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Department of Government & Professional Affairs

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Andrew Slavitt
Administrator
Center for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-5517-P Notice of Proposed Rulemaking Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Administrator Slavitt,

The American College of Clinical Pharmacy (ACCP) appreciates the opportunity to provide the following statement to the Center for Medicare and Medicaid Services (CMS) on the Notice of Proposed Rulemaking (NPRM) regarding implementation of the core Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

ACCP is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in patient care practice and research. ACCP's membership is composed of more than 17,000 clinical pharmacists, residents, fellows, students, scientists, educators and others who are committed to excellence in clinical pharmacy practice and evidence-based pharmacotherapy.

ACCP applauds CMS for its efforts to reform the existing fee-for-service (FFS) payment model that encourages volume in the delivery of health care and drives up health care costs while providing little incentive for the coordinated, high-quality, team-based, patient-centered process of care that is necessary to protect the long-term structural and financial viability of the Medicare program.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible clinicians or groups under

the PFS. The proposed rule would also establish incentives for participation in certain alternative payment models (APMs), supporting the Administration's goals of moving more fee-for-service payments into APMs that focus on better care, smarter spending, and healthier people. In addition, the proposed rule includes proposed criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in making comments and recommendations on physician-focused payment models and future APM development.

These comments summarize our organization's recommendations for improving clinical outcomes while reducing growth in Medicare spending by incorporating the direct patient-care services of clinical pharmacists as members of the patient's health care team. Specifically, as an essential objective for a modernized, cost-effective and quality-focused Medicare program, our comments focus on:

- Facilitating clinical pharmacists' full integration into patient care teams
- Achieving clinical outcomes to meet quality metrics by recognizing clinical pharmacists' contributions in quality and clinical practice improvement activity ("CPIA") performance measures
- Developing health information technology (HIT) resources to optimize the exchange of clinical information among members of the health care team

Facilitating Clinical Pharmacists' Full Integration into Patient Care Teams (Page 28293)

Within the section titled "Overview of Incentives for Participation in Advanced Alternative Payment Models," the proposed rule specifies the goal of building, "a portfolio of APMs that collectively allows participation for a broad range of physicians and other practitioners." The proposed rule goes on to say that "finding better ways to deliver care across settings and specialties can lead to improved health outcomes and more efficient health care spending."

ACCP applauds the agency's recognition of the importance of "managing medications to maximize efficiency, effectiveness and safety," highlighting the need to "reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups," and calling for the integration of pharmacists into care teams to achieve these goals. (Page 28576). In particular, we support the recognition of the contribution of the clinical pharmacist to the process of medication reconciliation post-discharge (Page 28403).

However, we believe that in order to achieve the overarching Administration strategy to transform health care delivery in America, it is necessary to transform payment structures to improve quality and patient outcomes and advance a forward-looking, coordinated framework for health care providers that rewards value and outcomes. In order to achieve a patient-centered health care system that delivers better care, smarter spending, and healthier people and communities, it is vital to establish a truly team-based, patient-centered approach to health care consistent with evolving delivery and payment models. Comprehensive medication management (CMM) is a direct patient care service, provided by clinical pharmacists[1] working as formal members of the patient's health care team that has been demonstrated to significantly improve clinical outcomes and enhance the safety of medication use by patients.

[1] American College of Clinical Pharmacy. Standards of Practice for Clinical Pharmacists. Pharmacotherapy 2014;34(8):794–797. Available from http://www.accp.com/docs/positions/guidelines/StndrsPracClinPharm_Pharmaco8-14.pdf

This team-based service of CMM is supported by the Patient Centered Primary Care Collaborative, (PCPCC), in which ACCP as well as the major primary care medical organizations are actively involved. CMM helps ensure that seniors' medication use is effectively coordinated, and in doing so enhances seniors' health care outcomes, contributing directly to Medicare's goals for quality and affordability. CMM can "get the medications right" as part of an overall effort to improve the quality and affordability of the services provided to Medicare beneficiaries[2].

In "getting the medications right," CMM also contributes to enhanced productivity for the entire health care team, allowing all team members to more fully focus on their own particular patient care responsibilities. By fully utilizing the qualified clinical pharmacist's skills and training to coordinate the medication use process as an interdependent team member, physicians and other team members are essentially freed to maintain focus on respective patient care activities that align with professional responsibilities as defined by scope of practice that reflect their particular area of expertise

ACCP urges you to incorporate clinical pharmacists as other "eligible clinicians" under MIPS and APMs and establish coverage for CMM services delivered under team-based, patient-centered payment and delivery structures.

