

STATEMENT FOR THE RECORD:
House Committee on Energy and Commerce
Subcommittee on Health
“Examining Bipartisan Legislation to Improve the Medicare Program”
Thursday, July 20, 2017

H.R. 1148, FAST Act

The American Heart Association is pleased to offer our support for the “Furthering Access to Stroke Telemedicine (FAST) Act” (H.R. 1148), sponsored by Representatives Morgan Griffith (R-VA) and Joyce Beatty (D-OH) which would help stroke patients gain timely access to highly effective treatments, thereby improving the quality of stroke care through telemedicine across the country.

As our nation’s No. 5 killer and a leading cause of serious, long-term disability and dementia, stroke takes an enormous toll on families and on our nation.¹ As the Baby Boomers age, it is critically important that we reduce the burden of this devastating disease on stroke survivors, their families and on federal health care programs. According to the Medicare Payment Advisory Commission (MedPAC), stroke is the leading Medicare diagnosis for inpatient rehabilitation stays,² and a leading diagnosis requiring nursing home care. A report released by the American Heart Association earlier this year projects that this burden is only going to increase. Despite better prevention, the number of people living with stroke will increase from 7.5 million Americans in 2015, to 11.2 million in 2035, a 50 percent increase over the next 20 years. The study also estimates that the medical costs of stroke in the U.S. will more than double, from \$37 billion in 2015, to \$94 billion in 2035.³ Improving access to telestroke care will ease this burden especially since telestroke can reduce the time it takes to respond to the onset of strokes and save lives as well as dollars. This is why we need the FAST Act.

¹ Benjamin EJ, et al. Heart disease and stroke statistics--2017 update: a report from the American Heart Association. *Circulation*. 2017;135:00-00.

² Medicare Payment Advisory Commission. March 2016 Report to the Congress: Medicare Payment Policy. March 15, 2016. Accessed online at: <http://www.medpac.gov/-documents/-reports>.

³ American Heart Association/American Stroke Association. Cardiovascular Disease-A Costly Burden for America: Projections through 2035. February 14, 2017. Accessed online at: http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491543.pdf.

In the treatment of stroke, time is brain. For every minute that a stroke goes untreated, 2 million brain cells and 14 billion connections between them die, and they don't grow back. The clot-dissolving drug Alteplase (or tPA) and mechanical clot-removal devices are highly effective treatments for the most common type of stroke – acute ischemic stroke – and significantly reduce disability from stroke by restoring blood flow to the affected areas of the brain. However, these treatments must be administered as quickly as possible after stroke symptoms start. Ischemic stroke patients who are treated with the clot-busting drug within 90 minutes of symptoms starting are nearly three times more likely to recover with little or no disability.⁴ Similarly, more than 90 percent of patients treated with a clot retrieval device within 150 minutes of stroke onset recover with little or no disability.⁵

Unfortunately, only about 3.4 to 5.2 percent of patients receive the clot-busting medication⁶ and even fewer patients are treated with clot retrievers. Among Medicare-eligible patient discharges, the national average tPA treatment rate is only 2.4 percent.⁷ There are a number of reasons why treatment rates have remained so low, including long distances to stroke center hospitals, a shortage of vascular neurologists, and patients not arriving at the hospital within the treatment time window.⁸ The good news, however, is that the use of telestroke has proven to be extremely effective in increasing the percentage of stroke patients who receive tPA and in reducing the time it takes to get the treatment started.

Telestroke Is Effective

Rapid and accurate diagnosis of acute ischemic stroke is a critical first step to ensuring that these patients receive the optimal care. A variety of conditions can mimic acute stroke, but many rural hospitals and even suburban community or inner-city hospitals do not have stroke neurologists available in house or on-call around-the-clock to examine and diagnose patients in-person. Even in urban or suburban settings, where approximately 94 percent of strokes occur, patients may experience delays to diagnosis and treatment. To a large extent this is because there is a shortage of vascular neurologists.

⁴ Marler JR et al. *Neurology*. 2000;55(11):1649-55

⁵ Goyal M et al. *Radiology*. 2016;270(3):888-97.

⁶ Adeoye O, et al. Recombinant tissue-type plasminogen activator use for ischemic stroke in the United States: a doubling of treatment rates over the course of 5 years. *Stroke*. 2011;42:1952-1955.

