

June 22, 2015

The Honorable Orrin Hatch
Chairman
United States Senate
Committee on Finance
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
United States Senate
Committee on Finance
Washington, DC 20510-6200

The Honorable Johnny Isakson
United States Senate
Committee on Finance
Washington, DC 20510-6200

The Honorable Mark R. Warner
United States Senate
Committee on Finance
Washington, DC 20510-6200

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

CVS Health thanks you and the members of the Senate Finance Committee's Chronic Care Working Group for the opportunity to submit recommendations to improve care for Medicare patients with chronic conditions. CVS Health is a pharmacy innovation company helping people on their path to better health. Through our more than 7,800 retail pharmacies, more than 900 walk-in clinics, a leading pharmacy benefits management business with more than 65 million members, and an expanding specialty pharmacy services business, we enable people, businesses and communities to manage health in more effective ways, by increasing access to high quality health care.

Today's health care delivery models are rapidly changing, which means health care providers and policy makers need to operate and think differently about our role and how we interact with others in the system and with patients. We see a unique role for CVS Health in helping chronic care patients on their path to better health. Half of all Americans have one or more chronic conditions, and chronic conditions account for 3 out of every 4 dollars spent on health care. Considering the fact that a majority of medications are used to treat chronic conditions, pharmacy care plays a pivotal role.

It is increasingly important to reach patients between care episodes. A patient with diabetes generally sees her primary care provider three to four times a year and takes only about half of her medications as prescribed. Physicians rarely know whether their patients are adherent. The same diabetic patient visits her local pharmacy approximately 9 times a month.

The Senate Finance Committee has identified bipartisan goals for policy recommendations. These goals—increased care coordination among individual providers, streamlining Medicare's current payment system to incentivize the appropriate level of care for patients, facilitating the delivery of high quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiency, and contributing to an overall effort that will reduce the growth in Medicare spending—are important goals to CVS Health, and we look forward to working with Congress to improve the quality and affordability of health care services. Our recommendations

to the Senate Finance Committee for policy action to improve the quality of care for patients with chronic conditions are the following:

Medicare coverage of home infusion services and supplies

Patients suffering from cancer, serious infections, and other chronic conditions may require infusion therapy—the administration of medication directly into the bloodstream via needle or catheter. Special equipment and supplies and professional services are required for the administration of medications via infusion. The Medicare fee-for-service program stands virtually alone among payers in the United States in not fully recognizing the clinical and cost benefits of providing infusion drug therapy to patients in their homes. Infusion therapy is fully covered by Medicare in hospitals, skilled nursing facilities, hospital outpatient departments, and physician offices, but not in patients’ homes. As a result, Medicare beneficiaries in need of infusion therapy often must receive their treatments in health care facilities rather than in their homes, which is the setting that is the most desirable, convenient, and cost-effective. In addition to the fact that the current Medicare benefit requires patients to go into the more costly settings to receive infusion treatments, it also subjects chronic care patients to the risk of secondary hospital-acquired infections. In the private sector, the accepted standard of care and practice for over 30 years is to provide infusion therapy at home where medically indicated and when requested by the attending physician. Patients with chronic conditions who have access to this benefit under their private plans lose this coverage when they enroll in Medicare. Closing the gaps in coverage would align the Medicare program with virtually all private payers, most Medicare Advantage plans, TRICARE, and many state Medicaid programs.

The Medicare Home Infusion Site of Care Act of 2015 (S. 275/HR 605) ensures that Medicare beneficiaries can receive infusion treatment in the home. This legislation would expressly provide coverage under Medicare Part B of the infusion-related services, equipment and supplies. CVS Health would be interested in discussing further the policy changes needed for home infusion.

Improvements to MTM program to better serve Medicare beneficiaries with chronic disease

Medicare prescription drug plans are required to have a medication therapy management (MTM) program for those beneficiaries who meet high-risk eligibility criteria. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provides that Part D sponsors, in offering MTM programs, must target individuals who: (1) have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure); (2) are taking multiple covered Part D drugs; and (3) are identified as likely to incur annual costs for covered Part D drugs that exceed a level specified by the Secretary.

