



January 26, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee U.S. Senate
Washington D.C. 20510

The Honorable Johnny Isakson
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document

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

The Network for Excellence in Health Innovation (NEHI) applauds the Senate Finance Committee's efforts to improve care for the millions of Americans managing chronic illness. It is vital to adopt innovation – in payment, delivery, therapies and technology – to improve quality and lower costs for patients with chronic conditions, and policies need to be put into place to facilitate this adoption.

As the nation's largest, most diverse, multi-stakeholder organization dedicated to identifying, analyzing and resolving critical health care issues, NEHI views innovation as the critical ingredient for improving the health care system. NEHI works by combining the collective vision of our over 90 multi-sector members with our independent, evidence-based research to move ideas into action. Our unique viewpoint cuts across silos to achieve consensus on the most significant barriers and opportunities for innovation, producing policy recommendations that have real impact on the future of health care.

NEHI's research and policy analysis has focused very intensively on improvements in medication management and patient medication adherence among the chronically ill. Medicare beneficiaries receive three fills or refills per month on average, with more seriously chronically ill patients often filling even more.ⁱ Our heavy reliance on drug therapy creates a significant management challenge, and failure can lead to patient harm: an estimated 4.5 million ambulatory medical visits occur each year due to Adverse Drug Events (ADEs), with the odds of an ADE increasing as a patient's medication regimen expands.ⁱⁱ Even when a patient does not suffer an Adverse Drug Event, sub-optimal use of medications means that the patient is less likely to enjoy good health outcomes, is less likely to adhere and persist in use of medications over time, and is more likely to incur avoidable health care costs that are estimated to total as much as \$200 billion per year for patients with major chronic conditions.ⁱⁱⁱ Costs are particularly important to patients managing chronic and multiple-chronic conditions. Fifty-eight percent

of patients with heart failure have reported managing up to five or more co-morbid conditions and were prescribed, on average, more than six medications.^{iv}

Successful medication management is first and foremost a priority for improving patients' lives, including the lives of chronically ill Medicare beneficiaries. But now it is also a significant federal budget and fiscal priority. Medicare is moving steadily away from fee-for-service reimbursement and towards value-based payment arrangements in which population health management goals are meant to be the guarantee of patient health care quality. Current population health goals include those pertaining to management of the "A-B-C's" (hemoglobin A1c for diabetes management, blood pressure, and cholesterol), COPD and other diseases are conditions that demand optimal use of medications.

To that end we urge the Working Group to state in the clearest possible terms that optimization of medication use, and improvements in patient medication adherence and persistence should be priority goals for continuous improvement in Medicare, necessitating continuous review of a wide range of policies that influence Medicare patients' daily use of medications as experienced over many years.

Study on Medication Synchronization: As noted above, the average beneficiary of Medicare prescription drug coverage fills three prescriptions per month to manage 3 co-morbid conditions. The approximately 35 percent of Medicare beneficiaries who suffer from 5 co-morbid conditions manage over 4 prescriptions per month, prescriptions that often come due for refill on different days of the month.^v Improvements in medication management within Medicare should aim to help patients successfully cope with medication regimen complexities that will otherwise reduce adherence and persistence and lead to unnecessarily poor outcomes and avoidable medical costs.

NEHI commends the Working Group for its support of the proposed CMS study of medication synchronization. Current evidence suggests that medication synchronization is a promising approach to improving patient medication use, adherence and persistence by allowing patients to secure their prescription drug refill at one single point in time. Medication synchronization programs now underway in the nation's retail pharmacy and health plan sectors not only simplify refills for patients but also facilitate the scheduling of medication reviews that can reduce medication risks and allow pharmacists or other professionals to optimize the patient's medication regimen alongside the patient. Since medication synchronization does entail purchasing refills at one point in time, the proposed CMS study should take care to examine how prescription drug co-pay policy can be structured to ensure that co-pays do not represent a barrier to patients who might otherwise opt for medication synchronization and benefit from this service.

Annual Reporting of Medication Adherence and Persistence: NEHI also recommends that CMS provide an annual report to Congress that will track levels of patient medication adherence and persistence among Medicare beneficiaries over time. In the past the lack of integrated (Parts A, B and D) longitudinal data from Medicare has impeded a clear understanding of the relationship between good medication use and total Medicare program costs. More recent studies make clear that in the long term safe, adherent and persistent medication use improves outcomes and reduces overall Medicare program spending.^{vi} Congress and the public should have access to credible, year-to-year measures of Medicare's

effectiveness in prompting safe, effective and persistent use of prescription drug therapy among Medicare's 60+million beneficiaries.

Medication Therapy Management: The Medicare Part D legislation enacted in 2003 not only greatly expanded access to prescription drugs for many older Americans, it also took the important step of creating a medication review benefit, the Medicare Medication Therapy Management (MTM).

It is now time for a major step forward in Medicare MTM. Eligibility for the existing MTM program is tied to the number and the cost to the individual patients of drugs prescribed, not to standards of actual patient health risk, measures of total patient medical costs (e.g. total-cost-of-care), or to measures of overall medication regimen complexity. As a result, the MTM benefit is at best only indirectly linked to measurable improvements in patient outcomes or to goals for reducing avoidable medical spending in Medicare.

CMS has recognized these gaps in its recent announcement that it will sponsor a pilot project on so-called Enhanced Medication Therapy Management – due to begin in 2017 and to last for five years. Enhanced MTM service is set up to integrate patient medical and medication data so as to target the intensity of MTM services by patient need, and to reimburse professionals for MTM services based on the intensity of the service required.

The CMS pilot is NEHI joins others in urging the Working Group to not only monitor the CMS pilot actively but to consider ways in which the Enhanced MTM concept can be extended more broadly, more quickly. More intensive forms of MTM should strive to achieve, or to at least approximate standards of care enumerated by numerous stakeholder groups as the Comprehensive Medication Management (CMM) model, in which the quality of medication reviews is assured by the active identification, resolution and documentation of specific drug-therapy problems discovered within an individual patient's overall medication regimen.

NEHI appreciates the opportunity to comment on the Bipartisan Chronic Care Working Group's Policy Options Document. We look forward to continuing to work with you, providing a unique cross-sector perspective and unbiased, evidence-based research to improve care for Americans managing chronic illness.

Sincerely,

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

Tom Hubbard
Vice President, Policy and Research
Network for Excellence in Health Innovation



ⁱ Data from the Medicare Chronic Care Data Warehouse ,” Average Fills per Person per Month by Part D Plan Type, 2006 – 2013, “ accessed Jan 25 at:

<https://www.ccwdata.org/web/guest/medicare-charts/medicare-part-d-charts>

ⁱⁱ Sarkar U, et al, “Adverse drug events in U.S. adult ambulatory medical care,” *Health Serv Res*, 2011 Oct;46(5):1517-33

ⁱⁱⁱ IMS Institute for Healthcare Informatics, “ Avoidable Costs in U.S. Healthcare,” June 2013

^{iv} Wong, CY, Chaudhry, SI, Desai, MM et al. “Trends in Comorbidity, Disability, and Polypharmacy in Heart Failure” *American Journal of Medicine* 120 (February 2011): 136–143.

^v Agency for Healthcare Quality and Researchy, “Multiple Chronic Conditions Chartbook 2010,” accessed Jan 25 at: <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf>.

^{vi} Stuart B, et al, “Increasing Medicare Part D Enrollment In Medication Therapy Management Could Improve Health And Lower Costs,” *Health Affairs* 32 (July 2013):71212-1220