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Transmitted via Email to chronic_care@finance.senate.gov

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The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Committee on Finance
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
Committee on Finance
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Re: Comments on the Bipartisan Chronic Care Working Group Policy Options Document

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

On behalf of McKesson Corporation (hereinafter "McKesson"), I am pleased to submit comments on the Bipartisan Chronic Care Working Group Policy Options Document.

For more than 180 years, McKesson has led the industry in the delivery of medicines and healthcare products. We deliver vital medicines, medical supplies, care management services and health information technology (IT) solutions that touch the lives of over 100 million patients in healthcare settings that include more than 25,000 retail pharmacies, 5,000 hospitals, 200,000 physician offices, nearly 12,000 long term care facilities and 2,400 home care agencies.

With respect to health IT solutions, McKesson is actively engaged in the transformation of healthcare from a system burdened by paper to one empowered by interoperable electronic solutions that improve patient safety, reduce the cost and variability of care and advance healthcare efficiency. McKesson has decades of experience serving the health IT needs of the largest and most diverse provider customer base in the industry, including 52 percent of our nation's hospitals, 20 percent of all physician practices and nearly 16 percent of home care agencies, which support nearly 50,000 home care visits annually.

Our comments address items included in the Policy Options Document, followed by items that were not included, but which we believe should be considered in future drafts.

Items Included in Policy Options Document

Improving Care Management Services for Patients with Multiple Chronic Conditions – p. 11

The chronic care working group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions. Managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit that often includes practice team members such as social workers, dieticians, nurses, and behavioral health specialists.

McKesson supports creating a high-severity chronic care management code to reflect the increased effort required to coordinate care for the most complex patients.

Providing (Accountable Care Organizations) ACOs the Ability to Expand Use of Telehealth – p. 17

The chronic care working group is considering modifying the requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program (MSSP). The HHS Secretary would be required to establish a process by which ACOs participating in MSSP two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

McKesson supports easing restrictions on telehealth for ACOs. We recommend expanding this policy to apply to all ACO participants, not just those in two-sided risk arrangements, to give every ACO the opportunity to leverage technology to improve care coordination, improve post-acute care outcomes, and reduce hospital readmissions.

Providing Flexibility for Beneficiaries to be Part of an ACO – p. 21

The chronic care working group is considering recommending that ACOs in MSSP Track One be given the choice as to whether their beneficiaries be assigned prospectively or retrospectively.

McKesson supports giving ACOs the option to have their beneficiaries assigned prospectively. We believe prospective assignment allows the ACOs to create strategies for managing their ACO population at the beginning of the performance period, increasing their effectiveness at improving outcomes.

Encouraging Beneficiary Use of Chronic Care Management Services – p. 23

The chronic care working group is considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code described above.

McKesson supports waiving the beneficiary co-payment for chronic care management. We believe this will increase adoption of chronic care management services and facilitate patient participation in such models and perhaps treatment plan adherence – all resulting in better care coordination for the patients that need it most.

Increasing Transparency at the Center for Medicare & Medicaid Innovation (CMMI) – p. 24

The chronic care working group is considering modifications that would either require CMMI to issue required notice and comment rulemaking for all models that affect a significant amount of Medicare spending, providers or beneficiaries, or require CMMI to issue notice and comment rulemaking for all mandatory models and at least a 30 day public comment period for all other innovation models.

McKesson supports the proposed policy to increase transparency at the CMMI in the absence of express congressional direction. We recommend allowing all stakeholders, with different experiences, knowledge bases, and expertise, to provide input before scaling and making permanent a significant new model. Such stakeholder engagement will improve the effectiveness and ease of implementation of new models.

