Wolters Kluwer

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Comments from Wolters Kluwer Health on the
Proposed CY 2019 Medicare Advantage and Part D Call Letter

Below are comments from Wolters Kluwer Health on the recently issued Advance Notice of Methodological Changes for CY 2019 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter. Overall, we believe the policy changes proposed in the draft Call Letter that pertain to the Part D program are sound and we support them.

As way of background, Wolters Kluwer is a leading global provider of information, business intelligence and point-of-care solutions for the healthcare industry. Key solutions include UpToDate®, Medi-Span®, Lexicomp®, Facts & Comparisons®, Pharmacy OneSource®, Health Language®, Emmi Solutions® and Medicom (China). Wolters Kluwer had annual revenues in 2017 of €4.4 billion.

Our comments address the proposed changes to the Star Ratings and quality measures for 2019 and beyond. We have also provided our views and ideas for how value-based pricing approaches can be incorporated into Medicare Part D.

Proposed Changes to Medicare Part D Star Ratings and Quality Measures

We support including the **Statin Use in Persons with Diabetes measure** in the Star Ratings in 2019. We also support updating the **Drug-Drug interaction** (DDI) and **High-Risk Medication** measures measure to reflect the changes and updates made by the Pharmacy Quality Alliance. We continue to believe DDI monitoring and alerts are vitally important to ensure patient safety [1] and urge CMS to add this measure to the Part D Star Ratings as soon as possible.

The **Use of Opioids from Multiple Providers and/or High Dosage in Persons Without Cancer** measure will undergo several modifications, including excluding from the denominator the use of buprenorphine for medication-assisted treatment. We support this. CMS also signaled possible new measures to be added in 2020, including **Concurrent Use of Opioids and Benzodiazepines**, and two Medication Adherence Measures, one for **Non-Warfarin Anticoagulants,** the other for **Non-Infused Disease Modifying Agents for MS.** We support adding all three measures to the Part D program.

Concerning the **Medicare Plan Finder (MPF) Price Accuracy** measure, we continue to doubt this measure's utility. Drug price fluctuation occurs, and for some drugs, these changes can happen daily. Plan sponsors cannot control these fluctuations, so it seems unfair to hold them accountable, particularly if demand for a specific drug is resulting in significant price increases during a set timeframe. Medicare beneficiaries certainly should be protected from any attempts to present an artificially low

[1] Studies suggest nearly 1 in 25 older adults are potentially at risk for a major drug-drug interaction. http://jama.jamanetwork.com/article.aspx?articleid=183125

MPF price as an inducement to enroll, but it is also important that beneficiaries understand that the price listed in the Plan Finder is only representative, and may not be the one they ultimately pay at the pharmacy. As such, we do not believe the proposed modification to allow plans to round a drug's cost to the second decimal point adequately addresses this measure's inherent flaw.

Overutilization Monitoring System

We support CMS' proposed change to the **Overutilization Monitoring System** (OMS) to include additional flags for high risk beneficiaries who use **potentiator drugs such as gabapentin and pregabalin** in combination with opioids. We also support the proposed days supply limit for initial fills of opioids, and directing plan sponsors to implement Point of Sale safety edits based on dosage level, or duplicative therapy for long-acting opioids. As we have consistently stated in previous comments to CMS, we believe the OMS can be a vital tool to curb opioid misuse and abuse and generally support giving the system a broad reach, but CMS must continue to protect access to appropriate fills and dosages of opioids for patients in hospice or suffering from cancer.

Value-based Insurance Design and Alternative Payment Models in Medicare Part D

We appreciate CMS' ongoing work to transform the health care reimbursement system from volume to value and would like to take this opportunity to share our thoughts on how this new paradigm can be applied to the Medicare Part D program. Below are ideas we believe hold the most promise.

