



August 21, 2017

[Submitted electronically via www.regulations.gov]

The Honorable Seema Verma
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-5522-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program [RIN 0938-AT13]

Dear Administrator Verma:

The undersigned pharmacy organizations would like to thank CMS for the opportunity to comment on the proposed rule for the “Medicare Program; CY 2018 Updates to the Quality Payment Program” (QPP) (hereinafter referred to as the “Rule”). Collectively, our organizations represent approximately 100,000 pharmacists across the full spectrum of practice settings.

I. Improving Care under MIPS and Advanced APMs by Recognizing and Attributing the Value of the Pharmacist and their Services

Our organizations and CMS share the same goal—to increase access to quality care and better health. We support CMS’s continuing efforts to promote the transition to value-based payment models for physicians and eligible clinicians by reducing the clinician burden and offering incentives for providing high quality, cost-effective care. As our nation continues to move towards more accountable care and outcome-based Alternative Payment Models (APMs), we applaud CMS’s continued recognition of the value of pharmacists and the implementation of policies that allow for pharmacists to increase health care access and contribute to efficiencies in care delivery, such as transitional care management (TCM) services, chronic care management (CCM), and the Part D Enhanced Medication Therapy Management (MTM) Model.

We also applaud CMS’s inclusion of metrics in the 2016 final MACRA rule that specifically mention pharmacists—including the medication reconciliation post-discharge measure and the implementation of medication management practice improvements that recognizes physician practices

for “integrating a pharmacist into the care team.”¹ Similarly, we are pleased to see pharmacists further included under the Rule’s NCQA medication reconciliation post-discharge measure in the Merit Based Incentive Payment System (MIPS) APM measures list for comprehensive ESRD care and in the new and modified MIPS specialty measure sets for the 2018 performance period (orthopedic surgery, nephrology, and general surgery). In addition to these specific measures, a significant number of measures are related to or impacted by medications, and would benefit from appropriate medication use and pharmacist-provided services. For example, pharmacists can also contribute to over 25% of the 271 current quality measures, including a number of the newly proposed measures in the Rule, as well as many of the improvement activity and advancing care information measures. Our organizations predict as practices and medications become more specialized, the role and the value of pharmacists will be critical. Our members who practice in APMs and with specialized practices, note the following MIPS quality measures as examples of measures in which pharmacists are currently contributing significantly:

- Controlling High Blood Pressure;²
- Hypertension: Improvement in Blood Pressure;³
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%);⁴
- Medication Reconciliation Post-Discharge;⁵
- Unplanned Hospital Readmission within 30 Days of Principal Procedure;⁶ and
- Falls: Risk Assessment.

While pharmacists are affecting these and other MIPS measures, because pharmacists are not MIPS “eligible clinicians,” their incorporation into team-based care is impeded, as is their impact on the effective and efficient delivery of quality care. With the increasing complexity of medications and the role that proper medication management will play under MIPS, APMs, and Advanced APMs, recognizing the unique and essential contributions that pharmacists make on patient care teams is fundamental to achieving successful APMs and will assist CMS to meet its triple aim goals. Given pharmacists’ unique access to, and relationship with, the patient community, and their ability to reduce the nearly \$300 billion in annual health care costs due to medication-related problems,⁷ pharmacists are critical to APMs “bending the Medicare cost curve by encouraging the delivery of high-quality, low-cost care” — a stated objective in the Rule. As you know, ninety-one percent of Americans live within five miles of a community pharmacy.⁸ In addition, pharmacists are providing services in physician offices practices and hospital-based clinics. Better utilizing pharmacists in providing care and contributing to value could have a profound, and immediate impact on access, quality, health

¹ See, CMS. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models. Final Rule. 81 FR 7206, 77564, 77565, 77787, 77822. November 4, 2016. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf>

² See, Margolis, K. et al. Effect of Home Blood Pressure Telemonitoring and Pharmacist Management on Blood Pressure Control: A Cluster Randomized Clinical Trial. JAMA July 2013. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23821088>

³ See, America’s Health Insurance Plans. Advancing Best Practices in Medication Therapy Management: A Compendium of Health Plan Initiatives, Chapter 2. Available at: <http://pharma-smart.com/wp-content/uploads/2015/03/AHIP-MTMInnovations12913.pdf>

⁴ See, Ip EJ, Shah BM, Yu J, Chan J, Nguyen LT, Bhatt DC. Enhancing diabetes care by adding a pharmacist to the primary care team: an analysis of short term clinical markers and long-term cardiovascular outcomes.” Am J Health-Syst Pharm May 2013. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23640349>

⁵ See, Kilcup, M. Postdischarge pharmacist medication reconciliation: Impact on readmission rates and financial savings. JAPhA Jan/Feb 2013. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23636160>

