Pharmacy Health Information Technology Collaborative

Via Electronic Submission to: https://www.regulations.gov

January 2, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-FC and CMS-5522-IFC
PO Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstances Policy for the Transition Year

Dear Sir or Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments for the *Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstances Policy for the Transition Year* final rule.

The Collaborative is supportive of the development of the final rule for CY 2018 Updates to the Quality Payment Program and the proposed interim final rule: Extreme and Uncontrollable Circumstances Policy for the Transition Year. We particularly call your attention to our comments regarding (i) MIPS Clinicians Facing a Significant Hardship.

Although pharmacists are not eligible clinicians under MIPS, they provide person-centered care and services, maintain various secure patient care records, and as part of the integrated health care team, they are directly involved with other health care providers (eligible MIPS clinicians) and patients in various practice settings in the MIPS Quality Payment Program. Pharmacists are users of health IT and are supportive of interoperability standards, especially those utilizing certified EHR technology (CEHRT). The Collaborative supports use of these particular standards which are important to pharmacists for allergy reactions, immunization historical and administered, immunization registry reporting, medications, medication allergies, patient problems, smoking status, reporting to public health agencies, clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing (including new versions).

The Collaborative has been involved with the federal agencies, including the Office of the National Coordinator (ONC) and the Center for Medicaid and Medicare Services (CMS), developing the national health information technology (HIT) framework since 2010.

The following are our comments regarding changes made to the final *CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstances Policy for the Transition Year***.**

c. Advancing Care Information (pages 28 and 397, PDF version)

The Collaborative supports finalizing the rule to allow MIPS eligible clinicians the option to use EHR technology certified to the 2014 Edition for the performance period in CY 2018, the 2015 Edition of CEHRT, or a combination of the two.

With regard to the proposed e-prescribing objective and measure exclusions for advancing care information and advancing care information transition, we request additional information explaining the proposed exclusion for any MIPS eligible clinician who writes fewer than 100 prescriptions during the performance period. The measure currently requires that a MIPS eligible clinician transmit at least one permissible prescription using CEHRT. It is not readily clear as to the reason for this proposed exclusion and if it's necessary based on the current requirement.

e. Submission Mechanisms (pages 30 and 196-216, PDF version)

The Collaborative supports allowing additional flexibility for submitting data through multiple submission mechanisms and delaying implementation of this policy change until the 2019 performance period. From an operations standpoint, we agree that this will allow more time to communicate the applicability to other policies. Additionally, we recommend that the six qualifying measures for submitting data through multiple submission mechanisms need to be CEHRT certified. The use of certified CEHRT still appears not to be specifically required for these measures. The Collaborative believes that the use of certified CEHRT should be required in all areas of the MIPS program and should be consistent with the definition of Meaningful EHR User for MIPS, which requires the use of certified CEHRT.

(**i) Submission Criteria for Quality Measures Excluding Groups Reporting via the CMS Web Interface and the CAHPS for MIPS Survey (page 224, PDF version)**

The CMS is finalizing the rule to remove the SSM, "Helping You Take Medication as Directed." The Collaborative requests that this action be delayed and reconsidered.

For many people, taking their medications according to their health care providers instructions is a challenge. Medication non-adherence in the United States is a problem, which has serious health consequences. Upwards of $300 billion in avoidable health care costs have

been attributed to medication non-adherence.[1] About half of patients with chronic diseases do not take their medications as directed.[2] The Collaborative believes that if it is structured properly and asks the appropriate questions this particular SSM could be a critical, useful step in determining the reasons for medication non-adherence and advancing adherence to prescribed medication regimens, thus improving outcomes.

Pharmacists have a unique, comprehensive knowledge of the safe and effective use of medications, as well as medication management systems. Pharmacists in all practice settings provide medication therapy management (MTM) for health care providers and patients. MTM includes five core elements: medication therapy review, personal medication record, medication-related action plan, intervention and referral, and documentation and follow-up.

In the final action section, no information or data is provided as to why this SSM has low reliability. CMS explains that "in an attempt to improve their reliability, removing questions from this SSM did not result in any improvements in reliability." This raises the thought that low reliability could possibly be the questions that were used and how they were presented to patients.

We would request that CMS share the questions used in this SSM for others, especially pharmacists, to review and provide suggestions to improve the SSM. Partnering with pharmacists on this SSM could make it more reliable.

Table 6: Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus Beginning with the 2018 Performance Period

In reviewing the care coordination activities in Table 6, they do not appear to include medication plans as part of those activities. The Collaborative recommends that medication plans be included as part of the care coordination activities.

(i) MIPS Clinicians Facing a Significant Hardship (pages 404-430, PDF version)

The Collaborative is particularly interested in the CMS' response to the occupational therapist commenter's "expressed concern about occupational therapists participating in MIPS were never eligible for the EHR Incentive Program." See pages 407-408, PDF version. The CMS responded, "We appreciate this comment and point out that under section 1848(q)(1)(C)(i)(II) of the Act, additional eligible clinicians such as occupational therapists could be considered MIPS eligible clinicians starting in the third year of the program. If we decided to add additional clinician types to the definition of a MIPS eligible clinician, it would be proposed and finalized through notice and comment rulemaking. We would support these clinicians and help them to become successful program participants."

