

June 22, 2015

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By Electronic Delivery

The Honorable Orrin Hatch
The Honorable Ron Wyden
The Honorable Johnny Isakson
The Honorable Mark Warner
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of AstraZeneca, I am writing to commend the announcement of the new Finance Committee chronic care working group and submit our initial comments to the Committee. AstraZeneca is a global, innovation-driven biopharmaceutical business that focuses on the discovery, development, and commercialization of prescription medicines, primarily for the treatment of cardiovascular, metabolic, respiratory, inflammation, autoimmune, oncology, infection, and neuroscience diseases.

AstraZeneca is committed to working with the Committee in pursuit of its initiative and hopes that our experience in chronic disease and our continued focus on improving care for patients with chronic health conditions can help inform the Committee's deliberations.

As you consider how to achieve improvements in care for Medicare beneficiaries with chronic conditions, AstraZeneca offers the following recommendations and ideas; we would welcome the opportunity to discuss further details with the Committee.

Summary of Recommendations

- Advance policies that increase medication adherence to improve health outcomes and reduce overall Medicare spending; establish safe harbors to provide additional flexibility for the development of medication adherence programs.
- Advance policies that improve the transition of care for patients moving from the hospital to the outpatient setting.
- Look to existing private sector initiatives and collaborations for innovative ideas to improve care coordination, increase patient engagement, and improve the quality of patient care.
- Address continued opportunities to increase Medicare beneficiary access to appropriate screening and diagnostic testing for chronic conditions.
- Support the development of Medicare coverage and payment policies that account for the increasing availability of personalized medicines targeted at chronic diseases to ensure timely access for patients.

- Ensure that CMS and Medicare decision-makers have timely access to relevant information about medicines.

Advance policies that increase medication adherence to improve health outcomes and reduce overall Medicare spending. Medication non-adherence remains a critical concern to the healthcare system despite longstanding efforts to address this “invisible epidemic.” We strive to raise awareness of the challenges created by non-adherence for both patients and the healthcare system as a whole. To that end, AstraZeneca is a member of Prescriptions for a Healthy America, A Partnership for Advancing Medication Adherence.¹

It is estimated that the cost of poor medication adherence is roughly \$100 billion a year, and results in 33% to 69% of medication-related hospital admissions in the US.² Over the last several years, we have seen an increase in the evidence base that shows medication adherence can help improve health, and reduce overall health care spending. In 2012, the Congressional Budget Office recognized that increases in prescription drug use by Medicare Part D beneficiaries led to reductions in spending for medical services.³ A study published by Harvard researchers showed that initial introduction of the Part D benefit significantly reduced the probability of beneficiary hospitalization for several chronic conditions including asthma, chronic obstructive pulmonary disease (COPD), and diabetes.⁴ We understand that the causes of medication non-adherence are complex and varied, and there is no silver bullet. However, we believe that Congress could take steps to increase flexibility in the Medicare program in order to evaluate new ways of addressing adherence.

One proposal that we recommend the Committee consider is requiring Part D plans to facilitate the synchronization of medication refills. In medication synchronization, all prescription fills are coordinated to one day of the month for patients to pick-up or receive via mail order. Pharmacists conduct outreach to the patient in advance of each fill to facilitate medication reconciliation and deliver medication management services. In a pilot conducted by Thrifty White Pharmacies and the Virginia Commonwealth University, patients who enrolled in such programs were 3.4 to 6.1 times more adherent to their medications than patients not enrolled. Patients not enrolled in the program had a 52% to 73% greater likelihood of becoming non-persistent to their medication regimens.⁵ We, along with a broad range of stakeholders, support testing the medication synchronization concept in Medicare to assess the intervention’s efficacy in improving adherence, lowering costs, and improving outcomes for stand-alone Part D plans and Part C Medicare Advantage Prescription Drug plans.

In evaluating how to improve medication adherence, the Committee should also consider how the Medicare program can ensure screening for and treatment of mental health conditions. For example, there is a high prevalence of diabetes and co-morbid depression. The presence of depression can

¹ The Prescriptions for a Healthy America partnership brings together a broad range of patient, physician and healthcare industry leaders to find ways to implement near-term solutions that will help reduce healthcare costs and improve the lives of patients through medication adherence interventions.

