March 23, 2016

House Ways & Means Committee
Health Subcommittee
1102 Longworth Office Building
Washington, DC 20515

Response to the March 2016 Health Subcommittee Hearing on Preserving and Strengthening Medicare

Dear Chairman Tiberi and Ranking Member McDermott:

The American Academy of Neurology (AAN), an association of more than 30,000 neurologists and neuroscience professionals dedicated to providing the best possible care for patients with neurological conditions, welcomes the opportunity to submit comments in response to the Health Subcommittee regarding strengthening Medicare.

Each year, neurologic disorders affect an estimated 50 million Americans and cost hundreds of billions of dollars in medical expenses and lost productivity. Often, these diseases represent the highest-need, highest-cost Medicare beneficiaries. It takes significant time and skill to provide ongoing cognitive care to manage complex chronic conditions for people with neurologic diseases like Alzheimer’s disease, Parkinson’s disease, epilepsy, traumatic brain injury, ALS, multiple sclerosis (MS), and headache.

One of the most devastating neurological conditions is stroke and we believe a small change in federal policy would have profoundly positive impact on stroke patients and the federal budget.

Improving Stroke Patient Access, Outcomes, and Costs via the FAST Act (HR 2799)

The Academy strongly supports the elimination of the originating site geographic restriction on reimbursement for telestroke services. Removal of this barrier to telestroke care would uniformly increase stroke care coordination, improve patient outcomes, and ultimately reduce Medicare and Medicaid spending.

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.1 About two-thirds of the total hospitalizations for stroke occur among adults age 65 and older,2 and approximately 94 percent of strokes occur in an urban or suburban area.3 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. 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.4
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 4.5 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, and only 27 percent of stroke patients arrive at the hospital within 3.5 hours of symptom onset. Additionally, there are currently only four neurologists per 100,000 persons in the US, 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 stroke 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 increasing the use of tPA and reducing the amount of time it takes to get treatment to patients, in both urban and rural areas. Another recent study of four urban hospitals in Illinois found that their utilization of tPA increased by two to six times after telestroke was implemented.

Finally, telestroke can save 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. 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. 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 nursing homes.

An analysis conducted by the American Heart Association/American Stroke Association found that lifting the rural site requirement specifically for telestroke evaluations could result in $1.2 billion in net savings to Medicare and Medicaid over 10 years. In addition to strong data in support of telestroke's efficacy, the savings from reduced disability would begin to accrue almost immediately, as opposed to years down the road. We strongly urge the Ways & Means Committee to pass HR 2799 the Furthering Access to Stroke Telemedicine (FAST) Act by Rep. Morgan Griffith (R-VA) and eliminate the originating site geographic restriction for telestroke.

As of March 23, 2016 HR 2799 has 66 cosponsors. The AAN appreciates the opportunity to bring this legislation to your attention in hopes of both improving the lives of those who suffer from a stroke and to save federal resources. If you have questions or would like to discuss this proposals further, please contact Mike Amery, Esq., at mamery@aan.com or (612) 928-6126.

Sincerely,

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology

ii Based on 2013 CDC survey data which reported the prevalence of stroke was 2.4 percent for adults living within a MSA and 3.2 percent 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.


