June 22, 2015

Senator Orrin Hatch, Chairman
Senator Ron Wyden, Ranking Member
United States Senate Committee on Finance
Washington, D.C. 20510

Re: Senate Finance Committee request for comments on chronic care reform

Chairman Hatch, Ranking Member Wyden, and members of the Senate Finance Committee,

As the Committee considers chronic care policy reform, the National Community Pharmacists Association (NCPA) appreciates the opportunity to provide our perspective and present solutions that could improve the health of millions of Medicare beneficiaries in a cost-effective manner.

NCPA represents the interests of pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. Together they employ over 300,000 full-time employees and dispense nearly half of the nation's retail prescription medicines. Independent community pharmacists are proud to play a vital role in the Medicare Part D program, and have been on the front lines of providing medications, related counseling, and assistance with plans since the inception of the program.

NCPA will be providing feedback on the following areas:

- Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures
- Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions; Strategies to increase chronic care coordination in rural and frontier areas; Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions
- The effective use, coordination, and cost of prescription drugs; Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Overall we have the following recommendations:

- Include pharmacists as essential health care providers on chronic care teams and the lead in coordinating safe and effective medication management, especially during care transitions.
- Grant pharmacists with formal recognition as providers to fulfill gaps in chronic care, especially in rural, medically underserved areas.
- Expand Medicare Part D MTM eligibility requirements and promote greater consistency through core, chronic disease state qualifications. Allow pharmacists to refer patients to MTM and CMR review, not just the eligible population identified through Plan Sponsor criteria.
- Empower patients in their care through greater face-to-face interactions during MTM, and taking control of medication use through personalized, coordinated refill programs. Plan sponsors should provide appropriate payment for professional pharmacy services related to refill synchronization, not just the dispensing of the medication. This could be billed as a monthly visit.
- CMS can better coordinate the care of beneficiaries by improving data sharing among Parts A, B, and D; and looking at the total cost of care, rather than individual benefits separately.

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Reforming payment policies that reward value over volume will spur innovative models of care

NCPA was pleased to see the historic announcement from the Health and Human Services (HHS) earlier this year that the Agency has set measurable goals and an aggressive timeline to change payment within the Medicare program towards a quality, and not quantity-based system for providers. We believe the shift to value-based payment for care is the right incentive for providers to change the way care is delivered and will ultimately result in improved patient outcomes. NCPA is also supportive of the work and research being generated out of the CMS Innovation Center (CMMI), which has collected promising data from transformative care models across the country and serves as an incubator of real-world practices that could chart a new pathway to chronic care payment reform. We encourage members of the Committee to examine the grants which have been awarded through CMMI and begin to implement policies with proven success. We hope the positive results from the CMMI grant projects will serve as a springboard for swift and meaningful payment policy changes in the Medicare program that reward high-quality, value-based care.

Strategies for improving medication use, chronic care coordination amongst Medicare beneficiaries

It's a well-known fact that a major driver of rising health care costs in America is the costs associated with treating chronic illnesses. For many of these chronic illnesses, medications are the most cost-effective course of treatment. And yet patients routinely miss doses, fail to fill or refill a prescription, take a lower or higher dose than prescribed, or stop taking a medication without consulting a health care professional. These actions constitute medication non-adherence, the economic costs of which are estimated at nearly $300 billion a year.[1] In addition, studies have found that higher rates of medication adherence result in significantly fewer hospitalizations and lower health care costs, and that these savings are greater for patients over age 65.[2][3]

Medication synchronization is increasingly being recognized as a tool to improve adherence. It refers to the process of a pharmacy coordinating all of a patient's chronic prescription medications to be filled on the same date each month. In order to achieve this, the pharmacist initially performs a comprehensive review of the patient's medication regimen to determine the appropriateness of each therapy and the patient receives a personal call each month to review their medications prior to filling them to ensure no changes have been made and to confirm the patient is still taking the medication.

