February 23, 2015

Sean Cavanaugh
Deputy Administrator & Director
Centers for Medicare
Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Deputy Administrator Cavanaugh:

Thank you for meeting with the Council for Affordable Health Coverage in December to discuss Medicare Part D and ways we might partner together to improve the programs. We appreciate your time and efforts in ensuring Part D continues to remain successful and commend your willingness to work with us on further improvements to the program.

The Council for Affordable Health Coverage (CAHC) is a broad-based alliance that reflects a comprehensive range of interests- organizations representing small and large employers, manufacturers, insurers, brokers and agents, retailers, physician organizations and consumers. We were convened with a singular focus: to bring down the cost of health care for all Americans. To that end, CAHC formed a campaign aimed at raising awareness of the growing cost and health challenges posed by medication non-adherence. That campaign, called Prescriptions for a Healthy America (P4HA), has developed policy recommendations that can significantly reduce overall health care costs and improve beneficiary health outcomes through medication adherence-related interventions.

At the meeting, you asked us to provide our thoughts on changes to the program that would continue to improve it for beneficiaries and taxpayers. Below are our suggestions:

<u>CMS should link Part D claims data to Parts A and B claims data</u>

As medication adherence is researched in the marketplace, data that links patient medical outcomes to patient pharmacy interventions is missing.

Currently, the Medicare Part D Medication Therapy Management (MTM) program is one of the only federal interventions in place that specifically aims to improve medication adherence. CMS has tailored the program to target 25 percent of Medicare Part D beneficiaries, but only 9 percent of those beneficiaries opt in to the program[i,ii,iii]. CMS, Medicare Part D plans, and Part D MTM providers are all limited in their ability to optimize the Part D MTM program because there is limited evidence on both program effectiveness and cost effectiveness. In order to gain a more accurate snapshot of why the program is not reaching its intended audience (i.e. the target criteria are outdated and inadequate, the beneficiaries are not notified appropriately, the intervention is not ideal, and/or beneficiaries do not benefit medically from the program, etc.), CMS should:

- Collect and release data for the purpose of analyzing the MTM program

- All MTM program data currently reported to CMS by Part D plans should be made available to external researchers. All qualified researchers in the private or public sectors should be permitted access.

- The MTM data file should include identifiers that allow direct linkages to the traditionally available CMS chronic condition warehouse research identifiable files, including CMS beneficiary administrative records, Parts A, B, and D claims data, and plan characteristics files. In particular, data elements should include: indicators for eligibility and participation in MTM and receipt of a Comprehensive Medication Review (CMR) or Targeted Medication Review (TMR); characteristics of the MTM services provided (e.g. setting, mode of delivery, date and duration of service, initial vs. follow up); provider characteristics; and characteristics of outreach efforts (e.g. frequency, method).

- Data on medical service use should also be made available for Medicare Advantage enrollees to allow for broader analysis of this and other programs.

- Encourage or conduct additional analysis of the MTM program. CMS could either perform or contract out research on the following studies that should inform efforts to modify the MTM program:

  - Evaluate MTM programs using all available data and compare the effectiveness of different MTM components in improving appropriate use of medications. CMS should also study how often MTM components (i.e. CMRs and TMRs) persist over the year and in which setting they occur.

  - Evaluate which Part D enrollees are most likely to benefit from MTM, including beneficiary populations who are not currently eligible for MTM, in order to inform the evolution of the MTM program and PDP decisions about eligibility criteria.

  - Reasons for low program participation.

CMS should also consider the opportunity to link pharmacy data with medical data to facilitate coordination between prescribers, plans, and pharmacies to improve patient adherence and health outcomes. For example, CMS can test how Health IT can be leveraged to supply providers with beneficiary level data within electronic health records (EHRs) to observe patient adherence patterns.

<u>PDPs should have timely access to Parts A and B data for their enrollees</u>

- PDPs are limited in their ability to identify beneficiaries who are most likely to benefit from MTM or other adherence improving activities because they cannot observe Medicare Parts A and B claims data, which can provide critical information about enrollees' use and spending on medical services, risk for adverse health events, and transitions in care. These data should be provided to PDPs on a regular basis in a format that is readily accessible to PDPs in their quality improvement efforts (e.g. flags indicating beneficiaries who recently experienced a hospital readmission).

