Pharmacy Health Information Technology Collaborative

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

September 27, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-1715-P: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other changes to Part B Payment; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; et al.

Dear Administrator Verma:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments on *CMS-1715-P: Medicare Program, et al.* The Collaborative's comments focus primarily on the "Medicaid Promoting Interoperability Program Requirements for Eligible Professionals" portion of the proposal.

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

Pharmacists provide essential patient-centered care and services to Medicare and Medicaid patients. Pharmacists are users of health IT, and in particular, e-prescription and EMR (EHR) systems. The Collaborative supports the use of these systems, which are important to pharmacists in working with other health care providers to provide needed medications and transmit patient information related to overall patient care, transitions of care, immunization (historical and administered), immunization registry and reporting, medication lists, allergies (including medications, food, and environmental intolerances and reactions), patient problem lists, smoking status, reporting to public health agencies clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing.

The following are our comments regarding the "Medicaid Promoting Interoperability Program Requirements for Eligible Professionals" of CMS-1715-P.

D. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals

2. eCQM Reporting Requirements for EPs under the Medicaid Promoting Interoperability Program for 2020 (page 607)

The Collaborative supports requiring (as was done for 2019) Medicaid EPs to report on any six Electronic Clinical Quality Measures (eCQMs) that are relevant to their specific scope of practice, regardless of whether reported via attestation or electronically.

The Collaborative supports the eCQMs available for Medicaid EPs to report in 2020 that are both part of the Core Sets and on the MIPS list and would be considered high priority, especially, CMS122, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%); CMS137, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment; and CMS165, Controlling High Blood Pressure.

The Collaborative supports allowing states to accept attestations for program year 2020 as early as October 1, 2020 from Medicaid EPs who choose to use an eCQM reporting period early in the year.

3. Objective 1:Protect Patient Health Information in 2021 (page 613)

The Collaborative supports allowing Medicaid EPs to conduct a security risk analysis at anytime during CY 2021, even if the EP conducts the analysis after the EP attests to meaningful use of certified EHR technology (CEHRT) to the state, and submitting the completed analysis to the state by December 31, 2021.

MIPS Value Pathways Request for Information

(3) Implementing MVPs
(a) MVP Definition, Development, Specification, Assignment, and Examples (page 725)

The Collaborative supports the four MVP guiding principles as defined. The Collaborative agrees that interoperability is a foundational element and applies to all clinicians, regardless of the specific MVP. The Collaborative also supports the use of CEHRT for care coordination and electronic health information exchange and agrees that CEHRT should be a key structural part of MVP uniformity.

With regard to Table 34: Examples of Possible MIPS Value Pathways, the Collaborative recommends adding a preventive care quality measure for substance use screening/treatment under Preventive Health. Such a measure would help address the opioid crisis, as well as align to other measures in promoting interoperability that incorporate Prescription Drug Monitoring Programs.

(i) Request for Feedback on MVP Approach, Definition, Development, Specification, Assignment, and Examples (page 737)

How would stakeholders like to be engaged in MVP development?

Given the operational considerations that may be involved in the development and implementation of MVPs for 2021, the Collaborative suggests that CMS hold public forum listening sessions, webinars, or other approaches, initially and early on in 2020, to gather more information as to what is important to clinicians, patients, and stakeholders, especially, if the goal is to accelerate the development of MVPs.

Improvement Activities Performance Category

b. Group Reporting (page 761)

The Collaborative supports revising § 414.1310(e)(2)(ii) to allow individual eligible clinicians who elect to participate in MIPS as a group to aggregate their performance data.

(i) Proposed Factors for Consideration in Removing Improvement Activities (page 829)

The Collaborative supports the seven factors, as proposed, for consideration when proposing the removal of an improvement activity. Activities should be removed as needed; particularly, those that may be duplicative.

Promoting Interoperability

(d) Promoting Interoperability Performance Category Measures for MIPS Eligible Clinicians
(i) Proposed Changes to Measures for e-Prescribing Objective
(B) Query of Prescription Drug Monitoring Program (PDMP) Measure
(aa) Query of PDMP Measure (page 839)

The Collaborative supports making the Query of PDMP measure optional for CY 2020. As the PDMP landscape is still maturing, and there are variations across the country as to how providers and states are implementing and integrating PDMP queries into health IT, the Collaborative agrees with the proposed CMS approach for the PDMP measure.

The Collaborative also supports using CEHRT to conduct a query of PDMP for prescription drug history.

Table 41: Objectives and Measures for the Promoting Interoperability Performance Category in 2020 (page 853)

The Collaborative supports all of the objectives and measures listed in Table 41, particularly those pertaining to e-Prescribing, Query of PDMP, and Immunization Registry and Reporting, as part of promoting interoperability.