Such coordinated refill programs reduce the potential for therapy gaps between refills, as well as medication-related hospital admissions, and provide mechanisms to help identify possible barriers to adherence. The key component of the model is the high-touch, personalized patient consultations each month, when a personal outbound call is made from the pharmacy to the patient to review all of their medications, and any notable changes that have occurred in the past month. This medication reconciliation process is a cornerstone of the model and allows the community pharmacist to identify any recent hospitalizations, especially those that may have resulted in changes in therapy (such as new medications, discontinuations, or dosage adjustments) during care transitions. The lack of organization and communication between health care providers in both the hospital and community setting when patients are discharged can lead to poor hand-offs and result in re-hospitalizations if medication reconciliation and patient education is not properly conducted, before and after a transition. In addition, research has confirmed that refill coordination at a single pharmacy is recognized as an effective tactic to improve adherence and patient outcomes.[4]

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[1] NEHI. Thinking Outside the Pillbox – a system-wide approach to improving patient medication adherence for chronic disease. 2009

[2] Roebuck MC, Liberman JN, Gemmill-Toyama M, Brennan TA. Medication adherence leads to lower health care use and costs despite increased drug spending. *Health Affairs* 2011;30(1):91-9.

[3] Sokol MC, *McGuigan* KA, *Verbrugge RR.* Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost. *Med Care* 2005;43(6):521–30.

[4] Choudhry NK, Fischer MA, Avorn J, Liberman JN, Schneeweiss S, et al. The implications of therapeutic complexity on adherence to cardiovascular medications. *Arch Intern Med* 2011;171(9):814-22

CMS has seen the benefits of medication synchronization, and has implemented several policy changes to facilitate greater adherence, reduce waste from unnecessary fills, and ensure that beneficiaries are only receiving the medications they need. As of January 1, 2014, Medicare Part D sponsors are required to apply a daily cost-sharing rate to most prescriptions that are dispensed for less than a 30-day supply. This provides a common sense approach when a patient is just starting out on new therapy and may not require a full month's supply, or is attempting to synchronize their refills. Coordinated refill programs are an example of a scalable, innovative model of care delivery that can achieve more coordinated, patient-centered care. They provide high-touch monitoring of medication regimens and empower the patient to be an engaged participant in their care. We encourage CMS and Part D sponsors to provide greater awareness to beneficiaries to take advantage of this benefit and hope that it will be more widely adopted across other models of care such as ACOs or patient-centered medical homes (PCMH).

The role of medications, and specifically medication adherence, plays a significant and direct role in the overall cost of health care and should be a key strategy in chronic care management. Community pharmacists are uniquely positioned to positively influence medication adherence due to frequent communications with patients regarding medications.

Aligned incentives and greater MTM eligibility consistency are needed to better coordinate chronic care

A program within Medicare Part D with the potential to improve chronic care among beneficiaries is Medication Therapy Management (MTM). MTM services provide qualifying beneficiaries with a complete review of their medication regimens, typically by a pharmacist, to provide counseling, identify any adverse drug events or inappropriate medication use, and improve adherence. However, despite CMS' efforts to heighten beneficiary awareness of such a benefit, the percentage of Part D enrollees who were received a comprehensive medication review (CMR) continues to hover around ten percent. We believe this is largely due to variability in eligibility criteria for MTM which is set by the Plan Sponsors, and the way MTM is structured in Part D.

NCPA maintains that effective MTM can generate savings for Medicare from avoidable hospitalizations and expensive acute care. Overall reduction in total annual health expenditures was found to exceed to the cost of providing MTM by more than 12 to 1 in a study examining clinical and economic outcomes of MTM.[5] NCPA especially shares CMS' concern that Part D plans are restricting MTM eligibility criteria to limit the number of beneficiaries who qualify for MTM. In addition, setting a high dollar threshold for qualifying beneficiaries may not capture those who have multiple chronic diseases but do not accrue enough in drug spend if they take mostly generic medications. We believe any beneficiary with a chronic disease requiring maintenance medications should be getting at least an annual check-up of their medications, through a CMR.