² Osterberg L, Blaschke T. Adherence to Medication. *New Engl J Med* 2005;2005;353(5):487-497.

³ CBO. Offsetting Effects of Prescription Drug Use on Medicare’s Spending for Medical Services. November 2012. <http://www.cbo.gov/publication/43741>.

⁴ C. Afendulis et al. the Impact of Medicare Part D on Hospitalization Rates. *Health Services Research*. August 2011.

⁵ Holford D, Inocencio T. Appointment-Based Model (ABM) Data Analysis Report. Prepared for Thrifty White Pharmacy. Virginia Commonwealth University. <http://www.ncpanet.org/pdf/adherence/thriftywhitemedadherencestudy.pdf> Accessed 6/15/2015.

reduce medication adherence and other aspects of diabetes self-care.⁶ We recognize that there are also other significant and broad implications for coordination of care for these patients.

Finally, the Committee may also want to consider whether CMS could use its current authority to facilitate the creation of “wellness tiers” in the Medicare Part D program in order to encourage adherence. We would support programs to ease patient access to certain medicines that are either preventative, or where evidence shows those medicines prevent acute exacerbations of existing disease. We understand that plans are taking different approaches to structuring the wellness tiers as they experiment with different value-based insurance design; in some cases these approaches include providing some medicines at \$0 cost for patients or exempting certain medicines from a deductible that would otherwise apply. We also believe these programs can be designed with guardrails to ensure that physicians still have the ability to prescribe the most appropriate medicine for each patient, based on individual clinical circumstances.

Establish safe harbors to provide additional flexibility for the development of medication adherence programs. Despite the significant interest in reducing medication non-adherence, providers, payers, manufacturers and other stakeholders may be discouraged from testing and implementing innovative medication adherence interventions due to concerns of Federal anti-kickback liability. As you may know, because the Federal anti-kickback law is broadly written and carries substantial penalties, Congress developed statutory safe harbors and empowered the Department of Health and Human Services (HHS) Office of Inspector General (OIG) to develop regulatory safe harbors to reduce the risk that the law would discourage beneficial arrangements. Although existing safe harbors would likely protect many adherence-related arrangements, there are currently no regulatory or statutory safe harbors that specifically and explicitly protect appropriately-designed adherence arrangements from anti-kickback liability. As a result, stakeholders may be discouraged from researching, testing, and implementing innovative adherence arrangements due to the lack of certainty and guidance a specific safe-harbor would provide.

Clearly, appropriately-designed adherence programs will play a critical role in meeting the Committee’s goal to improve outcomes for Medicare patients with chronic conditions. We urge you to consider the chilling effect that a lack of an anti-kickback safe harbor has on the creation and implementation of medication adherence arrangements. In March of this year, Prescriptions for a Healthy America submitted a proposed Safe Harbor to the OIG. The safe harbor would protect certain beneficial medication adherence arrangements designed to both improve patient outcomes and reduce costs to Federal Health Care Programs. Additionally, the proposed safe harbor included a number of safeguards to protect patients and federal programs. We urge the Committee to consider adopting a similar statutory safe harbor to encourage the development of these valuable programs.

Advance policies that improve the transition of care for patients moving from the hospital to the outpatient setting. We appreciate that the Committee has identified transition of care as an important area for further evaluation and recommend that the Committee build on current CMS efforts. We support the progress that CMS has made through the Hospital Readmissions Reduction Program (HRRP), which incentivizes the reduction of readmissions and highlights the underlying need for continuity of care throughout the care transition process. We also appreciate CMS’s recent proposal to include the 3-Item Care Transition Measure (CTM-3) in the Hospital Value Based Purchasing Program (VBP) in fiscal

⁶ Oladeji BD, Gureje O. The Comorbidity between Depression and Diabetes. *Curr Psychiatry Rep*. September 2013; 15(9): 390.

year 2018, as this shows CMS's continuing commitment to improving transitions of care. However, we would encourage the Committee to consider how to address certain gaps that remain with respect to transitions of care. We are specifically concerned with substantial gaps in medication therapy that may not be fully addressed by the current models, particularly for patients suffering from COPD or those who need chronic medication and follow up care due to acute coronary syndrome (ACS).