Based on almost ten years of experience in administering a Medicare Part D benefit, CVS Health’s perspective is that patient-centric consultations and support services can play a key role in optimizing cost of care, improving medical community costs and delivering higher quality of care for Medicare beneficiaries with chronic conditions. While CVS Health supports the expansion of the MTM program to beneficiaries where clinical evidence indicates that an expansion will benefit patients and lead to improved outcomes, we are concerned that the current

statutory and regulatory requirements do not allow the program to best meet the needs of chronic care patients.

CVS Health continues to believe that the appropriate level of MTM services targeted to the appropriate beneficiary provides the opportunity to (1) optimize therapeutic outcomes through improved medication use and (2) reduce the risk of adverse events. We would like to work with the Committee to ensure that Part D plans have the flexibility to develop MTM programs that best serve beneficiaries with chronic conditions.

Pharmacist Provider Status

As the U.S. healthcare system continues on its transformational path, a prevailing issue for public health leaders will be the adequacy of access to affordable, quality healthcare. According to the Medicare Payment Advisory Commission's (MedPAC) March 2013 Report to Congress, 22 percent of Medicare beneficiaries had at least some delay getting a doctor's appointment in 2012.¹ The same report found that 28 percent of seniors seeking a new primary care physician in the past year had problems finding one that would treat them. Many communities around the country already have physician shortages for the Medicare population. This problem will worsen as more people gain Medicare coverage while many physicians retire. Without ensuring access to requisite healthcare services for this vulnerable population, it will be exceedingly difficult to provide optimal care for Medicare beneficiaries with chronic conditions.

Pharmacists are highly trained and cost-effective health professionals, providing a broad spectrum of services, within their state scope of practice law, including conducting health and wellness testing, managing chronic diseases, performing medication management, and administering immunizations. In 47 states and the District of Columbia, pharmacists are authorized to enter into collaborative practice agreements with a physician or another prescriber, further expanding the services they are able to provide. And 31 states permit pharmacists to order and interpret lab tests. Pharmacists are accessible to Medicare beneficiaries, with nearly 62,000 pharmacy locations in the United States. According to an Acumen analysis conducted for MedPAC, 93 percent of rural Medicare enrollees live within ten miles of at least one pharmacy participating in Medicare Part D.²

CVS Health supports a more comprehensive approach to policies that enable pharmacists to realize their valuable role in the health care system and improve access and broad coordination of a wide range of services. Specifically, CVS Health supports the Pharmacy and Medically Underserved Areas Enhancement Act (H.R. 592/S.314) because it promotes cost-effective healthcare by increasing access to pharmacist care to Medicare beneficiaries who have problems accessing physician services. Medicare Part B coverage of pharmacist services will better integrate pharmacists into the clinical team and help harness the opportunity for system transformation.

Telehealth

¹ Medicare Payment Advisory Commission (MedPAC), Report to Congress: Medicare Payment Policy, March 2013.

² MedPAC, Report to Congress: Medicare and the Health Care Delivery System, June 2012

Telehealth and remote monitoring technologies align with the broader shift toward value-based care by facilitating patient engagement, care coordination and avoidance of high cost settings in appropriate circumstances. The benefits are well-established for patients with multiple chronic conditions, which affect more than two-thirds of Medicare beneficiaries.^[1] A literature review commissioned by the Alliance for Connected Care, of which CVS Health is a member, demonstrates the impact of telemedicine in chronic disease management. The study, conducted by professors at the University of Michigan and University of Kentucky, reviewed three chronic diseases – congestive heart failure (“CHF”), stroke, and chronic obstructive pulmonary disease (“COPD”).^[2] Among CHF patients, telemonitoring was significantly associated with reductions in mortality ranging from 15 percent to 56 percent as compared to traditional care. Meanwhile, telestroke provides an advantage for stroke patients without readily available access to stroke specialists. The various modalities of telestroke have demonstrated the ability to reduce mortality in the range of 25 percent during the first year after the event. In addition, there is evidence to support the economic benefit of telemonitoring among CHF, stroke, and COPD patients, as measured by changes in hospital admission and readmission rates and cost-benefit analyses.