Unfortunately, the current structure of the Part D payment model is counterintuitive to promoting MTM and improved medication adherence. This misalignment of incentives is further magnified for stand-alone Part D plans. For these plans, the drug spend is completely segregated from the health spend. As a result, any increases in drug spend, including those resulting from improved medication adherence, adds to the plan's overall costs and consequently increases their bid, regardless of any potential long-term savings from reduced hospitalization or other acute care stays. This misalignment of payment incentives and lack of shareable data across Medicare Parts A, B, and D could pose challenges to any coordinated care model and must be addressed.

Additionally, CMS considers MTM program services as an administrative cost included in the plan bid. By broadening the population eligible for MTM services, Plan Sponsors may see this as an added administrative cost, when their priority is to keep their bids low. If plans have to account for a greater number of beneficiaries to offer MTM services to while maintaining a competitive plan offering, we would caution that maintaining MTM as an administrative cost may not align interests and incentives for Plan Sponsors.

[5] Isetts BJ, Schondelmeyer SW, Artz MB. Clinical and economic outcomes of medication therapy management services: The Minnesota experience. *J Am Pharm Assoc.* 2008; 48 (2):203–211.

MTM services should be considered as a quality-improvement activity, as it can contribute to improved patient outcomes. We also believe that MTM billable services should be expanded beyond CMR to include targeted interventions that lead to positive outcomes before patients meet CMS defined MTM eligibility criteria. This could include pharmacist referrals of patients who are identified as appropriate candidate for MTM. We strongly believe that more beneficiaries can benefit from the Part D MTM program and we hope the Committee will work with CMS to create an innovative payment structure for MTM in the Part D program that aligns interests and provides meaningful quality improvement while providing overall savings to the cost of care.

Pharmacists provide and fulfill gaps in patient care, especially in underserved areas

NCPA strongly believes that community pharmacists play a vital role on an integrated health care team, as we work together with our allied partners in delivering safe, high-quality and cost-effective care to the Medicare population, and there is positive evidence to support the expanded role of the pharmacist. A white paper from the National Governors Association notes that integrating pharmacists into chronic-care delivery teams, has the potential to improve health outcomes because of the critical role medication management plays in treating chronic disease.[6] However, there are also barriers in the current fee-for-service program, preventing pharmacists from being able to provide their services to Medicare beneficiaries. In a 2011 Report to the Surgeon General, the Office of the Chief Pharmacist noted that "pharmacists may be the only health professionals (who manage disease through medications and provide other patient care services) who are not recognized in national health policy as health care providers or practitioners."[7]

We are pleased with the bi-partisan support from Congress for pharmacists' services, including members of the Finance committee, who serve as original co-sponsors of SB 314, the *Pharmacy and Medically Underserved Areas Enhancement Act,* which, if enacted, would permit pharmacists to perform patient care services consistent with their state's scope of practice if their pharmacy is located in a medically underserved area, health professional shortage area, or medically underserved population. More than any other segment of the pharmacy industry, independent pharmacies are often located in the underserved and rural areas that are home to many Medicare recipients. In fact, independent pharmacies represent 52% of all rural retail pharmacies and there are over 1,800 independent community pharmacies operating as the only retail pharmacy within their rural communities.[8] This could alleviate issues with primary care provider shortages in rural areas, and provide enhanced preventative services as well.

Conclusion

NCPA shares in the policy goals set forth by Finance Committee, and is committed to working with the staff and members of the Committee in its chronic care reform efforts. We look forward to additional collaborative efforts between community pharmacists and other health care providers to improve the quality of care for Medicare beneficiaries while reducing health care costs.

[6] National Governors Association. The Expanding Role of Pharmacists in a Transformed Health Care System. 2015.

[7] Giberson S, Yoder S, Lee MP. *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice*. *A Report to the U.S. Surgeon General.* Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.

[8] Based on NCPA Analysis of National Council for Prescription Drug Programs (NCPDP) data, Rural Urban Commuting Area (RUCA) Codes, and 2000 U.S. Census data.