APhA
American Pharmacists Association

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Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies [Docket Number: CMS-2024-0006]

[Part D redesign comments also submitted electronically to: PartDRedesignPI@cms.hhs.gov.]

Director Wuggazer Lazio,

The American Pharmacists Association (APhA) is pleased to submit comments on the "Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies" and the "Draft CY 2025 Part D Redesign Program Instructions."

APhA's members are committed to continuous quality improvement and support the development and use of meaningful measures that help patients achieve optimal health and medication outcomes. APhA supports CMS' work with the Pharmacy Quality Alliance (PQA) and urges the agency to better identify, attribute, and evaluate the contributions of pharmacists to patient care and outcomes to integrate pharmacy-level metrics into the Display Measures and Star Ratings system and to identify barriers within current service requirements that prevent scalable involvement of pharmacists.

Draft CY 2025 Part D Redesign Program Instructions

APhA commends CMS for clearly outlining in September 2022 the Medicare insulin and vaccine benefits under the Inflation Reduction Act (IRA) for Medicare Part D plans. APhA has created Vaccine Confident resources for pharmacists and patients on the benefits of the IRA. However, in December 2023, CMS also acknowledged "that the amount plan sponsors and PBMs that

serve plans in Medicare…pay pharmacies for some vaccine administrations is causing many pharmacies and other providers of vaccines to lose money administering vaccines, discouraging them from providing these vaccines," which can impact the effectiveness of CMS measures, for example, Adult Immunization Status. CMS also stated the agency "is very concerned about payment practices that may impede access to recommended vaccinations, and it is imperative that plans and PBMs take immediate steps to ensure adequate payment for and access to vaccines." APhA has provided direct data to CMS leadership that current PBM payment policies are underwater every time a pharmacy fills and administers many Advisory Committee on Immunization Practices (ACIP)—recommended vaccines, which clearly disincentivizes pharmacist stocking and administration of vaccines. Accordingly, APhA strongly encourages CMS to monitor the implementation of the CY 2025 Part D Redesign Program Instructions provision that "[d]uring CY 2025, Part D plans must not apply the deductible to an ACIP-recommended adult vaccine and must charge no cost-sharing at any point in the benefit for such vaccines," and consider PBM compliance and practitioner reimbursement as a potential new measure concept for Part D and MA plans.

Measure Updates for 2025 Star Ratings

There are a number of measures on the Part C and Part D Star Ratings list that pharmacists can meaningfully impact. APhA offers comments on the following measures:

2025 Star Ratings Measures

Annual Flu Vaccine (Part C, Process Measure, Weight 1)
APhA urges CMS to gather data from MA prescription drug plans (MA-PD) plans to better monitor, measure, and attribute the impact different providers, including pharmacists, have on the vaccination rates of Medicare beneficiaries.

Medication Reconciliation Post Discharge (Part C, Process Measure, Weight 1)
As CMS understands, the medication reconciliation review can be conducted by a pharmacist. APhA requests CMS clarify how the efforts of pharmacists in delivering medication reconciliation services would be captured under this measure by plans since the primary provider's database is the one that is used for the data in calculating this measure.

Transitions of Care (Part C, Process Measure, Weight 1)
Patients could benefit greatly if pharmacists were better included in transitioning MA patients from an inpatient setting to home.

Care Coordination (Part C, Patients' Experience and Complaints Measure, Weight 4). See the comments below under 2025 Measurement Year and Beyond.

Statin Therapy for Patients with Cardiovascular Disease (Part C, Process Measure, Weight 1). See the comments below under 2025 Measurement Year and Beyond.

Medication Adherence for Diabetes Medication/Medication Adherence for Hypertension (RAS Antagonists)/ Medication Adherence for Cholesterol (Statins)/ MTM Program Completion Rate for CMR (Part D, Process Measure, Weight 1) (Part D). See the comments below under 2025 Measurement Year and Beyond.

As CMS understands, despite clear evidence supporting the value of pharmacist-led MTM services, these programs continue to be significantly underutilized. APhA has been advocating for years that CMS and Part D plans need to be more transparent about the importance of the impact of MTM program on outcomes to beneficiaries. Accordingly, APhA strongly urges CMS and plans to prioritize the impacts of upcoming proposed MTM changes to Medicare Part D. APhA continues our offer to serve as a resource to help analyze CMS data to determine the impact of the current and proposed changes to the MTM program and the impact on plan measures.

Statin Use in Persons with Diabetes (Part D, Process Measure, Weight 1)
APhA supported this PQA-endorsed measure becoming a Star Ratings measure to facilitate increased focus on the evidence-based use of statin therapy in persons with diabetes as this measure is standard practice and due to the clinical importance of this measure in improving health outcomes of persons with diabetes. APhA also agrees with CMS' proposal to use continuous enrollment (CE) to fully align with the PQA specifications and to no longer adjust for member-years to provide for more accurate measurement.

Changes to Existing Star Ratings Measures for the 2025 Measurement Year and Beyond

Future Universal Foundation Star Ratings Measures.
CMS is working to include all of the Universal Foundation measures as part of the Part C and D Star Ratings pending future rulemaking. A number of CMS' current set of measures included in the Adult "Universal Foundation" can be impacted by pharmacists:

- Wellness and Prevention: 26: Adult Immunization Status
- Chronic Conditions: 167: Controlling High Blood Pressure - The Centers for Disease Control and Prevention's (CDC's) Division for Heart Disease and Stroke Prevention recognized the contribution that community pharmacists can make to improve

population health. APhA recommends CMS and Part C and D plans reference the CDC developed, "Using the Pharmacists' Patient Care Process to Manage High Blood Pressure: A Resource Guide for Pharmacists," which explains how the use of the Pharmacists' Patient Care Process can help prevent and manage high blood pressure through team-based care to meet the goal of reducing heart disease and stroke in the United States.