⁷ Kleindorfer DO, Yingying X, et al. US Geographic Distribution of rt-PA Utilization by Hospital for Acute Ischemic Stroke. *Stroke*. 2009;40:3580-3584.

⁸ Schwamm, LH., et al. Recommendations for the implementation of telemedicine within stroke systems of care: A policy statement from the American Heart Association. *Stroke*. 2009.40.7:2635-2660.

Many hospitals do not have any, and in those that do neurologists having competing demands on their time that prevent them from being in the Emergency Department 24/7 in person. Telemedicine can meet this need. We estimate from 2014 data that the number of Medicare beneficiaries 65 and older who have a stroke and would be newly eligible for a telestroke consultation to be approximately 522,000. This would include individuals in rural areas that do not meet the current and fairly narrow definition of “rural” for Medicare payment of telestroke services.

Telestroke Saves Money

In addition to improving access to the recommended care, we believe that greater use of telestroke will also result in healthcare cost savings by reducing chronic disability and the need for more extensive and ongoing medical care. Several studies have clearly shown that the use of tPA is cost-saving for stroke care. According to a study published in the *New England Journal of Medicine*, stroke patients receiving clot-busting therapy were at least 30 percent more likely to have minimal or no disability at three months, compared to patients who did not receive this treatment. These patients also have shorter hospital stays and are more frequently discharged to their homes rather than to more costly nursing homes.⁹ Another study found that the average cost savings when administering tPA was \$4,255.00 in 1996 dollars per treated patient, largely as a result of decreased utilization of nursing home and rehabilitation care by the patient.¹⁰ Yet another study aimed at evaluating the cost utility of telestroke networks estimated net savings of \$1,436 per patient, even after accounting for the costs of implementing the telestroke network and administering tPA.¹¹

In fact, the American Heart Association has estimated that the Medicare and Medicaid programs could save as much as \$1.2 billion over 10 years, even after the costs of providing more telestroke evaluations and more tPA treatments are factored in. Finally, MedPAC, in its June 2016 report to Congress, found telestroke to be one of the most beneficial and cost-effective applications of telehealth and suggested that policymakers may want to expand Medicare coverage of telestroke to urban settings.¹²

⁹ The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. Tissue plasminogen activator for acute ischemic stroke. *N Engl J Med*. 1995;333:1581-1587.

¹⁰ Fagan SC, Morgenstern LB, Petitta A, Ward RE, et al. Cost-effectiveness of tissue plasminogen activator for acute ischemic stroke. *Neurology*. 1998;50:883-890.

¹¹ Demaerschalk BM, Switzer JA, Xie J, Fan L, Villa KF, and Wu EQ. Cost utility of hub-and-spoke telestroke networks from societal perspective. *Am J Manag Care*. 2013;19:976-85.

¹² Medicare Payment Advisory Commission. June 2016 Report to the Congress: Medicare and the Health Care Delivery System. June 15, 2016. Accessed online at: <http://www.medpac.gov/-documents-/reports>

The Association is heartened by the growing number of lawmakers and organizations that have endorsed telestroke care.

Expanding the use of telestroke will greatly improve the quality of care that stroke patients receive, increase the utilization of effective acute stroke treatments, reduce stroke-related disability for many Americans, and save the health care system money. These win-win opportunities are rare in healthcare, and we urge the House Energy & Commerce Committee to act quickly to move this bill to the Full Committee and to then to the House floor.

Discussion Draft: To amend Title XVII of the SSA to Extend Therapy Cap Exceptions

The Association applauds this Committee's work to repeal and update Medicare's policies which place caps on outpatient therapy services. As noted earlier, stroke is one of the top killers of Americans and the number 1 cause of disability with more than 800,000 strokes occurring every year in the U.S.. These arbitrary caps pose a significant problem for beneficiaries who suffer a stroke and who frequently require lengthy and intensive rehabilitation. These limits are particularly devastating for survivors of severe strokes as these patients frequently need all three types of therapy – physical therapy, occupational therapy, and speech-language therapy – in order to learn to walk, talk, and live independently again.

While we appreciate that Congress has acted a dozen times now to temporarily protect Medicare beneficiaries from the therapy caps, stroke survivors in Medicare need the enduring assurance that they will have access to critical services. As the Committee continues to work to find a long-term solution, we would urge that patients who require extensive therapy are not subjected to policies that would limit access to critical care or cause excessive waiting periods. The Association stands ready to work with the Committee to find and craft pragmatic policy solutions that work for everyone.

