Pharmacy Health Information Technology Collaborative

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

December 15, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS- 3310 & 3311-FC
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-3310 & 3311-FC – Medicare and Medicaid Program; Electronic Health Record Incentive Program – Stage 3 and Modification to Meaningful Use in 2015 through 2017

Dear Sir/Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit further comments on specific sections of the final rule – *Medicare and Medicaid Program; Electronic Health Record Incentive Program – Stage 3 and Modification to Meaningful Use in 2015 through 2017.*

The Collaborative is supportive of the proposed modifications for transitioning to the Merit-Based Incentive Payment System (MIPS) starting in 2018, as established by the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Collaborative supports value-based payment systems.

Although pharmacists are ineligible for electronic health record (EHR) incentives, they will need to exchange information with EHR systems to connect to and ensure needed bidirectional communication with eligible professionals (EPs). Pharmacists provide patient-centered care and services, and as part of the integrated health care team, they are directly involved with patients in various practice settings, particularly with a patient's medication action plan. Pharmacists have standards in place to meet Stage 3 requirements.

As we understand it, CMS will be issuing proposed rulemaking for the MIPS by mid-2016 and that CMS is seeking additional comments on certain sections of this EHR Incentive Program final rule for consideration in developing the proposed MIPS rules. In addition to the sections open for comment, the Collaborative has one recommendation

that is not addressed by these specific sections but is part of a change to the EHR incentive program authorized by MACRA that concerns pharmacists.

The following are our comments for CMS- 3310 & 3311-FC: *Electronic Health Record Incentive Program – Stage 3 and Modification to Meaningful Use in 2015 through 2017.*

Medicare Access and CHIP Authorization Act of 2015 (MACRA)

Recommendation

Concerning the recent enactment of MACRA and the changes that will be made to the EHR Incentive Program, the Collaborative recommends that pharmacists be included in the list of MIPS eligible professionals (EP), if permitted under changes adopted in MACRA. The Secretary has been given discretion to specify additional EPs as that term is defined in Section 1848(k)(3)(B) of the Act. While it appears that the Medicare Access and CHIP Reauthorization Act of 2015 does not specifically list pharmacists as a health care professional eligible for EP designation, we appreciate CMS's support and use of regulatory discretion in helping increase patients access to health care through pharmacist-provided care.

As recognized patient-centered, health care providers and HIT users, pharmacists play an important role in providing treatments and care to patients. 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 electronic health records (EHR) quality measure domains. Many quality measures required currently by CMS, as well as the announced HHS goals for fee-for-services in Medicare, focus on medication use and will be influenced by pharmacists. Some examples include safe and appropriate medication use, adherence, and the use of high-risk drugs for the elderly.

Pharmacists play an integral role in providing 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. Pharmacists provide this information not only to patients but to EPs, as well.

Section II.B.1.b.(3).(iii): EHR Reporting Period in 2017 and Subsequent Years (page 77)

The Collaborative supports finalizing the proposal for full calendar year reporting for providers beginning in 2018 with a limited exception for Medicaid providers in their first year of demonstrating meaningful use. The Collaborative also supports the

optional 90-day reporting period for providers demonstrating the Stage 3 requirements for an EHR reporting period in 2017.

Section II.B.1.b(4).(a): Considerations in Review and Analysis of the Objectives and Measures for Meaningful Use (page 83)

The Collaborative supports evaluating those measures that are "topped out" to determine whether they should be considered for removal from the EHR Incentive Program. The Collaborative also supports the precedent of focusing on the advanced use of CEHRT to eliminate measures that are now redundant, duplicative, and topped out; create a single set of objectives for all providers with limited variation between EPs, eligible hospitals, and CAHs as necessary; and provide flexibility within the objectives to allow providers to focus on implementation that support their practices.

Section II.B.2.b: Objectives and Measures for Stage 3 of the EHR Incentive Programs (page 280)

Objective 1: Protect Patient Health Information

As noted in our June 15, 2015 comments for the final rule, the Collaborative supports the proposed measure to protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical standards. The Collaborative also supports the proposed measure to conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of data stored in certified EHR technology, implement security updates as necessary, and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process

Objective 2: Electronic Prescribing (page 291)

As stated in our June 15, 2015 comments for the final rule, the Collaborative supports retaining the Stage 2 objective and measures for electronic prescribing for meaningful use in 2015 through 2017, including maintaining the query function for drug formularies. The Collaborative supports the change to generate e-prescriptions for controlled substances where permissible as an option because of the various state requirements.