Adherence to treatment in COPD is an essential part of optimizing disease management.⁷ Higher adherence levels have been associated with lower healthcare resource use and costs in patients initiating treatment for COPD.^{8,9} Despite the benefits of treatment, adherence to COPD medication in the US remains low.⁹ A US retrospective database study showed that patients new to inhaled corticosteroid/long-acting beta-agonist therapy filled their medication only approximately 3-4 times during the 12 month study period, each fill covering an estimated 30 days of treatment.¹⁰

In our work with the ACS patient population, we have also seen gaps in follow-up treatment post-discharge. The duration of oral antiplatelet (OAP) therapy should generally be at least 12 months, according to national and global standards.^{11,12} Failure to ensure medication continuity for patients on OAPs has negative consequences; discontinuation of OAP therapy early after hospital discharge (within 90 days) is associated with an increased incidence of death and myocardial infarction.¹³ Discontinuation of OAP therapy within one month after hospital discharge occurs in up to 36% of patients.¹⁴ Similar data are seen up to one year after discharge.¹⁵

As the Committee considers programs like the Medicare HRRP and the VBP Program, we believe that more can be done to support the reduction of readmissions and improve outcomes by focusing on the discharge process and ensuring that patients understand their prescribed medication therapy. For example, in our comments to the recently proposed hospital inpatient prospective payment rule, we recommended to CMS that it include more robust discharge planning and transition of care quality measures in the hospital VBP, with a particular focus on medication therapy. AstraZeneca recommends that the Committee evaluate ways in which Medicare payment systems can be updated, and direct CMS to include more robust transition of care quality measures to create incentives for improved transition of care.

⁷ Bourbeau J, Bartlett SJ. Patient adherence in COPD. *Thorax*. 2008;63:831-838.

⁸ Toy, E. Treatment of COPD: Relationships between daily dosing frequency, adherence, resource use and costs. *Respiratory Medicine* 2011. (105): 435-44.

⁹ Simoni-Wastila L, Wei YJ, Qian J, et al. Association of chronic obstructive pulmonary disease maintenance medication adherence with all-cause hospitalization and spending in a Medicare population. *Am J Geriatr Pharmacother*. 2012;10:201-210.

¹⁰ Strange CB, Racketta J, Kern DM, et al. Comparative effectiveness of budesonide/formoterol combination (BFC) and tiotropium bromide among chronic obstructive pulmonary disease (COPD) patients new to controller treatment [abstract]. *Am J Respir Crit Care Med*. 189;2014:A3725.

¹¹ Leving GN, et al. 2011 ACCF/AHA/SCAI Guidelines for Percutaneous Coronary Interventions: A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions. *Circulation* 2011;124:2574-2609.

¹² Hamm CW, et al. ESC Guidelines for the management of acute coronary syndromes in patients presenting without ST-segment elevations. *European Heart Journal* 2011;32:2999-3054.

¹³ Ho PM, et al. Adverse events after stopping Clopidogrel in post-acute coronary syndrome patients: Insights from a large integrated healthcare delivery system. *Circ Cardiovasc Qual Outcomes*. 2010; 3:303-308.

¹⁴ Data on file, 2645302, AstraZeneca.

¹⁵ Ko DT, et al. Patterns of use of thienopyridine therapy after percutaneous coronary interventions with drug-eluting stents and bare-metal stents. *Am Heart J* 2009;158:592-598.