PDPs should have more flexibility in how they target and communicate with beneficiaries related to MTM

- We propose that CMS allow PDPs more flexibility in developing communications and approaches that increase beneficiary understanding, participation and the effectiveness of the MTM program. Such approaches may include coordinating communications with prescribers and pharmacists, where there is no conflict of interest.

Realign incentives for PDPs to invest in medication management services

- CMS should explore ways in which incentives could be provided to Part D plan sponsors that can demonstrate a link between successful MTM program interventions and corresponding reductions in hospitalizations, use of emergency rooms, or physician visits that lead to Medicare program savings.

- P4HA suggests that CMS pilot a program that incentivizes PDPs to improve adherence and reduce under treatment among enrollees with chronic conditions, such as through a quality bonus or shared savings program.

    - PDPs are in the best position to know what adherence improving activities they are capable of and willing to implement in a manner that is cost effective, quality improving and wide reaching. If certain regulatory restrictions are removed and appropriate incentives are created, PDPs may implement and test new strategies and interventions aimed at improving medication use with a particular emphasis on medication adherence (e.g. enhanced, well-targeted MTM, medication synchronization, or strategies similar to those currently employed in the commercial market).

    - This pilot program should be voluntary and require that participating PDPs develop strategies to improve adherence, health outcomes, and reduce unnecessary and avoidable use of medical services. PDPs should submit detailed descriptions of proposed strategies and a plan to evaluate the impact of the strategies following implementation.

Improve Medicare Plan Finder

Plan Finder includes a list of the medicines offered by the different insurers and is intended to allow beneficiaries to select the plan that gives them the best deal on their particular medications, based on cost. Because cost is an important influence of patient adherence, P4HA believes Plan Finder can be improved to include information on comparing pharmacies and mail order with the various plans in order for beneficiaries to choose the most appropriate plan. More specifically:

- Plan Finder should display a pharmacy's usual and customary (U&C) price when it is lower than a beneficiary's copay. Because beneficiaries pay the lower amount of the U&C or copay, this means that beneficiaries may not be aware that their actual cost at the pharmacy counter will be less than what is displayed on Plan Finder for many

pharmacies- particularly preferred pharmacies- in their geographic area.

- Plan Finder currently prompts users to select a pharmacy before the costs of plans and prescriptions are displayed. An alternative approach would be for users to first see information on plan and prescription costs based on the most affordable pharmacy options before selecting a pharmacy.

- During the pharmacy selection process, Plan Finder displays an alphabetical list of retail pharmacies based on geographic distances that are much smaller than the 2, 5, and 10-mile radius criteria used to assess a plan's pharmacy network adequacy in urban, suburban, and rural areas respectively. An alternative approach would be to display all pharmacies in a user's area, ordered by cost within the user's selected plan. This would allow for the user to select the most appropriate plan and pharmacy combination, based on their specific needs.

- Plan Finder should allow users to select mail-service pharmacies during the pharmacy selection process to compare prices.

- Plan Finder should add a function to the "lower my costs" option that highlights when certain drugs are less expensive at certain pharmacies.

Thank you again for meeting with us. We appreciate the opportunity to provide additional details on how CMS can improve medication adherence within its patient population. We believe these suggestions are a right step toward creating a healthier and less costly healthcare system.

If you have any questions or would like to discuss further, please do not hesitate to reach out to Joel White, President, Council for Affordable Health Coverage and Prescriptions for a Healthy America, at joel.white@cahc.net or (202)559-0192.

Sincerely,

Joel C. White
President

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[i] MedPAC. Letter to Administrator Tavenner re: Request for comments on the Medicare Program; Contract Year 2015 policy and technical changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, proposed rule. http://medpac.gov/documents/comment-letters/02282014_partd_comment.pdf?sfvrsn=0

[ii] MTM data: D. Berwick, response to questions from the Committee on Ways and Means, US Congress, following his testimony on Feb. 10, 2011, submitted for the *Congressional Record,* http://waysandmeans.house.gov/uploadedfiles/berwickqfrs.pdf

[iii] Federal Register. Proposed Rule: Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf