Pharmacy e-Health Information Technology Collaborative

VIA Electronic Submission to AdvanceNotice2014@cms.hhs.gov

February 28, 2013

Jonathan Blum
Center for Medicare
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, MS: 314G
Washington, DC 20201

Re: Medication Therapy Management Section of the Advance Notice of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies

Dear Mr. Blum:

On behalf of the membership of the Pharmacy e-Health Information Technology Collaborative (Collaborative), we are pleased respond to the Medication Therapy Management (MTM) section of the Advance Notice of Methodological Changes for CY 2014. The Pharmacy e-HIT Collaborative is supportive of the continued use of MTM services within the Part D drug program and would encourage CMS to expand MTM services to improve and promote coordination of care of Medicare beneficiaries.

We agree that beneficiaries should be encouraged to complete their annual Comprehensive Medication Review (CMR) prior to their annual wellness visit and to take their standardized medication action plan and personal medication list from their CMR to their annual wellness visit or any medical encounter (primary care physician or specialist visit, hospital admission, etc.).

The Pharmacy e-HIT Collaborative supports the use of this summary in an electronic form as a valuable tool to share information across providers especially providers that have adopted electronic health records (EHR). We applaud CMS' plans to include this message to beneficiaries beginning with the 2014 Medicare & You Handbook or other beneficiary communications. We are in support of encouraging Part D sponsors and MTM providers, including community pharmacists, to communicate this recommendation to beneficiaries when notifying beneficiaries of their enrollment in the MTM program and when offering or scheduling CMRs and to explore other opportunities to use MTM to better coordinate care with

their pharmacists, including having a pharmacist-provided CMR after a transition in care or after a hospitalization.

The Pharmacy e-HIT Collaborative supports the encouragement of plan sponsors to adopt standardized health information technology (HIT) for documentation of MTM services and the use of structured, universal clinical codes (e.g SNOMED CT) to measure MTM outcomes by pharmacists. The Collaborative supports the expansion of the MTM reporting requirements to collect the findings and recommendations that were discussed during CMRs and listed in the beneficiary's medication action plan. The Collaborative agrees and supports standardizing HIT for documentation of MTM services, including the use of SNOMED CT and National Council for Prescription Drug Programs (NCPDP)/Health Level 7 (HL7) MTM Templated CDA in a standardized format based on standard elements in databases and EHRs rather than manipulating free-form text documents.

The Pharmacy e-HIT Collaborative agrees with the CMS two-year study findings regarding the effectiveness of MTM, particularly on high-risk populations/individuals that had problems with their drug therapy regimens and had high rates of hospital and emergency visits before enrollment. The study also confirms that Medicare beneficiaries who were enrolled in MTM programs in 2010, particularly those who received annual comprehensive medication reviews (CMRs), experienced significant improvements in drug therapy outcomes when compared to beneficiaries who did not receive MTM services. The Collaborative also understands that the next stage of the CMS project will involve analysis to evaluate the effect of MTM on individuals with diabetes. We look forward to reviewing those findings when completed.

Pharmacists provide a range MTM services, including CMRs, diabetes management, hypertension (improving systolic blood pressure control), and asthma, to a diverse payment group in many patient-care settings. MTM is a distinct service or group of services that optimizes therapeutic outcomes for individual patients. MTM services, and especially the CMRs, can be used to promote and improve the coordination of care.

The service model for MTM is the *Medication Therapy Management in Pharmacy Practice: Core elements of MTM Service Model; Version 2.0*, (available online at http://www.pharmacist.com/sites/default/files/files/core_elements_of_an_mtm_practice.pdf) also known as the "MTM Core Elements." The MTM Core Elements include five core elements: 1) medication therapy review, 2) personal medication record, 3) medication-related action plan, 4) intervention and referral, and 5) documentation and follow up.

The following is a brief overview of three components of MTM that we would encourage CMS and other sponsors to incorporate as valuable tools not only in patient care but in the overall coordination of care.

MTM Related to Transitions of Care

Patients are vulnerable at transitions of care, defined as the movements of patients between health locations, providers, or different levels of care within the same location as their conditions and care needs change. These transitions may involve multiple health care providers, as well as the patient, family members, and other caregivers. Medication reconciliation, particularly the use of CMRs, at transitions of care should be part of all providers' EHR documentation process in all practice settings.

At a minimum, the following information should be provided electronically to pharmacists at transitions of care: medication list and directions for use, medical condition (diagnosis) or problem list, and allergies. For optimal MTM services at transitions of care, the full content of an electronic version of a structured document (e.g. Continuity of Care Document (CCD)), including laboratory values, prescriber information, and medication history, should be provided electronically to pharmacists.

Medication Reconciliation

Medication reconciliation (MR) is the process of comparing a patient's medication orders to all of the medication that the patient has been taking. This should be done at every transition of care in which new medications are ordered or existing orders are rewritten. The comprehensive goal of MR is to maintain and electronically communicate accurate patient medication information and then take appropriate actions to resolve any discrepancies.