We also recommend that the Committee focus on the important role of the caregiver, especially in the context of transitioning care from the hospital to the outpatient setting. For example, several states have passed or are considering legislation that would ensure patients have the opportunity to designate a caregiver following admission to the hospital. The hospital would consult with the designated caregiver and issue a discharge plan (to both the patient and caregiver) that describes a patient's after care assistance needs. We believe involving the caregiver is an important step towards reducing hospital readmissions and easing the burden of transition of care for patients and caregivers, and that this aligns with the Committee's interest in empowering patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

Finally, the Committee should explore private sector efforts to improve transitions of care as examples for pilot programs that could be tested in the public sector. The transition of care issues that we have highlighted caused AstraZeneca to consider how we could help patients on their journey post-discharge. Over the past few years we have invested in the development of programs focused on patient engagement, care coordination and risk stratification. All of these programs align to the chronic conditions that AstraZeneca has experiences and expertise in: cardiovascular disease, diabetes, asthma and COPD. In recent years, for example, we have launched programs to support transitions for patients with respiratory disease and cardiovascular disease. We have a team of Respiratory Care Specialists with a strong respiratory clinical background in disease management who can help provide comprehensive information and education to health care teams with the intent to improve engagement and outcomes of respiratory patients. We also launched a program to help ensure medication supply post-discharge for patients with ACS, and are supporting transitions for ACS patients through Cardiovascular Nurse Consultants that are available to educate allied healthcare professionals within hospitals and pharmacies on the need for medication therapy post discharge. Finally, we also offer SteadySTART™, a diabetes education program that focuses on helping adults with type 2 diabetes by offering them access to Clinical Educators, who provide participants education focused on healthy eating and being active, as well as treatment support. These types of efforts by AstraZeneca and other stakeholders could serve as models for public-sector demonstrations designed to test ways to improve care coordination and transitions of care. We would be happy to discuss these programs and our learnings in more detail with the Committee.

Look to existing private sector initiatives and collaborations for innovative ideas to improve care coordination, increase patient engagement, and improve the quality of patient care. We support the Committee's evaluation of private sector partnerships and collaborations that could help inform Medicare demonstrations or pilot programs. In addition to the programs that support transitioning from hospital to home discussed in the previous section, AstraZeneca is committed to learning how to better support patients and health systems in the various aspects of care coordination. This evolution includes integration of the health information technology platforms being built to support healthcare professionals and patients. Below we highlight two examples – one is an example of an AstraZeneca collaboration with a non-profit health system to improve chronic care for patients with cardiometabolic disease, and the second an example of a program designed to empower and engage patients with diabetes. We hope that these programs can serve as illustrations of non-traditional platforms designed to improve management of and outcomes for patients with chronic disease. We would be happy to discuss the details of these programs further with the Committee.

Earlier this year, AstraZeneca and not-for-profit health system Sutter Health announced the start of a research and innovation collaboration in which the organizations will team up over the next three years to design, prototype, and pilot innovative approaches to improve the lives of patients with cardiometabolic disease by creating a more personalized, health care experience through physician and patient partnership. Cardiometabolic care focuses on the treatment and management of diseases such as diabetes, hypertension and high cholesterol and common, co-occurring serious health complications such as heart attack, stroke, limb loss, and blindness. Improvements in cardiometabolic care can potentially improve the health of patients, reduce complications of these diseases, and lower overall healthcare costs.

Through this collaboration, with improved access and understanding of data and use of leading-edge technologies, researchers hope to re-engineer the delivery of cardiometabolic care, enabling patients and doctors to spend more time together personalizing care options. In an effort to help speed diagnosis and improve patients' quality of life, researchers hope to create forward-looking technologies and treatments through a better understanding of existing gaps in cardiometabolic care. The Committee should consider ways to work with the Administration in support of initiatives like this, and how this type of work could also inform innovative payment models. The collaboration will focus on the following areas:

- Making data meaningful. Researchers will pull key data from across the Sutter Health network into a comprehensive, electronic system, and conduct novel, essential analytical steps to continually identify gaps in care; recognize and monitor patient needs; and translate these insights into guideline based care recommendations.
- Personalizing care. Researchers will design, develop, and implement new tools to help patients and providers work together on care options personalized to a patient's needs and then develop innovative care approaches for use outside the traditional face to face clinic visit.
- Ongoing learning. By tracking the impact of work, researchers will continually grow and evolve their efforts.