The findings of the literature review are proving true in health care settings across the country. St. Vincent Health in Indiana conducted a study to determine the impact of a remote care management program on patients with CHF and COPD recently discharged from the hospital. During the 30-day follow-up period, the remote care management program included daily monitoring of patient biometrics (*e.g.*, blood pressure, body weight), interactive daily questionnaires, and video conferencing. Initial results showed a reduction in hospital readmissions to 5 percent as compared to 20 percent in the control group – a 75 percent reduction. Translated to the Medicare program, which spends an estimated \$26 billion on readmissions annually, of which over \$17 billion is preventable, this type of connected care program could significantly reduce program costs, while improving beneficiary outcomes.

For the 26 million people living with type 2 diabetes, clinical care delivered through telemonitoring has shown statistically significant improvements in clinical markers, such as A1c levels, as compared to usual care.^[3] In addition, mobile phone technology is becoming a useful tool in managing the disease. In a 2011 study of 163 patients over 26 primary care practices, the combination of mobile coaching with blood glucose data, lifestyle behaviors, and patient self-management data individually analyzed and presented with evidence-based guidelines to providers substantially reduced A1c levels over a one year period.

There are reams of studies showing similarly positive results. While the health care system is moving toward value-based payment models, there must be a transition period in Medicare in which providers are reimbursed for using telemedicine and remote patient monitoring. Without reimbursement during a phase of transition to full implementation of MACRA and full risk

^[1] Centers for Medicare & Medicaid Services (CMS), “Medicare Dashboard Advances ACA Goals For Chronic Conditions,” Press Release (March 28, 2013).

^[2] Rashid L. Bashshur, et al. “The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management,” *TELEMEDICINE AND EHEALTH* (September 2014).

^[3] Parks Associates, “Implementing an Enhanced Care Management Program Utilizing Telemonitoring Delivers Improvements in the Quality of Care for Patients with CHF, COPD, or Diabetes” (May 2013).

ACOs, it is very difficult for providers to invest in the technology, work flow changes and time for patient education required to implement the use of these tools. The Committee should consider a time limited, targeted reimbursement program for the purpose of allowing providers to invest in these important technologies.

Medication adherence/appropriate medication use

Medication adherence has been demonstrated to improve health outcomes and reduce costs in the Medicare program. Even though Part D plans have substantial infrastructure to encourage medication adherence, there is no financial reason to invest in services that, if successful, could lead to increased spending against fixed budgets that fund Part D plans. Congress should develop quality payment adjustments for Medicare Part D based on Part D Star ratings. Establishing Star ratings as a measure for quality payment adjustments would encourage Part D plans to innovate and figure out how to improve those measurements. This would encourage competition and quality as opposed to the current focus on completion of comprehensive medication reviews (CMRs). As quality payment mechanisms are developed for Part D plans, issues specific to low-income subsidy (LIS) populations must be taken into consideration. Adjustments should be made to avoid penalizing plans with a disproportionate share of the LIS population, understanding that those beneficiaries participating in LIS plans tend to have significantly lower medication adherence rates due to matters beyond the control of the plan.

In addition, prescribers must also focus on medication adherence. Physician incentive programs should incorporate quality measures that incentivize providers to close gaps in care and work with pharmacies and pharmacists to improve beneficiary adherence with respect to a more robust array of medications than current Medicare quality metrics include. While prescribing the appropriate medication is critical, these improvements in quality are not fully realized unless the beneficiary takes his or her medications. Therefore, incentivizing this practice must be complemented by engaging the physician to encourage therapeutic adherence. CVS Health supports efforts to align this practice as a quality measure.

We appreciate the Senate Finance Committee's efforts to improve care for patients with chronic conditions, and we look forward to working with the committee on this important initiative. Should you have any questions on the policy recommendations mentioned above, please do not hesitate to contact me at ann.walker@cvshealth.com or at 202-772-3503.

Sincerely,

A handwritten signature in black ink that reads "Ann Walker". The signature is written in a cursive, flowing style.

Ann Walker
Director, Federal Government Affairs