Pharmacy Health Information Technology Collaborative

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

June 3, 2016

Department of Health and Human Services
Office of the National Coordinator
for Health Information Technology
Attn.: RFI Regarding Assessing Interoperability for MACRA
330 C Street, SW, Room 7025A
Washington, DC 20201

Re: RFI Regarding Assessing Interoperability for MACRA

Dear Sir or Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to respond to the *RFI Regarding Assessing Interoperability for MACRA*.

The Collaborative and its member organizations support interoperability and certification of health information technology and electronic health records (EHRs). The Collaborative has been involved with the ONC and the Center for Medicaid and Medicare Services since the early development of the standards and criteria as they apply to the Meaningful Use EHR Incentive Program and their affect on non-eligible pharmacist health care providers. The Collaborative also supports and provided numerous comments on the ONC's *Connecting Health and Care for the Nations: A Shared Nationwide Interoperability Roadmap*.

Although pharmacists are ineligible for EHR incentives, pharmacists provide patient-centered care and services to Medicaid and Medicare, and they are part of many integrated health care teams comprising eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). The exchange of information through interoperable health IT and certified EHR is essential to pharmacists.

The following are our comments the questions posed.

Scope of Measurement: Defining Interoperability and Population

Should the focus of measurement be limited to "meaningful EHR users," as defined in this section…and their exchange partners?

The Collaborative supports the focus of the measurement being limited to meaningful EHR users as defined and those that attest to the meaningful use of certified EHR technology under the CMS EHR Incentive Programs. At this stage, we do not believe the focus of the measurement should be on exchange partners who are not eligible to participate in the CMS EHR Incentive Programs. As noted previously, pharmacists are ineligible for EHR incentives, even though they provide patient-centered services and are part of many integrated health care teams that may comprise EPs, eligible hospitals, and CAHs. Our concern is that MACRA may become an unfunded mandate for pharmacists working with EPs, etc., should measurements be based on exchanges by ineligible groups.

We have raised concern in numerous comments throughout the development of the meaningful use process about pharmacists being ineligible for the EHR Incentive Programs. We strongly recommend that pharmacists be included as "eligible clinicians" in the new MIPS program now that the Secretary appears to have the authority to expand the list of eligible clinicians.

How should eligible professionals under the Merit-Based Incentive Payment System (MIPS) and eligible professionals who participate in the alternative payment models (APMs) be addressed?

The Collaborative believes they should be addressed as MIPS eligible clinicians to be consistent with the proposed MACRA rule; not MIPS eligible professionals as suggested. As mentioned in the previous question, there is a change regarding EPs in the proposed MACRA rule. The proposed MACRA rule changes that term to eligible clinicians and specifically refers to them as MIPS eligible clinicians. Additionally, the MACRA provides the Secretary with authority to expand the list of eligible clinicians in subsequent years.

As mentioned previously, pharmacists, who are clinicians and provide medication-related patient-centered services to Medicaid and Medicare, are not included in the list of eligible clinicians. We strongly request that pharmacists be included as eligible clinicians. Pharmacists play an integral role in providing patient-centered services and information related to medication therapy management, wellness and prevention, chronic disease management programs, safe and appropriate medication use and adherence, complex case management related to multiple medications with complex medication dosing regimens, and the use of high-risk drugs for the elderly. The services and patient-centered care provided by pharmacists help in improving health outcomes and provide overall cost savings.

ONC seeks to measure various aspects of interoperability (electronic sending, receiving, finding and integrating data from outside sources, and subsequent use of information

electronically received from outside sources). Do these aspects of interoperability address both the exchange and use components of section 106(b)(1) of the MACRA?

The Collaborative believes these aspects address the exchange of health information. They do not; however, appear to address use components of section 106(b)(1) of the MACRA, which specifically requires the use of certified EHR technology by EPs and now eligible clinicians. Use of certified EHR technology appears to be omitted from the question posed above.

Should the focus of measurement be limited to the use of certified EHR technology? Alternatively, should we consider measurement of exchange and use of outside certified EHR technology?

The Collaborative believes the MACRA is clear in this regard and specifically states under Section 106(b)(1) that only the use of certified EHR technology would be permitted. The Collaborative supports the use of certified EHR technology. It is not clear, however, what is meant by "use of outside certified EHR technology?" Does this mean certification by an outside source other than certification by the ONC? Or does it mean non-certified EHR technology? We believe a clarification needs to be made regarding this particular term. If the term "outside certified EHR technology" means EHR technology that is certified but not certified by the ONC, the Collaborative believes that the outside certification group and technology needs to fully meet the certification standards established by the ONC, and the ONC should review the certification process and standards used by an outside group. If the ONC certification standards are met, then there should not be an issue considering measurement of exchange for "outside certified EHR technology," if as discussed, this is what the term means.

