2021

# CARDIOVASCULAR HEALTH POLICY SUMMIT


PARTNERSHIP TO ADVANCE Cardiovascular Health

IfPA Institute for Patient Access

AfPA Alliance for Patient Access

# Overview

The fourth annual Cardiovascular Health Policy Summit welcomed health care providers, policymakers, advocates and other stakeholders to explore how policy solutions can improve the health and lives of Americans living with cardiovascular disease.

This year's event, held virtually, examined issues such as:

- Non-medical switching
- Updating and implementing medical guidelines
- Medicare part D reform
- Disparities with peripheral artery disease.

**Dharmesh Patel, MD**, of the *Partnership to Advance Cardiovascular Health* urged meaningful policy change in his welcoming remarks. "Our patience with half measures, lip service, empty promises, passing the buck – our patience has worn thin," Dr. Patel observed. "So, I ask you today," he continued, "Where better to apply this renewed sense of urgency than to the policies that shape cardiovascular health?"

The summit was convened by the Partnership to Advance Cardiovascular Health and co-hosted by the Institute for Patient Access and Alliance for Patient Access.

> **"We didn't survive the pandemic just to return to the status quo. We emerged ready to fight for something better."**
>
> **-Dharmesh Patel, MD**

# Congressional Speakers

## U.S. Representative Mariannette Miller-Meeks, MD,

an ophthalmologist and member of Congress from Iowa's second congressional district, emphasized the harmful effects utilization management has on patients' access to care.

Rep. Miller-Meeks noted that a large bipartisan group of legislators are pushing for change. One bill in particular, the Safe Step Act of 2021, is seeking to curb step therapy, whereby health plans require patients to try and fail insurer-preferred medications before they're approved for the medicine their doctor prescribed.

When asked how step therapy harms patient-centered care, Rep. Miller-Meeks said, "It interferes with the patient-physician relationship."

The congresswoman also noted that bipartisan legislation could reduce costs for patients, specifically through rebate reform. "Pharmacy benefit managers are making money," Rep. Miller-Meeks emphasized, adding, "We have no transparency about how much the middleman acquires." She referenced how the rebate system had driven the price of insulin up over the past few years, to the point where many people can't afford it.

"Patients should be receiving the cost savings, plain and simple," she concluded.

## U.S. Representative Donald Payne, Jr.,

reflected on his experience creating the Congressional PAD Caucus, which aims to increase awareness about peripheral artery disease and raise federal funds to cover screening costs. Peripheral artery disease occurs in the legs and feet when fatty materials reduce or block blood flow. If PAD is left untreated, amputation is required.

He emphasized that vascular screenings are the only way to diagnose PAD and save limbs from unnecessary amputations. His motivation for starting the PAD Caucus, he explained, was to educate providers as well as fellow members of Congress so they can convey important and potentially limb-saving information to their constituents.

The congressman introduced the Amputation Reduction and Compassion Act, which requires Medicare and Medicaid to cover preventive PAD screenings for high-risk patients.

"We can make a difference for PAD patients – today and in the future," Rep. Payne concluded.


# Non-Medical Switching: It's a Big Deal

Panelists voiced concerns about non-medical switching, which occurs when insurers switch a stable patient off his or her treatment to another drug to protect the health plan's profits.

"Can you imagine the ramifications of me telling a patient you need this medication, and then the insurance company saying, 'No, try this non-indicated treatment instead?'" asked **Dharmesh Patel, MD**. "This is a big deal," he emphasized.

If patients cannot gain access to the right medicine or experience gaps in treatment, they are likely to go back to the hospital for heart-related issues, Dr. Patel underscored.

Given that cardiovascular disease remains the number one killer of Americans, Dr. Patel emphasized, now is not the time to be switching or limiting access to heart medications.

**Brian Henderson** from the *State Access to Innovative Medicines Coalition* echoed Dr. Patel's point. "You wouldn't want to switch a stable patient," he said, adding, "If it isn't broken, don't fix it."

The panelists acknowledged that common comorbidities such as diabetes or high blood pressure can further complicate the potential impact of a non-medical switch. Both panelists agreed the key to combatting rising cardiovascular death rates in America is patient-centered care.

A few states have passed laws to curb non-medical switching, but more must be done, Henderson explained.

The discussion was moderated by **Amanda Conschafter** of the *Alliance for Patient Access.*

# TAKING PART D TO HEART:
# Improving Access for Seniors

There's a rising concern across the country about older patients' lack of access to medication.

Moderator **Lindsay Videnieks, JD**, from the *Alliance for Patient Access' Cardiovascular Disease Working Group*, said "Often, we don't hear much about Part D policy in the CV space, even though it's such a common comorbidity to other conditions."

To dive deeper into the topic, Videnieks welcomed **Andrew Sperling**, of the *National Alliance on Mental Illness*, to the conversation.

Sperling noted that, while many people think Medicare's Part D benefits are costing the U.S. health care system too much money and resources, they actually are not.

"Of the Part D claims," Sperling explained, "97% of them are generic low-cost antidepressants. So, the idea that this is driving costs higher is simply not the case," he said.

Sperling echoed earlier panelists' thoughts about patients living with comorbidities.

Cardiovascular patients dealing with other concurrent conditions may benefit from Medicare's six protected classes policy, for example. The policy requires that Medicare plans cover all or substantively all drugs that fall under oncology, HIV/AIDS, immuno-suppressants, anti-seizure medications, antidepressants and antipsychotics.