To focus on patient engagement, last year, AstraZeneca launched Fit2Me¹⁶, a robust cross-portfolio consumer engagement program designed to provide customized information about those areas that impact ability to control diabetes, including recipes, fitness, and treatment options. Free to consumers, Fit2Me is a diet and lifestyle support program that allows people with Type 2 diabetes to create a diabetes care plan that is custom fit to their likes and dislikes. The program helps people with Type 2 diabetes plan their meals and activities, based on their likes and dislikes instead of just tracking calories eaten and burned. Unlike diet, exercise, and diabetes trackers, Fit2Me is a program that focuses on the future, not the past. It also provides users information about activity "trade-offs" they would have to make to eat certain foods. Fit2Me focuses on four key areas of diabetes management – food, activity, support team, and treatment support. Since the launch in October 2014, over 1 million people have visited Fit2Me.com to set up their customized diabetes care plan.

AstraZeneca recommends that the Committee encourage CMS to incorporate patient engagement programs into payment and delivery reform efforts. For example, Congress should encourage CMS to continue including more robust patient engagement metrics when measuring the performance of

¹⁶ www.fit2me.com

accountable care organizations (ACOs) participating in programs like the Medicare Shared Savings Program, the Pioneer ACO Model, and the Next Generation ACO Model.

Address continued opportunities to increase Medicare beneficiary access to appropriate screening and diagnostic testing for chronic conditions. We support the recent establishment of an annual wellness visit in the Medicare program, and believe this has been an important step to ensuring that Medicare beneficiaries have routine access to preventive services. Earlier detection of disease creates opportunities for earlier treatment, better health outcomes, and savings to the Medicare program. We would encourage the Committee to protect current Medicare beneficiary access to preventive screenings, and evaluate whether these benefits should be enhanced.

Support the development of Medicare coverage and payment policies that account for the increasing availability of personalized medicines targeted at chronic diseases to ensure timely access for patients. AstraZeneca is applying personalized health care approaches to 80% of the drug projects in our pipeline. Advances in science mean we can increasingly design and use tests to determine how an individual patient is likely to respond to a particular medicine before the medicine is prescribed. Personalized health care can help all payers, including Medicare, to plan and make decisions with confidence that a treatment is targeted at those patients who may benefit most.

We believe that promoting both early diagnosis and supporting personalized medicine with the use of companion diagnostic testing to identify patients who may respond best to a drug therapy brings significant value to the system. For example, as an organization that is committed to developing new therapies for lung cancer, we support initiatives that are aimed at improving the diagnosis, management, and treatment for individuals affected by this condition. Appropriate assessment of some patients may require both novel screening technologies as well as diagnostics. We support a recent decision by CMS to expand Medicare beneficiary access to screening for lung cancer with low dose computed tomography (LDCT) to make sure the technology is available to those patients who at risk, based on current scientific evidence and clinical guidelines. Increasingly, patients also may be candidates for diagnostic testing that evaluates a biomarker linked to the disease; the outcome of such testing can help determine the best treatment option. In some patients with lung cancer, for example, a diagnostic test may be used to assess a patient's epidermal growth factor receptor (EGFR) mutation status – positive or negative. EGFR mutation testing in non-small cell lung cancer patients can help physicians prescribe the most appropriate treatment for each patient. A Medicare payment system that supports the full range of testing for patients to receive early diagnosis and the most appropriate treatment for his/her disease profile will yield improved patient outcomes and likely lower total program expenditures.

Developing medicines in this way changes the way healthcare is delivered to patients. AstraZeneca recommends that the Committee work with CMS to evaluate how the Medicare coverage and payment system could be streamlined to ensure timely consideration of personalized therapies and the tools that are used to establish diagnosis and eligibility to receive those therapies.

Additionally, advances in personalized medicine should be a primary consideration when Medicare payment and delivery reforms are developed and implemented. Alternative payment models (APMs) inherently create incentives to control costs based on healthcare spending at a set point of time, potentially creating a barrier to the adoption of new tests and technologies introduced after implementation of the APM. These incentives come into play even when those technologies are the

best choice for the patient and may be more cost-effective in the long-term. Patients with multiple chronic conditions may be extremely expensive to treat and manage, particularly in APMs where outpatient drug spending is included in cost measures. It is extremely important that as the healthcare system moves from paying from volume to value, APMs do not create disincentives for providers to use the technologies and treatments that result in the best outcomes for patients and potentially lower long-term costs to federal healthcare programs.