(g) Future Direction of the Promoting Interoperability Performance Category

(i) RFI on Potential Opioid Measures for Future Inclusion in the Promoting Interoperability performance category (page 865)

The Collaborative supports measure logic and timing elements that can be captured by CEHRT in standard clinical workflow, especially those that are represented by clinical and claims vocabularies in SNOMED CT, LOINC, RxNorm, ICD-10, and CPT.

(ii) RFI on NQF and CDC Opioid Quality Measures

(A) NQF Quality Measures (page 868)

(B) CDC Quality Improvement Opioid Measures (page 870)

The Collaborative supports the use of the following NQF-endorsed quality measures, stewarded by the Pharmacy Quality Alliance (PQA), for inclusion in the Promoting Interoperability Program:

- *Use of Opioids at High Dosage in Persons Without Cancer (OHD) (NQF #2940)*
- *Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) (NQF #2950)*
- *Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer (NQF #2951)*
- *Concurrent Use of Opioids and Benzodiazepines (COB) (NQF# 3389) (not mentioned)*

As we outlined in our June 24 *CMS-1716-P: Medicare Program* comments, these measures align with the *CDC Opioid Prescribing Guideline for Prescribing Opioids for Chronic Pain* and published evidence that demonstrates an association between these prescribing patterns and an increased risk of opioid misuse and overdose. They also relate to activities likely to be successful in combatting the opioid epidemic and can be supported using CEHRT. Although it is not included in the NQFs proposed for use in the Promoting Interoperability performance category, we recommend *COB (NQF #3389)* be used, as well, which could include using health IT to electronically prescribe the opioid medication, to query a PDMP, and to identify where naloxone co-prescription may be appropriate based on information received through health information exchange with other health care providers.

Although PQA's composite measure, *Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (#2951),* is also NQF-endorsed, the individual measures (OHD #2940 and OMP #2950) may be most useful for the Medicaid Promoting

Interoperability Program. In addition to recent adoption into the Medicare Shared Savings Program (for informational purposes only), PQA opioid measures are used in the Medicare Part D Quality Program, Medicaid 1115 Substance Use Disorder Waivers, and the OHD and COB measures are included in the Medicaid Adult Core Set, creating alignment of opioid measures across programs.

Clinical Quality Language and Fast Healthcare Interoperability Resources (FHIR) compliant versions of the opioid measures would be needed. An additional consideration is identifying appropriate exclusions for the measures, including hospice, cancer, and sickle cell disease to mitigate potential unintended consequences.

The Collaborative supports the use of the *Implementing the CDC Prescribing Guideline for Prescribing Opioids for Chronic Pain* as a way to help opioid quality measure development. The Collaborative encourages monitoring and reviewing quality measurement implementation, particularly for unintended consequences. Of the 16 CDC measures, the following would be particularly beneficial in the management and coordination of short- and long-term opioid therapy, especially if linking them to EHRs:

- Measure 2: The percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing.
- Measure 11: The percentage of patients on long-term opioid therapy who had documentation that a PDMP was checked at least quarterly.
- Measure 16: The percentage of patients with an opioid use disorder who were referred to or prescribed medication-assisted treatment.

Although evidence shows PDMPs as an effective tool in reducing "negative health outcomes associated with the medically unnecessary use of controlled substances," the actual use of PDMPs by physicians and in clinical care is low.[1] Including these particular CDC measures as part of CMS' CQMs may help improve PDMP usage and support the integration of pharmacists on care team given their familiarity with PDMP. Integrating PDMP information into EHRs would also make it easier for clinicians to check a patient's PDMP record.[2]

(iv) RFI on Provider to Patient Exchange Objective

(A) Immediate Access (page 879) and

(B) Persistent Access and Standards-based APIs (page 880)

The Collaborative supports ONC's 21st Century Cures Act proposed rule to move to an HL7 FHIR-based API under 2015 Edition certification. Although the ONC proposed rule is not finalized, the Collaborative would be supportive of a possible bonus under the Promoting Interoperability for early adoption of FHIR-based API in the intermediate time before ONC's final rule's compliance date.

[1] https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/

[2] Ibid.

(C) Available Data (page 881)

With regard to ONC proposing to adopt a new 2015 Edition certification criterion for electronic health information (EHI) export, the Collaborative believes incorporating an alternative measure under the Provider to Patient Exchange Objective that would require health care providers to use technology certified to the EHI criteria to provide patients their complete electronic health data contained within an EHR would be effective in encouraging the availability of all data stored in health IT systems.

The Collaborative also believes that CMS should include a health IT activity that promotes and encourages bidirectional exchange of health information and bidirectional communications across the care continuum.

(D) Patient Matching (page 883)

The Collaborative supports efforts to identify patient matching options. We encourage CMS, as we also stated in our May 3, 2019 interoperability/information Blocking comments to ONC 's 21st Century Cures proposed rule on this topic and in our June 3, 2019 comments on CMS 9115-P comments,[3] to look at NCPDP's Universal Patient Identifier (UPI), which was developed in partnership with Experian Health, as a solution to match and manage patient identities.[4] The NCPDP UPI leverages Experian's "expansive consumer demographic information and referential matching methodologies to identify record matches and duplicates in a patient roster file, and then assign a unique NCPDP UPI to each patient in the file."[5] The NCPDP UPI can be used across all health care entities.