Optimizing clinical outcomes to meet quality metrics by recognizing pharmacists' contributions in quality and clinical practice improvement activity ("CPIA") performance measures. (Page 28263)

In order to enhance access to high-quality care and to ensure the overall sustainability of the Medicare program, it is essential that progressive payment and delivery system improvements that have emerged and are being actively utilized in both public and private-sector integrated care delivery systems be facilitated and aggressively promoted -- especially those that measure and pay for quality and value, not simply volume of services, and that fully incentivize care that is patient-centered and team-based.

To that end, we urge you to consider the importance of CMM, delivered by clinical pharmacists, as a means to achieving the highest potential score for Clinical Practice Improvement Activity (CPIA) performance category[3]. Specifically, the following CPIAs are proposed with 'high' weighting (Table 23, Page 28263). These examples include, but are not limited to, opportunities within existing care delivery processes where qualified clinical pharmacists fully engage in team-based care[4]:

- Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors)
- MIPS eligible clinicians and MIPS eligible clinician groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance period, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one or more of these clinical practice improvement activities: Patients are being managed by an

[2] Integrating comprehensive medication management to optimize patient outcomes. PCPCC Resource Guide, Second Edition June 2012. Available at https://www.pcpcc.org/guide/patient-health-through-medication-management.
[3] ACCP Issue Brief: "Comprehensive Medication Manegement in Team Based Care." Available at: http://www.accp.com/docs/positions/misc/CMM%20Brief.pdf
[4] Garcia DA, Witt DM, Hylek E, Wittkowsky AK et al. Delivery of optimized anticoagulant therapy: consensus statement from the Anticoagulation Forum. Ann Pharmacother. 2008;42(7):979-88.

anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic INR testing, tracking, follow-up, and patient communication of results and dosing decisions.

- For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and MIPS eligible clinician groups must attest to having: For the first performance period, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least age, comorbidities, and risk for hypoglycemia; and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for the first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.

In addition, Appendix Table A summarizes proposed 2017 quality measures for MIPS reporting and lists a number of new, high-priority core measures for which clinical pharmacist-delivered CMM would be routinely targeted at the general family practice, internal medicine, or specialist practitioner level. These include, but are not limited to, the following:

- Diabetes: Hemoglobin A1c Poor Control (HbA1c >9%)
- Heart Failure: Angiotensin-Converting Enzyme Inhibitor or Angiotensin Receptor Blocker Therapy for Left Ventricular Systolic Dysfunction
- Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
- Coronary Artery Disease: Beta-Blocker Therapy – Prior Myocardial Infarction or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction
- Anti-Depressant Medication Management
- Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet
- Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

Developing health information technology (HIT) resources to optimize the exchange of clinical information among participating members of the health care team. (Page 28172)

The proposed rule requires that a MIPS eligible clinician demonstrate that the certified EHR technology used was "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." (Page 28172).

Clinical pharmacists, working collaboratively with physicians and other members of the patient's health care team, utilize a consistent process[5] of direct patient care that enhances quality and safety, improves clinical outcomes and lowers overall health care costs. Enabling clinical pharmacist access to relevant patient information through interoperable HIT and certified EHRs under Medicare is essential to allow practitioners deliver effective CMM. By helping ensure that seniors' medication use is effectively coordinated, this service is a benefit that enhances seniors' health care outcomes and contributes directly to Medicare's goals for quality and affordability.

[5] American College of Clinical Pharmacy. Standards of Practice for Clinical Pharmacists. Pharmacotherapy 2014;34(8):794–797. Available from http://www.accp.com/docs/positions/guidelines/StndrsPracClinPharm_Pharmaco8-14.pdf

ACCP supports the comments submitted by the Pharmacy HIT Collaborative on the Proposed Rule that were developed by nine pharmacy professional associations, representing 250,000 members dedicated to ensuring the nation's health care system is supported by meaningful use of health IT that facilitates the integration of pharmacists for the provision of quality patient care.

In summary, we thank you for the opportunity to provide feedback on the Proposed Rule and for your consideration of these materials. ACCP is dedicated to advancing a quality-focused, patient-centered, team-based approach to health care delivery that helps assure the safety of medication use by patients and that achieves medication-related outcomes that are aligned with patients' overall care plans and goals of therapy through the provision of CMM.

As part of the process of exploring opportunities to improve the overall quality of care delivered to seniors we urge you to integrate coverage of CMM services provided by clinical pharmacists as members of the patient's health care team within your broader payment reform efforts. We would welcome the opportunity to provide further information, data, and connections with successful practices that provide CMM services to help further inform the agency toward integrating this process into Medicare payment and delivery system reform that will modernize and sustain the program for the future.

Please do not hesitate to contact us if we can be of further assistance.

Sincerely,

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cc: Michael Maddux, Pharm.D., FCCP, Executive Director