Items Not Included in Policy Options Document

As we stated in our comments to the Workgroup on June 22, 2015, we believe there are several pharmacist and health information technology (IT)-related policy options that could be undertaken that would facilitate the delivery of high quality care, produce stronger patient outcomes, and contribute to an overall effort to reduce growth in Medicare spending. Specifically, we reiterate the following recommendations:

Expand the Role of Pharmacists in the Healthcare System

As we move from a volume- to value-based healthcare system, it is imperative that we maximize the use of cost-effective resources. McKesson believes that pharmacists, currently an underutilized resource, should play a more prominent role in the provision of healthcare services – especially for patients with chronic conditions. Examples of pharmacists' capabilities include access to health tests, help in managing conditions such as diabetes and heart disease, and expanded immunization services. We join the National Association of Chain Drug Stores (NACDS) in supporting several policy initiatives that should be pursued to promote an expanded role for pharmacists.

Adherence and MTM

In the U.S., adherence rates for chronic medications average only 50 percent, with one-third of all prescribed medications going unfilled. This lack of adherence accounts for an estimated 125,000 deaths annually in the U.S., as well as $300 billion in added costs – the result of the utilization of healthcare services, especially hospitalizations, that could otherwise have been avoided. Medication Therapy Management (MTM) is an important tool in helping improve medication adherence rates. In recent years, CMS has made programmatic changes designed to increase eligibility and enrollment in MTM by

Medicare Part D beneficiaries. One example is CMS' Part D Enhanced MTM Model, an opportunity for stand-alone basic Prescription Drug Plans (PDPs) in eleven states to offer innovative MTM programs during a five-year performance period which begins in January 2017. We commend this model but believe it must be accelerated and broadened to include more states. Overall, we believe stronger incentives for MA-PDs and stand-alone PDPs are necessary to establish and maintain robust MTM programs.

Policy initiatives designed to increase enrollment in MTM programs should be considered, such as the bipartisan Medication Therapy Management Empowerment Act (S. 776), sponsored by Sens. Pat Roberts (R-KS), Jeanne Shaheen (D-NH), Sherrod Brown (D-OH), and Mark Kirk (R-IL). The legislation would amend The Social Security Act to allow Medicare Part D beneficiaries to become eligible for MTM services if they suffer from a single chronic condition that has been shown to respond well to improved medication adherence, resulting in better health outcomes and reduced overall medical costs. Specifically, the bill would provide access to MTM services for beneficiaries with diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and high cholesterol.

Pharmacist Provider Status

We encourage the Committee to consider taking actions that would allow pharmacists to practice at the top of their licenses and to provide services in medically underserved areas. One example is the bipartisan Pharmacy and Medically Underserved Areas Enhancement Act (S. 314), sponsored by Sens. Chuck Grassley (R-IA), Robert Casey (D-PA), Mark Kirk (R-IL), and Sherrod Brown (D-OH). This legislation would enable patient access to, and coverage of, Medicare Part B services provided by pharmacists in medically-underserved communities. The legislation would also improve patient access to care provided by pharmacists and would foster greater opportunities for collaboration between pharmacists, physicians, and other healthcare providers.

Interoperability of Health IT

We need to move from a fragmented transactional model of care where each patient-clinician encounter is disconnected from the other to a model where care is coordinated across the continuum and where, while optimizing the care of every individual, we are proactively managing populations – especially those with chronic conditions. Interoperable health IT is foundational to this transformation. We cannot change the healthcare delivery model without it. Interoperable health IT will drive quality improvements, make our care delivery system more efficient and improve the experience for patients and their families. The automation provided by technology will allow us to cost effectively achieve these goals at scale.

In order to achieve person-centered interoperability, we believe that Congress should declare health IT interoperability to be a national priority, set a final national deadline for achievement of widespread health IT interoperability, and direct the Department of Health and Human Services (HHS) to set a series of goals, with corresponding deadlines, towards achievement of the final national deadline. By the final national deadline,

individuals and their healthcare team across the care continuum should be able to electronically send, receive, find, and use a common set of health information.

Conclusion

McKesson appreciates the opportunity to offer these recommendations, and we thank the Committee for its leadership on this important topic. We look forward to working together to improve care for Medicare beneficiaries with chronic conditions.

Should you have questions or need further information, please contact Adrian Durbin, Director of Public Policy, at 415-983-8654 or Adrian.Durbin@McKesson.com.

Sincerely,

Pete Slone