Before the Medicare Part D benefit went into effect in 2006, patient-centered care was almost nonexistent, Sperling noted. Some states used to weaken these protections, leaving Medicare patients with fewer treatment options. And for the patient who has, for example, hypertension, diabetes and comorbid depression, insufficient access led to inadequate treatment.

Sperling emphasized that Medicare part D and the six protected classes have helped tremendously with patient-centered care.

Sperling also touched on rebate reform. When pharmacy benefit managers are the ones negotiating directly with drug manufacturers, Sperling noted, patients are left out of the equation.

"We want to see more transparency. That also means passing the cost-savings onto the patient," Sperling concluded.

# Getting Real on Guidelines

Medical guidelines are used by clinicians to provide insight on standards of care and best practices. To remain effective, patient care must stay current with guidelines, and guidelines must stay current with the latest science. But keeping pace with innovation is a real challenge.

**Alexander Blood, MD**, from *Brigham and Women's Hospital* said the guidelines create a "Reader's Digest" for providers on how to treat their patients in the best way possible. But that's hard to do when long lags between innovation and clinical uptake slow down the process.

"The lag is substantial," said **Eileen Handberg, PhD, ANP-BC**, from the *University of Florida*. "Getting a drug's development to the bedside can take up to 10 years."

"About 30-40% of patients are receiving medication not based on scientific evidence," Handberg noted, "and about 20-25% of patients are receiving treatments that are unnecessary or even harmful."

Panelists noted, for instance, that one in four cardiovascular patients with high blood pressure are not at goal, and cost isn't a barrier for getting their blood pressure down. "These are not new drugs," noted Handberg. "They are not expensive drugs, and yet we do not have the guidelines implemented in one of the biggest risk factors for CVD. We owe it to our patients to have evidence-based practice."

Both providers noted that there are a lot of new drugs, widening health care providers' arsenal. There are also new opportunities to implement guideline-directed, evidence-based medicine.

Dr. Blood said a good goal for providers is to reduce the barriers between patients and providers. Using telehealth technology, such as smartphones, laptops, tablets and watches, Dr. Blood has been able to cut cholesterol levels by more than 40% in patients. What's more, over 90% of hypertension patients reached their goal level on Dr. Blood's team's initiative.

"It's not magic," he said. "It's making it easier to engage between patients and providers."

Handberg applauded the use of telemedicine as an avenue for care. She explained telemedicine use and reimbursement were made even easier this past year when the Centers for Medicare and Medicaid Services loosened their reimbursement policies.

The discussion was moderated by **Ryan Gough** of the *Partnership to Advance Cardiovascular Health*.


# PAD AWARE:
# Raising Awareness & Filling Policy Gaps

Peripheral artery disease, or PAD, occurs when fatty materials block one's blood vessels in the feet or legs. If the condition progresses without intervention, amputation is required. Moderator **Jasmine Patel, MPH**, of the *Partnership to Advance Cardiovascular Health*, spoke with both patients and health care providers to gain insight about the disease's prevalence and impact.

**Elizabeth Beard**, a patient from Texas, wasn't diagnosed with PAD until 10 years after she suffered a stroke. The public lacks awareness of PAD, she noted, but unfortunately so do some health care providers. Like many other patients, Beard never thought she would experience a cardiac event, even with a family history of cardiovascular disease.

"I wish I would've taken my family history more seriously," Beard reflected. "I wish someone would have talked to me about that."

**Elvis Johnson**, a PAD patient from Louisiana, suffered a heart attack on the way to the doctor's office. Johnson struggled to get a PAD diagnosis until he found a provider who took his concerns seriously. He said finding a trusted physician is critical for optimal outcomes. Johnson agreed that mitigating risk factors is the best way to avoid a heart attack or stroke, and he encouraged people to take lifestyle changes seriously.

"Stay active," he urged the audience. "Just because we age doesn't mean we need to stop moving."

Both panelists said having a trusted health care provider is crucial. "Surround yourself with health care providers who will support you," Beard concluded.

# PAD:
# The Provider Perspective

**Joshua Beckman, MD, MS**, from *Vanderbilt University Medical Center* explained that PAD "is a terrible marker for someone and can diminish your quality of life severely." He noted that people living with PAD are also more likely to die from cardiovascular disease.

Dr. Beckman emphasized that it's crucial for health care providers to check the limbs and feet of their patients with diabetes, current or former smokers, and older patients.

Even if patients and providers are aware of PAD, there is still a fourfold difference for Black Americans. Many factors drive this disparity, explained **Kuni Matsushita, MD**, from *Johns Hopkins University*.

Diabetes is more common among Black adults. There are also links to lower income and education that drive the wedge between appropriate and accessible care. Dr. Matsushita alluded to a recent study that underscored the role of social determinants of health in PAD and amputations among communities of color.

> **"We should focus on the social determents affecting this community. Then the amputations can stop."**
>
> **-Kuni Matsushita, MD**

The American Heart Association started an initiative that would reduce limb amputations by 20% by 2030. The key is collaboration between payers, policymakers, health care providers and patients. Consistent reimbursement for screenings, for one, is needed to ensure that people with PAD are diagnosed in a timely manner and are not losing their limbs unnecessarily.

# Conclusion

To learn more about topics discussed at the summit and the Partnership to Advance Cardiovascular Health's policy priorities and advocacy initiatives, visit www.advancecardiohealth.org.

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