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MCKESSON

Transmitted via Email

June 22, 2015

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: Stakeholder Request on Improving Care for Medicare Patients with Chronic Conditions

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

On behalf of McKesson Corporation (hereinafter "McKesson"), I am pleased to submit comments and recommendations on ways to improve care for Medicare beneficiaries with chronic conditions.

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. We process billions of financial healthcare transactions annually for physicians, hospitals, pharmacies, insurers and

financial institutions, and provide care and claims management solutions to most of America's health insurance companies.

McKesson appreciates the opportunity to provide recommendations on ways to improve care for Medicare patients with chronic conditions. We share the Committee's belief that, if left unaddressed, the impact of chronic diseases on the Medicare program will worsen, with beneficiaries continuing to suffer and the system plagued by financial stress.

We have organized our policy recommendations according to the relevant bipartisan goals outlined in the Committee's letter of May 22, 2015.

Policies That Increase Care Coordination Among Individual Providers Across Care Settings Who Are Treating Patients Living With Chronic Diseases

Engagement in Regional Multi-Payer Initiatives

The characteristics of the U.S. healthcare system vary significantly across geographic regions. This variation – which is driven by multiple factors, including population demographics and the regional market dynamics of the healthcare industry – must be taken into account as the Committee considers major Medicare policy reforms. A one-size-fits-all approach may not be advisable in all circumstances.

Along those lines, we believe that Medicare should participate in local multi-payer collaboratives to develop value-based programs that are tailored to local dynamics. This would give providers a standard set of models with which to work, rather than requiring them to follow different rules when providing care for patients covered by commercial payers, Medicaid, and Medicare. Inconsistencies in payment models make it difficult for providers to establish processes and for vendors to build products to administer programs efficiently, resulting in slower adoption of value-based models.

For example, the Arkansas Health Care Improvement Initiative (AHCII) is a multi-payer, statewide system being built around patient-centered care delivery models focusing on what the patient needs, rather than being designed around any particular delivery system structure. AHCII has made significant progress in a short time, but identifies its largest challenge as "the lack of full participation of Medicare with the care needs of its eligible participants and their volume of care consumed." We encourage the Committee to consider language that would promote or direct Medicare to participate in patient-centered delivery care models like AHCII.

Another example is the Comprehensive Primary Care Initiative (CPCI), a four-year multi-payer initiative underway in seven U.S. regions. Through this program, the Centers for Medicare and Medicaid Services (CMS) convenes Medicare, Medicaid Managed Care and commercial payers to support primary care practice transformation through enhanced, non-visit-based payments, data feedback, and learning systems. Results of the program to date have been encouraging, with a two percent reduction in Medicare Part A and B expenditures per beneficiary. These reductions appear to be driven by decreases in hospitalizations, emergency department visits and unplanned 30-day admissions.

Although CPCI is a relatively new program, based on the results to date, McKesson encourages the Committee to promote expansion of CPCI or similar multi-payer models.

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.

Policies That Facilitate The Delivery of High Quality Care, Improve Transitions, Produce Stronger Patient Outcomes, Increase Program Efficiency, and Contribute To An Overall Effort To Reduce Growth in Medicare Spending

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. Several policy initiatives should be pursued to promote an expanded role for pharmacists:

Adherence and MTM

In the U.S., adherence rates for chronic medications average only fifty 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. Despite these efforts, enrollment rates remain low, due

largely to the lack of strong incentives for MA-PDs and standalone Prescription Drug Plans 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.

Pharmacists as Providers

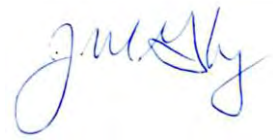
We encourage the Committee to consider taking actions that would allow pharmacists to practice at the top of their licenses and to provide services in medically underserved areas. One example is the bipartisan Pharmacy and Medically Underserved Areas Enhancement Act (S. 314), sponsored by Sens. Chuck 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 healthcare through pharmacists and their patient care services.

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 me at 415-983-7600 or Joe.Ganley@McKesson.com.

Sincerely,



Joseph M. Ganley