Measures Based Upon National Survey Data

The Collaborative believes that national survey data could aid in the evaluation of interoperability from the two perspectives being considered by the ONC: providers (hospitals and office-based physicians who electronically exchange health information with clinicians) and transactions. The Collaborative agrees that some caution would be needed in using national survey data, particularly regarding nationally collected data that is self-reported. National survey data may not necessarily reflect all types of health care providers; transaction-based measures of exchange activity may not necessarily be reported; and self-reported data may be subject to potential biases. These factors need to be taken into consideration if using data from these surveys.

CMS Medicare and Medicaid EHR Incentive Program Measures

The Collaborative supports the EHR Incentive measures being considered for possible use in evaluating interoperability with regard to providers receiving a summary of care record for a patient transitioning to a new provider. Of particular importance to

pharmacists are the measures considered that will look at the proportion of transitions of care where a summary of care record was created using certified EHR technology and exchanged or transmitted electronically; the proportion of transitions of care where medication reconciliation is performed; and for 2017 and subsequent years, the proportion of transitions and referrals received in which the health care provider performs clinical information reconciliation for medications, medication allergies, and problem lists.

Although these proposed measures evaluate interoperability by examining the exchange across encounters or transitions of care rather than across health care providers, we agreed it could be valuable to develop measures to evaluate interoperability progress across health care providers, even though the initial data source may be EPs in the EHR Incentive Programs.

Can state Medicaid agencies share health care provider-level data with CMS similar to how Medicare currently collects and reports on these data in order to report on prepress toward widespread health information exchange and use?

To answer this question, particularly with regard to any barriers that may exist at the state level, the Collaborative recommends that the ONC consider speaking directly with the states' Medicaid directors or surveying them. By reaching out to the states, we believe this approach would better encourage them to become further engaged in the process, especially with regard to how this is connected to the ONC's proposed roadmap for nationwide interoperability.

During the 2015 comment period for the ONC's *Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1*, the Collaborative recommended this approach to a similar question and objective that were proposed. We mentioned that a particular barrier to interoperability is the various state laws concerning privacy, data collection, and security. The roadmap suggested that states revise their regulations and policies to align with federal definitions of permitted uses for data under HIPAA and the ONC standard on what constitutes Basic Choice. There may be other barriers. Direct conversations with the states may bring those to the forefront and possible solutions for overcoming them.

Overarching Questions

If ONC seeks to limit the number of measures selected, which are the highest priority measures to include?

As discussed previously, measures under consideration that are of particular importance to pharmacists are those concerning bi-directional exchange of electronic prescriptions (e.g. prescription fill status, change, cancel and indication information), transitions of care including sharing of standard electronic structured documents (e.g. C-

CDA eCare Plans) and the reconciliation of medications, medication allergies and problem lists.

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 the quality of patient outcomes, especially for those patients utilizing medication management services. Many quality measures required currently by CMS focus on medication use and will be influenced by pharmacists.

*****

The Pharmacy HIT Collaborative's vision and mission are to assure the nation's health care system is supported by meaningful use of HIT, the integration of pharmacists for the provision of quality patient care, and to advocate and educate key stakeholders regarding the meaningful use of HIT 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.

*****

On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the *RFI Regarding Assessing Interoperability for MACRA*.

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

Respectfully submitted,

Shelly Spiro

Shelly Spiro
Executive Director, Pharmacy HIT Collaborative

Shelly Spiro, RPh, FASCP
Executive Director
Pharmacy HIT Collaborative
shelly@pharmacyhit.org

Susan A. Cantrell, RPh, CAE
Chief Executive Officer
Academy of Managed Care Pharmacy
scantrell@amcp.org

Peter H. Vlasses, PharmD, DSc (Hon), BCPS, FCCP
Executive Director
Accreditation Council for Pharmacy
Education (ACPE)
pvlasses@acpe-accredit.org

Rylan Hanks, PharmD
Regulatory Intelligence
Global Regulatory and R&D Policy – Biosimilars
Amgen, Inc.
rhanks@amgen.com

William Lang, MPH
Senior Policy Advisor
American Association of Colleges of Pharmacy
wlang@aacp.org

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

Stacie S. Maass, BS Pharm, JD
Senior Vice President, Pharmacy Practice
and Government Affairs
American Pharmacists Association (APhA)
smaass@aphanet.org

Arnold E. Clayman, PD, FASCP
Vice President of Pharmacy Practice &
Government Affairs
American Society of Consultant Pharmacists
Aclayman@ascp.com

Jillanne M. Schulte, JD
Director, Federal Regulatory Affairs
American Society of Health-System Pharmacists
jschulte@ashp.org

Tony Matessa
Cardinal Health - Commercial Technologies
Director, Product Marketing Lead
www.cardinalhealth.com/fuse

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

Ronna B. Hauser, PharmD
Vice President, Pharmacy Affairs
National Community Pharmacists Association
(NCPA)
ronna.hauser@ncpanet.org

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

Cynthia Kesteloot
Vice President of Operations
OutcomesMTM
ckesteloot@outcomesmtm.com

Cathy DuRei
Director, Trade Channel Management
Pfizer US Trade Group
Cathy.DuRei@Pfizer.com