H.R.1155, To amend title XVIII of the Social Security Act to allow physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs

Although not the subject of this hearing, we strongly encourage the Committee to act on H.R. 1155 – a bipartisan bill related to the supervision of cardiac rehabilitation – during this session of Congress. The

bill would allow physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac and pulmonary rehabilitation programs on a day-to-day basis under Medicare. This policy has strong bipartisan support and clearly meets the goals of incentivizing the appropriate level of care for beneficiaries, facilitating the delivery of high quality care, and producing stronger patient outcomes.

Cardiac rehabilitation is a medically supervised program designed for patients with certain cardiovascular diseases or after suffering a cardiac event – like a heart attack – that consist of exercise training, education on heart-healthy living, and counseling to reduce stress. These programs help patients return to an active lifestyle and recover more quickly. The benefits are clear and tangible: research has shown that cardiac rehabilitation reduces mortality by over 50% compared with those patients who do not participate and can also reduce the likelihood of hospital readmissions for all causes by 25%.^{13,14} Simply put, these programs reduce the risk of a future cardiac event by stabilizing, slowing, or even reversing the progression of cardiovascular disease.¹⁵ Research also suggests these programs reduce health care costs. A study presented at the Canadian Cardiovascular Congress found that cardiac rehabilitation reduced costs associated with hospital readmissions from a heart attack by \$8.5 million a year, and another study in Vermont found that hospitalization costs over the follow-up period for cardiac admissions were roughly \$900 less for patients who completed a cardiac rehabilitation program.^{16,17}

Unfortunately, the utilization rate for eligible Medicare beneficiaries is only 12%.¹⁸ One reason for low participation in cardiac rehabilitation programs is due to the lack of program availability and access as a result of current requirements under Medicare that require a level of direct physician supervision for cardiac and pulmonary rehabilitation programs that is inappropriately and unnecessarily stringent. This particularly leads to reduced access to these services in physician shortage areas, and it adds unnecessary costs.

H.R. 1155 would change existing Medicare program requirements that require a physician to be

¹³ Dunlay, SM et al. Participation in cardiac rehabilitation, readmissions, and death after acute myocardial infarction. *The American journal of medicine.*2014. 127.6: 538-546.

¹⁴ Plüss, Cet al. Long-term effects of an expanded cardiac rehabilitation programme after myocardial infarction or coronary artery bypass surgery: a five-year follow-up of a randomized controlled study. *Clinical rehabilitation.* 2011. 25.1 : 79-87.

¹⁵ Balady GJ., et al., Referral, enrollment, and delivery of cardiac rehabilitation/secondary prevention programs at clinical centers and beyond: a presidential advisory from the American Heart Association. *Circulation.* 2011; 124:2951-2960.

¹⁶ Humen D, et al. A Cost Analysis of Event Reduction Provided by a Comprehensive Cardiac Rehabilitation Program. *Canadian Journal of Cardiology.* 2014; 29.10: S156.

¹⁷ Ades PA, et al. Cardiac rehabilitation participation predicts lower rehospitalization costs. *American heart journal.* 1992; 123.4: 916-921.

¹⁸ Suaya, JA., et al. Cardiac rehabilitation and survival in older coronary patients. *J Am Coll Cardiol.*2009. 54(1): 25-33.

immediately available for each cardiac rehabilitation session and instead allow a physician assistant, nurse practitioner, or clinical nurse specialist to directly supervise these programs. A physician would still be required to serve as a Medical Director to ensure that the programs are safe, comprehensive, cost effective, and medically appropriate for individual patients. The safety of cardiac rehabilitation in a medically supervised, community-based program is well established, and non-physician practitioners are highly trained to respond should emergencies arise.^{19,20}

We strongly encourage the Committee to take up H.R. 1155 at their earliest convenience to ensure Medicare beneficiaries have access to critical cardiac rehabilitation programs that are proven to improve health outcomes, reduce health care costs, and lead to a better quality of life.

¹⁹ Safety of Monitoring Exercise for Early Hospital-based Cardiac Rehabilitation. Chul Kim, Chang Jin Moon, Min Ho Lim. *Ann Rehabil Med.* 2012 April; 36(2): 262–267.

²⁰ Safety of cardiac rehabilitation in a medically supervised, community-based program. Scheinowitz M, Harpaz D. *Cardiology.*