January 29, 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 undersigned organizations include members of the AFib Optimal Treatment Task Force who are working to advance recognition and care for individuals suffering from atrial fibrillation (AFib). The Task Force was formed by the Alliance for Aging Research in 2011 to address disparities in the diagnosis and prophylactic treatment of stroke among AFib patients. We applaud your efforts to advance the Senate Finance Committee's initiative on multiple chronic conditions (MCCs) and we appreciate the opportunity to comment on the most recent policy options white paper released by the committee's MCC working group. We believe that two specific items contained in this options paper warrant further exploration for the positive improvements they could make in care for older AFib patients.

Establishing a One-Time Visit Code Post Initial Diagnosis of Serious or Life-Threatening Illnesses

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 healthcare providers, clinicians or advanced practice providers 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, healthcare providers, clinicians or advanced practice providers 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. **We urge 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.**

<u>Improving Care Management Services for Individuals with Multiple Chronic Conditions</u>

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.**

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,

AF Association
Alliance for Aging Research
American Foundation for Women's Health/StopAfib.org
The Anticoagulation Forum
ClotCare.org
Mended Hearts
Men's Health Network
OWL- The Voice of Women 40+
Preventative Cardiovascular Nurses Association
Society for Women's Health Research
WomenHeart: The National Coalition for Women with Heart Disease

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[ii] 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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