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934668/

[2] https://catalyst.nejm.org/optimize-patients-medication-adherence/

The Collaborative has raised this same concern numerous times on behalf of its pharmacy members, who are not meaningful use eligible providers or MIPS eligible clinicians, since the beginning of the Meaningful Use EHR Incentive program and received a different response from the CMS than what was given to the occupational therapist commenter.

Pharmacists participate in these programs through their partnerships and working with eligible clinicians, even though they are not eligible for the incentives.

As recognized person-centered, health care providers and health IT users, pharmacists play an integral role in bringing value to the health care system by providing treatments, care, and services to patients, which improve quality outcomes, reduce or eliminate additional hospital stays through medication therapy management (MTM), comprehensive medication management, medication reconciliation, and help reduce overall health care costs. In some settings, pharmacists are first-line-of-care providers.

Pharmacists are the most readily accessible health care professionals, and they are in a unique position in the health care continuum to assist in improving quality in all EHR quality measure domains, as well as improving patient outcomes. Many of the quality measures currently required by the CMS, as well as the HHS goals for fee-for-services in Medicare, focus on medication use and are influenced by pharmacists.

In our most recent comments to the CMS regarding MIPS (June 27, 2016, CMS-5517-P comment period; as well as, MACRA RFI comments on November 17, 2015 and June 3, 2016), the Collaborative presented a detailed request and rationale for pharmacists to be made eligible clinicians for the MIPS program at the beginning of the third year, citing the MACRA sections that appeared to allow the CMS to expand the eligible clinicians list. Our request was based on section 1848(q)(1)(9)(C)(u) and (v) of MACRA, which also gives the CMS authority to expand the eligible clinician list, as does section 1848(q)(1)(C)(i)(II) of the Act cited by the CMS in its current response.

It was our belief and interpretation that the CMS had the authority under MACRA to correct this omission and add pharmacists as eligible clinicians to MIPS, as the CMS now states it has in its response to the occupational therapist commenter. The CMS, however, responded in the final rule to our June 27, 2016, request that it did not have the authority to expand the list, indicating that to have that authority would require a change by Congress.

It now appears that the CMS has revised its previous position regarding its authority to expand to the eligible clinicians list, which the Collaborative is pleased to see. The Collaborative hopes that the CMS would now support adding pharmacists to the list of eligible clinicians in year three and help them become successful participants in the program.

(a) Considerations for Social Risks (page 719, PDF version)

The Collaborative supports the areas of social risk factors listed to help improve beneficiary outcomes and reduce health disparities. In addition to the social risk factors mentioned in the final rule, the Collaborative recommends that behavioral lifestyle factors, such as smoking, alcohol, poor diet, lack of physical activity (exercise), and sexual behavior be included.

Proposed Interim Rule: B. Changes to the Extreme Uncontrollable Circumstances Policies for the MIPS Transition Year (page 1168, PDF version)

The Collaborative supports the automatic extreme and uncontrollable circumstance policy and trigger events that may impact some MIPS eligible clinicians, particularly with regard to acts of nature (e.g., hurricanes, earthquakes).

Additional Comment: Net Neutrality Repeal

The Collaborative strongly encourages and recommends that the CMS examine the potential impact of the net neutrality repeal on MIPS and other CMS programs, in which health care provider participants in these programs are required to use health IT, if it has not already begun to explore this area. The ending of net neutrality could go well beyond the average Internet user's day-to-day experience. It is our concern that repealing net neutrality may have a major and substantial negative impact on the health care arena, health IT that is reliant on the Internet, and the sharing of health care data via the Internet. Health care programs and providers could find their abilities to provide and share health care data with others slowed if they are not in a position to pay for prioritized access (aka, fast lanes). ISPs could become information blockers, as they would be controlling the flow of information and data, which would impede achieving the interoperability goals established the Office of the National Coordinator for the use of health IT nationwide. Information blocking is an issue that Congress has examined and included a prohibition of such in the 21st Century Cures Act.

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The Pharmacy HIT Collaborative's vision and mission are to assure the nation's health care system is supported by meaningful use of health IT, the integration of pharmacists for the provision of quality patient care, and to advocate and educate key stakeholders regarding the meaningful use of health IT and the inclusion of pharmacists within a technology-enabled integrated health care system. The Collaborative was formed in the fall of 2010 by nine pharmacy professional associations, representing 250,000 members, and also includes associate members from other pharmacy-related organizations. The Pharmacy HIT 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 and health information networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. For additional information, visit www.pharmacyhit.org.

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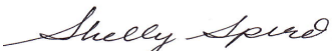
On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on *CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstances Policy for the Transition Year*.

For more information, contact Shelly Spiro, Executive Director, Pharmacy HIT Collaborative, at shelly@pharmacyhit.org.

Respectfully submitted,



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