Objective 3: Clinical Decision Support (page 304)

The Collaborative appreciates the recognition given to the integration of clinical decision support (CDS) in pharmacy systems.

As stated in our June 15, 2015 comments for the final rule, the Collaborative supports retaining the Stage 2 objective and measures for clinical decision support (CDS) for meaningful use in 2015 through 2017. We also support the proposed objective and measures to use CDS to improve performance on high-priority health conditions.

Objective 4: Computerized Provider Order Entry (page 317)

As stated in our June 15, 2015 comments for the final rule, the Collaborative supports retaining the Stage 2 objective and measures for CPOE for meaningful use in 2015 through 2017.

Objective 5: Patient Electronic Access to Health Information (page 331)

The Collaborative supports retaining the Stage 2 objective and Measure 1 for medication reconciliation for meaningful use in 2015 through 2017 with the modification for the numerator for Measure 2.

Objective 6: Coordination of Care through Patient Engagement (page 356)

The Collaborative supports the finalizing of this objective with the modification to remove the reference to "communication functions" because of the adoption and use of an application programming interface (API).

Objective 7: Health Information Exchanges (page 378)

The Collaborative supports revising this objective for Stage 3 to allow the inclusion of transitions of care and referrals in which the recipient provider may already have access to the medical record (e.g., summary of care document) maintained in the referring provider's CEHRT. Pharmacists are involved in transitions of care and having access to summary of care documents is beneficial. Summary of care documents provide the pharmacist with relevant and the most up-to-date information about the last patient encounter.

The Collaborative supports proposed Measure 3, which incorporates the Stage 2 objective for medication reconciliation; expands the options to allow for the reconciliation of other clinical information; and requires providers to implement clinical information reconciliation for medication, medication allergy, and current problem list. With regard to current problem list, Measure 3 states that it is a review of the patient's current and active diagnoses. Although it could be presumed that the current problem list includes medication problems that is not clear. We ask CMS to clarify that current problem list should include a review and record of medication problems.

The Collaborative agrees that an electronic exchange of information following the transition of care of a patient is the most efficient method of performing medication and clinical information reconciliation.

Section II.D.1.e: Methods for Demonstrations of the Stage 3 Criteria of Meaningful Use for 2017 and Subsequent Years (page 548)

The Collaborative supports finalizing the proposal with modifications to allow providers flexible CEHRT options for an EHR reporting period in 2017 to continue to use EHR technology certified to the 2014 or 2015 Editions for Stage 3; to be required to fully upgrade to the 2015 Edition in the EHR reporting period in 2018; and flexibility to report clinical quality measures (CQM) or to attest to CQMs using either EHR technology certified to the 2014 or 2015 Editions.

Section II.G.2: EHR Reporting Period and EHR Reporting Period for a Payment Adjustment for First Time Meaningful Users in Medicaid (page 606)

The Collaborative supports finalizing the proposal with the limited exception (90-day EHR reporting period) for first time Medicaid providers demonstrating meaningful use in 2017 and subsequent years and formalizing how states report to CMS regarding providers attesting to meaningful use, as well as their implementation and oversight activities.

Paragraphs (1)(ii)(C)(3), (1)(iii), (2)(ii)(C)(3), and (2)(iii): Definition of an EHR Reporting Period (page 695)

The Collaborative supports the changes for EHR Reporting Period for first time EPs demonstrating meaningful EHR use (continuous 90-day period within CY 2017 and 2018); CAH demonstrating the Stage 3 objectives/measures for any continuous 90-day period within CY 2017; and eligible hospital and CAH first demonstrating meaningful use in FY 2018 for any continuous 90-day period within the calendar year.

*****

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

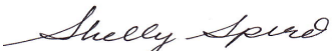
Associate Members represent e-prescribing and health information networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. For additional information, visit www.pharmacyhit.org.

*****

On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the Request for Comment for *Medicare and Medicaid Program; Electronic Health Record Incentive Program – Modification to Meaningful Use in 2015 through 2017.*

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

Respectfully submitted,



Shelly Spiro
Executive Director, Pharmacy HIT Collaborative

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

Edith A. Rosato, RPh, IOM
Chief Executive Officer
Academy of Managed Care Pharmacy
erosato@amcp.org

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

Thomas Felix, MD
Director, Regulatory Affairs, R&D Policy, and Global Regulatory Affairs and Safety
Amgen, Inc.
thfelix@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, B S 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

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

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

Steve Long
Director, Technical Operations, Retail Services
Greenway Health
steve.long@greenwayhealth.com

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

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