, or little need, for regular follow-up lab tests. However, renal function declines in older adults and should be monitored frequently so that dose adjustments can be made and contraindicated drugs can be identified.

Many patient interactions with providers related to testing and monitoring of anticoagulants occur outside of a standard face-to-face visit and can involve a range of healthcare professionals. The establishment of a high-severity chronic care management code would provide a missing avenue to pay for these time-intensive and critical interactions. **We support the working group's proposal to institute the high-severity chronic care management code and encourage the use of this code for Medicare beneficiaries with complex health needs including AFib.**

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.^{vi} 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.^{vii} 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. Many of these recommendations was subsequently included in comments submitted by the Alliance to Centers for Medicare and Medicaid Services in September of 2015 responding to the agency's proposed rule change regarding Infection Prevention and Control Programs (IPCP) in long-term care facilities (LTCFs).

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.^{viii} **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). 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, such as the [CDC Core Elements for Antibiotic Stewardship in Nursing Homes](#).

The Alliance for Aging Research feels that every long-term care facility should have an Infection Prevention and Control Officer (IPCO) who has specialized training in infection prevention and control. Stewardship programs work best when they are led by an infection specialist whom has specific clinical knowledge in infections and proper antibiotic use. **An additional recommendation the Alliance for Aging Research would like the Committee to consider is requiring that the contact information for an IPCO to be made publically available for family members of patients.** This would allow family members to contact the IPCO if there is a potentially infectious item, surface, or area that would otherwise go unnoticed. **We would also ask that special consideration be made for rural long-term care facilities such as telehealth options. It is foreseeable that rural facilities will have difficulty in filling an IPCO that could fulfill training requirements.**

Lastly, we believe that federal programs should encourage healthcare workers in long-term care settings to receive influenza vaccinations. According to a 2010 [CDC survey](#), over a third of health care professionals working in long-term care facilities did not receive a seasonal influenza vaccination. Over [90% of influenza-related deaths](#) in the United States are in individuals age 65 and older. Residents of long-term care facilities are particularly susceptible to influenza because. **While the Alliance recognizes that a balance needs to be struck between the safety of patients and the rights of the health care workers, we believe that the MCC initiative should mandate the use of influenza vaccinations among direct-contact health care workers long-term care facilities and set targets for vaccination rates.**

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.^{ix} More than 50 percent of flu-related hospitalizations are in people age 65 and older.^x 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.^{xi} In the U.S. flu costs over \$87 billion^{xii} alone and shingles costs approximately \$1 billion.^{xiii} Medicare beneficiaries hospitalized for pneumonia have almost \$16,000 in higher expenses than those without this infection.^{xiv}

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 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 initiative 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.**

Independence at Home

The Alliance for Aging Research was encouraged to see that a priority of the MCC working group is the continuation of the Independence at Home (IAH) program under Medicare. We advocated for the Medicare IAH demonstration project’s inclusion in the Patient Protection and Affordable Care Act because of its potential to improve care and lower cost. The home-based primary care provided by IAH allows providers to spend more time with patients and assume greater accountability for all aspects of patient care. The focus it places on appropriate and timely care has the dual benefits of improving quality of life for patients while delaying the need for institutionalization.

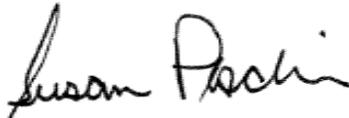
Patients who participate in the IAH program have follow-up contact from their provider within 48 hours of a hospital admission, hospital discharge, or emergency department visit; have fewer hospital readmissions within 30 days; have their medications identified by their provider within 48 hours of discharge from the hospital; have their preferences documented by their provider; and use inpatient hospital and emergency department services less for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection. In its first demonstration year CMS released [data](#) showed that the IAH program saved more than \$25 million. The average per patient savings was \$3,070. The American Academy of Home Care Medicine estimates that 1.5 million patients would be eligible for IAH program if it were implemented at the national level, generating \$4.5 billion in savings annually. **We support the working group’s proposal to expand the current IAH demonstration into a permanent, nationwide program.**

Telehealth and Remote Patient Monitoring

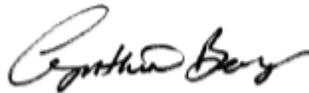
We are pleased that several of the policy options included in the recent MCC Working Group white paper acknowledge the value that telehealth and other medical technology holds in delivery of optimal care for patients managing multiple chronic conditions. The Alliance [joined](#) eleven other organizations in October of 2015 to call attention to a narrow proposal that that would lift Medicare’s restrictions on the use of telemedicine, and reimburse for remote patient monitoring technology for patients with chronic conditions. The proposal, known as the “bridge,” enables wider use of connected care technologies by the creation of a waiver program during a limited transition period (through 2021) as the Medicare Access and CHIP Reauthorization Act (MACRA) is implemented and Accountable Care Organizations (ACOs) work to achieve risk-based models. **We continue to support inclusion of this narrow “bridge” proposal.**

Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner, we applaud your leadership of this thoughtful effort to improve MCC care delivery. We appreciate your consideration of our views and we offer our ongoing assistance to you and the Senate Finance Committee staff as you begin the legislative drafting process. If you have any questions or would like additional information, please do not hesitate to contact Cynthia Bens at 202-293-2856 or by email at cbens@agingresearch.org.

Sincerely,



Susan Peschin, MHS
President and CEO



Cynthia Bens
Vice President, Public Policy

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^{vii} 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.

^{viii} 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/QA_stateSummary.html. Last accessed on June 20, 2015.

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^{xii} 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.

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