Therefore, APMs must be carefully designed to ensure that participating providers are not discouraged from using new technologies when clinically appropriate. Potential solutions include “carve outs” for new technologies, similar to what is used currently in Medicare’s inpatient and outpatient hospital prospective payment systems. For example, for a period of time after a new technology becomes available, the cost of the new technology would not be included in financial measures used to determine payments to providers participating in APMs. Additionally, provider risk could be limited through the use of outlier payments for high-cost patients, similar to what is used in the inpatient prospective payment system. These are just a few of the many ways in which APMs can be structured to ensure that providers are not discouraged from using new technologies inherent in the drive towards personalized medicine. We would encourage the Committee as it considers APMs to ensure the appropriate guardrails and avoid disincentives that could prevent patients from accessing innovative medicines, screening tests, and diagnostics.

Finally, we recognize there is a significant debate waging regarding the cost and value of prescription medicines that could come into play as the Committee advances its chronic care initiative. In setting the price of medicines, AstraZeneca considers the total cost of care and aims to reflect the value and cost-effectiveness of our therapies in the context of the larger health care ecosystem, while also taking into account the significant research and development investments required to bring a new medicine to market. We believe that ensuring the right treatment for the right patient adds value to the healthcare system, and have entered into commercial risk-based contracting on this principle. We have also indicated publicly that we will explore alternative pricing models for some of our medicines. We would be happy to discuss our preliminary thoughts in this area with the Committee.

Ensure that CMS and Medicare decision-makers have timely access to relevant information about medicines. Regulatory approval of an innovative new product or approval of a new indication for an approved product is not the end of the path to bring new treatments to patients. In the case of a new therapy or a new indication for an approved therapy, Medicare and other payer decision-makers often need up-to-date scientific information prior to FDA product approval, to assist in scientific review related to coverage and reimbursement. This information allows decision makers to become familiar with a new product and address issues such as coding, coverage, or payment prior or proximate to the time of FDA approval, thereby avoiding delays in patient access to beneficial new uses and products. This process may become even more important as FDA approves more products under the accelerated approval pathway or as breakthrough therapies, where FDA may rely on different endpoints for approval than are used under the traditional approval pathway. Medicare may look to have complete and accurate scientific data about these products in order to align standards for reimbursement and coverage with FDA standards for approval. Ideally, this alignment should occur prior to product approval so that patients may have timely access to the product.

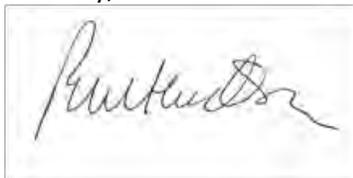
Unfortunately, the rules governing manufacturers' ability to communicate this information to these entities lack clarity. In the absence of such clarity, manufacturers may be reluctant or may choose not to communicate legitimate and important information about an investigational product to payors and similar entities. As a consequence, patient access to the product upon approval may be delayed.

AstraZeneca recommends that the Committee work alongside the Senate HELP Committee to ensure that the FDA establishes clear and comprehensive guidance regarding this area of pre-approval communication within a specific time frame. Any guidance or policy issued by the FDA should be consistent with the principles and limitations of the Food and Drug Cosmetic Act (FDCA) as well as the First Amendment. Such guidance will help ensure that patients receive timely access to new therapies but would also ensure that the Medicare decision-makers have the opportunity to more fully consider the medicine and address coverage and payment considerations prior to the new medicine or therapy becoming available.

Conclusion

AstraZeneca greatly appreciates the opportunity to provide these comments. We look forward to continued engagement with the Committee to explore ways to improve the health of Medicare beneficiaries with chronic conditions, and find ways to address growth in total Medicare spending. If you have any questions or would like additional information on these or any other related topics, please contact either Jacqueline Kirby or Bela Sastry in our Washington, DC office at (202) 350-5500.

Sincerely,



Paul Hudson
President, AstraZeneca US and
Executive Vice President, North America