Targeted Review and Data Validation and Auditing

(3) Qualified Clinical Data Registries (QCDRs) (page 977)

The Collaborative supports requiring QCDRs to support three performance categories: quality, improvement activities, and promoting interoperability beginning with the 2021 performance period and for future years, and to attest to the ability to submit data for these performance categories. We understand that the requirement applies if the eligible clinician, group, or virtual group is using CEHRT, and that a third party could be excepted from this requirement if its MIPS eligible clinicians, groups, or virtual groups fall under the reweighting policies at §414.1380(c)(2)(i)(A)(4), (c)(2)(i)(A)(5), (c)(2)(i)(C)(1) through (c)(2)(i)(C)(7), or (c)(2)(i)(C)(9).

[3] https://ncpdp.org/Products/NCPDP-Universal-Patient-Identifier
[4] Ibid.
[5] Ibid.

Public Report on Physician Compare

(5) Promoting Interoperability (page 1019)

The Collaborative supports requiring a MIPS eligible clinician to submit an attestation of "yes" to statements containing specific representations about a clinician's implementation and use of CEHRT so as to verify that a MIPS eligible clinician has not knowingly and willfully taken action to limit or restrict (e.g., block) the compatibility or interoperability of certified EHR technology.

Other Provisions of the Proposed Regulation

5. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs)(page 1200)

The Collaborative supports aligning the eCQMs for Medicaid EPs in 2020 with those available for MIPS eligible clinicians for CY 2020 performance period.

Table Group B: New Specialty Measures Sets Proposed for Addition and Previously Finalized Measure Sets Proposed for Modification for 2022 MIPS Payment Year and Future Years

B.1. Allergy/Immunology (pages 1356-57)

Adult Immunization Status

The Collaborative supports the inclusion of this measure for the 2020 performance period.

Pneumococcal Vaccination Status for Older Adults

The Collaborative requests that CMS provide additional information regarding the rationale for removing this measure beginning with the 2022 MIPS Payment Year. Table C does not provide a sufficient explanation as to the rationale. This is being removed from other areas, as well (e.g., B.21, B.27, B.34).

B.21. Nephrology (page 1475)

Medication Reconciliation Post Discharge

The Collaborative requests that CMS provide additional information regarding the rationale for removing this measure beginning with the 2022 MIPS Payment Year. Table C does not provide a sufficient explanation as to the rationale.

B.22. General Surgery (page 1480)

Medication Reconciliation Post Discharge

The Collaborative requests that CMS provide additional information regarding the rationale for removing this measure beginning with the 2022 MIPS Payment Year. Table C does not provide a sufficient explanation as to the rationale.

B.27. Infectious Disease (page 1505)

Adult Immunization Status

The Collaborative supports the inclusion of this measure for the 2020 performance period.

B.34. Geriatrics (page 1534-35)

Adult Immunization Status

The Collaborative supports the inclusion of this measure for the 2020 performance period.

Medication Reconciliation

The Collaborative requests that CMS provide additional information regarding the rationale for removing this measure beginning with the 2022 MIPS Payment Year. Table C does not provide a sufficient explanation as to the rationale.

B.36 Skilled Nursing Facilities (page 1543)

Adult Immunization Status

The Collaborative supports the inclusion of this measure for the 2020 performance period.

B.37 Endocrinology

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (page 1545)

The Collaborative supports the inclusion of this measure in the Endocrinology specialty set.

Adult Immunization Status (page 1549)

The Collaborative supports the inclusion of this measure for the 2020 performance period.

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The Pharmacy HIT Collaborative comprises the major national pharmacy associations, representing 250,000 members, including those in pharmacy education and accreditation. The Collaborative's membership is composed of the key national pharmacy associations involved in health information technology (HIT), the National Council of Prescription Drug Programs, and nine associate members encompassing e-prescribing, health information networks, transaction processing networks, pharmacy companies, system vendors, pharmaceutical manufacturers, and other organizations that support pharmacists' services.

As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative's vision and mission are to ensure the U.S. health IT infrastructure better enables pharmacists to optimize person-center care. Supporting and advancing the use, usability, and interoperability of health IT by pharmacists for person-centered care, the Collaborative identifies and voices the health IT needs of pharmacists; promotes awareness of functionality and pharmacists' use of health IT; provides resources, guidance, and support for the adoption and implementation of standards driven health IT; and guides health IT standards development to address pharmacists' needs. For additional information, visit www.pharmacyhit.org.

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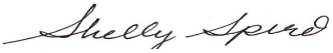
On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on *CMS-1715-P: Medicare Program, et al.*

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

Respectfully submitted,



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