⁶ See, ASHP-APhA Medication Management in Care Transitions Best Practices 2013. Pgs. 9-10, 15, 20, 26, 38, 44-45, 60. Available at: http://media.pharmacist.com/practice/ASHP_APhA_MedicamentManagementinCareTransitionsBestPracticesReport2_2013.pdf

⁷ New England Healthcare Institute. Thinking Outside the Pillbox: A System-Wide Approach to Improving Patient Adherence for Chronic Disease. August 2009. Available at: <http://www.nehi.net/publications/17-thinking-outside-the-pillbox-a-system-wide-approach-to-improving-patient-medication-adherence-for-chronic-disease/view>

⁸ NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

outcomes and costs for a large portion of the population, particularly in medically underserved communities. Therefore, our organizations recommend CMS incorporate and/or test an APM model focused on optimizing medication use and health outcomes as part of coordinated care delivery through the use of pharmacists. Moreover, absent a statutory change, APhA recommends that CMS take advantage of any regulatory discretion to remove regulatory barriers preventing physicians and eligible clinicians from utilizing pharmacists under team-based, patient-centered payment and delivery structures. Pharmacists are often an underutilized resource that cannot only help achieve the objectives of better outcomes through MIPS, but they can help ease the transition of physician and other eligible clinician practices to QPP participation.

In addition, consideration should be given to how reporting systems can meaningfully capture the contributions of various health care practitioners, including pharmacists to improving quality outcomes and managing costs. Our organizations would welcome the opportunity for a face-to-face meeting to share specific information with CMS on our own internal analyses on how and where pharmacists can contribute to the existing QPP metrics and those included in the Rule. We would include pharmacists in this meeting who are practicing in APMs and working with physicians and other eligible clinicians to influence MIPS measures to share their experiences, successes, and impacts.

II. Improving Clinical Information Exchange Between Pharmacists and Other Practitioners

One of CMS's strategic objectives under the Rule for the QPP is "to improve data and information sharing to provide accurate, timely, and actionable feedback to clinicians and other stakeholders." In previous comments, we have applauded CMS for recognizing that improving the exchange of clinical information between pharmacists and physicians and other health care practitioners would create opportunities for patients to interact with providers to maximize coordinated and team-based care. Pharmacists regularly provide the services envisioned within the QPP, including services focused on safe and appropriate medication use; medication adherence for the elderly and other populations; medication reconciliation; wellness and prevention; chronic disease management services; and case management for beneficiaries with multiple medications that require complex medication dosing regimens. While patients will often see multiple physicians and specialists to receive primary and specialized care, they often may only see one pharmacist. The nature of this personal relationship between pharmacist and patient allows the pharmacist to provide accurate, timely, actionable, and coordinated feedback to all members of the health care team. However, pharmacists are frequently blocked from the exchange of relevant clinical information with other health care providers using health information technology. Such restrictions impede the ability of CMS and patients to benefit from coordinated, team-based care. While CMS extends flexibility under the Rule to eligible clinicians to choose which version of Certified Electronic Health Record Technology (CEHRT) (i.e., the 2014 or 2015 version) they will employ, a key missing component is a requirement that either version of CEHRT provide access to pharmacists to maximize coordinated care efforts which are necessary to align with the Rule with MACRA and other, existing statute.^{9,10}

⁹ See, 81 Fed. Reg. 77030 which states "A health care provider must attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times:... (4) implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors." Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf>

¹⁰ See, 42 U.S.C. 300jj(3) defining health care provider as "The term "health care provider" includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, health care clinic, community mental health center (as defined in section 300x-2(b)(1) of this title), renal dialysis facility, blood center, ambulatory surgical center described in section 1395I(i) of this title,[1] emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy ... and any

Finally, we also support the comments submitted by the Pharmacy Health Information Technology (PHIT) Collaborative, of which many of our organizations are active members. In particular, the implementation of the Pharmacist eCare Plan will be instrumental facilitating standardized, interoperable exchange of pharmacists' medication-related activities, plans and goals for patients. Enabling pharmacist access to relevant, standardized patient information with easy reporting (Qualified Clinical Data Registries (QCDRs), EHRs, etc.) is essential to improve patient care and help clinicians deliver effective care. Implementing the Rule without addressing pharmacists' need for and reporting of information restricts pharmacists' integration into team-based care, fails to optimize pharmacists' contributions to care, and is inconsistent with the principles of value-based and coordinated care models that underpin the QPP program. Not having pharmacists' contributions documented in the EHR infrastructure also minimizes the ability to measure the value they provide as well.

Thank you for the opportunity to provide feedback on the Rule and for your consideration of our comments. We encourage CMS to use our organizations as a resource as it considers new health care payment and delivery mechanisms and look forward to working with CMS on identifying and implementing policy to improve the care provided to Medicare beneficiaries.

Sincerely,



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