The pharmacy industry's *Improving Care Transitions: Optimizing Medication Reconciliation* (a 2012 white paper published by Collaborative members APhA and ASHP and available online at: http://www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx) states that the comprehensive goals of medication reconciliation are "to obtain and maintain accurate and complete medication information for a patient and use this information within and across the continuum of care to ensure safe and effective medication use," to electronically communicate accurate patient medication information, and then take appropriate actions to resolve any discrepancies.

Medication Adherence

Medication adherence should be addressed as part of a comprehensive MTM service, not separately or apart from the total medication-use process. With access to electronic health information from sources such as the CCD and not just prescription claims data from medication histories, pharmacists and other providers will have the ability to better assess medication adherence outcomes, target medication-related problems, and improve patient care.

The Pharmacy e-HIT Collaborative, including pharmacy professional associations, the Pharmacists Services Technical Advisory Coalition (PSTAC), MTM intermediaries, and the National Council for Prescription Drug Programs (NCPDP), are defining the pharmacist's MTM role in HIT. Pharmacists in all practice settings provide MTM services and document those services manually and electronically. During the electronic exchange of clinical information,

components of MTM can be shared between providers by means of CCD using consolidated Clinical Document Architecture (cCDA). It is evident that access to HIT solutions can enhance the pharmacist's ability to improve the overall medication-related safety and quality of patient care in coordination with other health care providers. Formed in the fall of 2010, the Collaborative's focus is to assure the meaningful use (MU) of standardized EHR that supports safe, efficient, and effective medication use, continuity of care, and provides access to the patient-care services of pharmacists with other members of the inter-professional patient care team.

The Pharmacy e-HIT Collaborative seeks to ensure pharmacist-provided patient care services are integrated into the National HIT interoperable framework. The Collaborative's founding organizations represent pharmacists in all patient care settings and other facets of pharmacy, including pharmacy education and pharmacy education accreditation. The Collaborative's Associate Members represent e-prescribing networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. The Collaborative was founded by nine pharmacy professional associations representing over 250,000 members and includes six associate members from other pharmacy related organizations. For additional information, visit www.pharmacyhit.org

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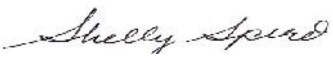
On behalf of the Pharmacy e-HIT Collaborative, thank you again for the opportunity to respond to the MTM section of the Advance Notice of Methodological Changes for CY 2014. For more information, contact Shelly Spiro, Executive Director, Pharmacy e-HIT Collaborative at shelly@pharmacyhit.org.

Respectfully submitted,



Shelly Spiro
Executive Director, Collaborative

Shelly Spiro, RPh, FASCP
Executive Director
Pharmacy e-Health Information Technology Collaborative
shelly@pharmacyhit.org

Mark N. Brueckl, RPh, MBA
Assistant Director, Pharmacy Affairs
Academy of Managed Care Pharmacy
mbrueckl@amcp.org

Mike Rouse B.Pharm (Hons); MPS
Assistant Executive Director, Professional Affairs and Director, International Services
Accreditation Council for Pharmacy Education (ACPE)
mrouse@acpe-accredit.org

William Lang, MPH
VP Policy and Advocacy
American Association of Colleges of Pharmacy wlang@aacp.org

C. Edwin Webb, Pharm.D., MPH
Associate Executive Director
Director, Government & Professional Affairs
American College of Clinical Pharmacy
ewebb@accp.com

Marcie Bough, PharmD
Senior Director, Government Affairs
American Pharmacists Association
mbough@aphanet.org

Lynne Batshon
Director, Policy & Advocacy
American Society of Consultant Pharmacists
Lbatshon@ascp.com

Christopher J. Topoleski
Director, Federal Regulatory Affairs
American Society of Health-System Pharmacists
ctopoleski@ashp.org

Marc J. Ricker
CMO
IQware Solutions
mricker@iqwaresolutions.com

Kim Swiger, RPh
Vice President, Pharmacy Services
Mirixa Corporation
kswiger@mirixa.com

Rebecca Snead
Executive Vice President and CEO
National Alliance of State Pharmacy Associations
rsnead@naspa.us

Ronna B. Hauser, PharmD
VP Policy and Regulatory Affairs
National Community Pharmacists Association (NCPA)
ronna.hauser@ncpanet.org

Lynne Gilbertson
VP Standards Development
National Council for Prescription Drug Programs (NCPDP)
lgilbertson@ncpdp.org

Stephen Mullenix. RPh
Sr VP, Communications & Industry Relations
National Council for Prescription Drug Programs (NCPDP)
smullenix@ncpdp.org

Patty Kumbera, RPh
Chief Operating Officer
Outcomes
pkumbera@outcomesmtm.com

Roger Pinsonneault, R.Ph.
Vice President, Business Development
RelayHealth – Pharmacy
Roger.Pinsonneault@RelayHealth.com

Michael E. Coughlin
President, CEO and CFO
ScriptPro
mike@scriptpro.com

Ken Whittemore, Jr., RPh, MBA
Senior VP, Professional & Regulatory Affairs
Surescripts
ken.whittemore@surescripts.com