Rewarding High Performing Pharmacists and Pharmacies

We are delighted to hear that CMS intends to expand the **Enhanced Medication Therapy Management** (MTM) model to additional Part D plans and plan sponsors. The model offers opportunities to leverage MTM programs to improve outcomes at lower costs and **empower pharmacists to take on a more prominent role within the care team.** Because they typically see patients more frequently than other health professionals, pharmacists can readily identify and counsel at-risk individuals, optimize medication use by discontinuing inappropriate, duplicative or unsafe medications, and improve patient adherence to their therapy. MTM model participants should be encouraged to involve pharmacists in strategies aimed at reducing medication-related complications such as the prevalence of falls associated with the use of psychoactive or blood pressure medications.

Ultimately, CMS should seek ways to reward Medicare Advantage and Part D plan sponsors who **promote closer care coordination** among providers and pharmacists, and **broaden the types of services pharmacist can provide**. For example, plan sponsors should be encouraged to compensate pharmacists for providing services typically reserved for physicians, including immunizations, diabetes management or wellness visits. Assuming such services are included under state licensure rules, this would not only save money and enhance the contribution of the pharmacist to the care team, but also increase access to services for Medicare beneficiaries living in rural or urban areas where primary care doctors may be in short supply.

As part of the Center for Medicare and Medicaid Innovation's **Value-based Insurance Design (VBID) pilot** for Medicare Advantage plans, CMS allows plans to reduce cost sharing for beneficiaries to encourage them to use high value drug therapies (i.e. taking ACE inhibitors for enrollees who previously had an AMI) or to enroll and participate in a disease management program that may provide greater

education or monitoring of their drug therapy. CMS also envisions that reduced cost sharing may extend to consultations with high quality providers. This concept could also include **high performing pharmacists or pharmacies** that have demonstrated track record of helping to lower overall costs through strategies such as successful engagement with patients, drug-drug interaction screening and working with physicians to choose the most effective therapy.

Appropriate Use Criteria for Drug Therapy

Section 218(b) of the Protecting Access to Medicare Act of 2014 requires ambulatory clinicians to consult **appropriate use criteria** prior to ordering an advanced imaging test. Congress' purpose in adding this new law was to reduce inappropriate and unnecessary imaging tests not supported by clinical evidence. This same concept could be applied to high cost or high utilization drug therapies where clinical efficacy may be lacking in certain situations or for certain patients. Since Medicare currently lacks the statutory authority to test this approach for Part A and B drugs, the concept might be piloted through Medicare Advantage and Part D plan sponsors. For example, a class of drugs (i.e. opioids), or perhaps a discrete set of 3-5 high priced drugs could be selected for the pilot. Prior to ordering a prescription for one of the class of drugs in scope, providers would be given the opportunity to consult appropriate use criteria via a clinical decision support mechanism.

Another approach that can leverage appropriate use criteria for drug therapies involves **quality measures.** The Merit-based Incentive Payment System (MIPS) includes measures tracking appropriate use of certain drug therapies, including systemic antimicrobial therapy, antibiotics for acute sinusitis, and amoxicillin. CMS should consider adding such measures to the Part D measure set, and to encourage the development of new appropriate use measures for the more frequently used and high-priced drug therapies.

Comparative Effectiveness Research and Drug Pricing

Finally, organizations such as the Institute for Clinical and Economic Review (ICER) conduct comparative effectiveness research on drug therapies and then **determine a price range commensurate with relative benefit of the therapy as compared with its peer group**. This has the potential to revolutionize the ways drugs are priced. While CMS is not directly involved in negotiating Medicare Part D drug prices with pharmaceutical companies, it can encourage Part D plan sponsors to utilize comparative effectiveness research (CER) data in its negotiations with manufacturers. Such performance-based pricing strategies are already cropping up in the commercial health marketplace. And price negotiations are not the only possible use of CER. In a report released in 2015, the Center for American Progress recommended that **CER results be conveyed to physicians and beneficiaries using a Star Rating system** that will potentially influence provider prescribing and beneficiary usage patterns.

Thanks again for the opportunity to comment. If you have questions about any of our comments, please contact Bob Hussey (bob@bobhussey.com or (612) 281-8741), who can arrange contact with the relevant Wolters Kluwer Health staff.