- Chronic Conditions: Diabetes: 204: Hemoglobin A1c Poor Control (>9%) -- Studies have shown that patients with baseline uncontrolled diabetes who were managed by a clinical pharmacist in the outpatient setting had a higher decrease in A1c compared with usual care. CMS should examine chronic condition management measures that utilize pharmacist interventions to improve chronic conditions.
- Behavioral Health: 672: Screening for Depression and Follow-Up Plan - Mental health clinical pharmacists perform assessments to determine appropriate treatment modalities and to monitor efficacy and toxicity and should be considered similar to the new measure concepts for the Health Outcomes Survey (Part C). The typical diagnoses of patients evaluated by mental health clinical pharmacists for depressive disorders uses the same assessment tools as do other mental health professionals, including: 1. Mental status exams 2. Suicide risk assessment (e.g., Columbia Rating Scale) 3. Psychiatric rating scales (e.g., Patient Health Questionnaire-9, PTSD Checklist-17, Generalized Anxiety Disorder-7, Brief Psychiatric Rating Scale, CAGE) 4. Physical assessments (e.g., weight, blood pressure) 5. Ordering and interpretation of laboratory tests (e.g., lithium level, complete blood count, basic metabolic panel, hemoglobin A1c). APhA also urges CMS to work with MA plans to include pharmacist-provided depression screenings.
  394: Initiation and Engagement of Substance Use Disorder Treatment - Mental health clinical pharmacists have developed many practices in the treatment of those with substance use disorders, including: 1. Initiation and continuation of buprenorphine, with 11 states authorizing physician initiation of buprenorphine. 2. Monitoring patients on buprenorphine 3. Naltrexone initiation, monitoring, and continuation 4. Naltrexone administration in select states 5. Naloxone prescribing, education, and recommendation 6. Methadone maintenance therapy.
- Equity: Screening for Social Drivers of Health/ Social Need Screening and Intervention. APhA recommends CMS and the plans involve pharmacists, as the agency moves forward with the Universal Foundation and the application of the health equity index (HEI) for plans to summarize performance among enrollees with social risk factors across multiple measures into a single score.

Statin Therapy for Patients with Cardiovascular Disease (Part C, Process Measure, Weight 1). This measure is being modified to address patients who no longer statin intolerance form a

muscle condition. APhA recommends CMS examine studies on how pharmacists can significantly improve statin use rates among eligible patients through multiple intervention types and across different clinical settings.

Care Coordination (Part C, Patients' Experience and Complaints Measure, Weight 4).
Pharmacists are often the first health care provider generally responsible for coordinating medication-related information on patient-care teams. APhA recommends CMS consider a mechanism for plans to gather information on beneficiary experiences with pharmacists in delivering and coordinating care.

Medication Adherence for Diabetes Medication/Medication Adherence for Hypertension (RAS Antagonists)/ Medication Adherence for Cholesterol (Statins) (Part D).
APhA supports PQA's proposed non-substantive changes and the risk adjustment for the PQA adherence measures, which also take into account health equity issues.

Display Measures

Adult Immunization Status (Part C).
APhA encourages CMS to determine vaccine indicators for COVID-19, respiratory syncytial virus (RSV) measurement, and eventually Hepatitis B for adults ages 19-59 for HEDIS measurement year 2025. In addition, APhA supports lowering the denominator age from 66 to 65 years for measurement year 2025 for the pneumococcal indicator to account for multiple doses. APhA also continues to support adding the annual immunization status to the Star Ratings for Part C and D plans and attributing pharmacist vaccinations. For example, thanks to ongoing changes in state laws, pharmacists are playing an increasingly critical role in increasing influenza vaccination rates across the United States. The odds that an adult would receive the flu shot increased by 7.8 percent in states that allowed pharmacists to be immunizers. CDC data also confirms that every year pharmacists have consistently provided the most influenza vaccinations to adults. APhA urges CMS to aggregate data from MA prescription drug plans (MA-PD) and Part D plans to better monitor, measure, and attribute the impact different providers, including pharmacists, have on the vaccination rates of Medicare beneficiaries.

Polypharmacy: Use of Anticholinergic Medications in Older Adults (Poly-ACH) (Part D).
APhA supports the PQA update to the Poly-ACH measure specifications in the draft 2024 Measure Manual for the 2026 display page to align with the American Geriatric Society 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults that identified 14 medications for removal due to low usage or medication unavailability in the United States.

Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) / Poly-ACH (Part D).
APhA supports removing the index prescription start date (IPSD) from the measure for both Polypharmacy measures for the 2026 display page to more accurately apply to instances of 2 or more prescription claims for the same target medication on different dates of service when determining the earliest date of service for any target.

Use of Opioids at High Dosage in Persons Without Cancer (OHD) / Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) / Concurrent Use of Opioids and Benzodiazepines (COB) / Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D).
APhA supports PQA testing, and CMS considering, applying an update to exclude beneficiaries more broadly with cancer-related pain treatment from these opioid-related measures for measurement year 2025 to align with the updated 2022 Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain. APhA also supports the retirement of the OMP measure from the 2027 display page (2025 measurement year) if the PQA Measure Update Panel and Quality Metrics Expert Panel votes in favor of retirement consideration due to the very low measure rates that do not differentiate between good and poor performance.

Medication Adherence for HIV/AIDs (Antiretrovirals) (ADH-ARV) / Antipsychotic Use in Persons with Dementia, Overall (APD) / Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH) / Use of Opioids at High Dosage in Persons without Cancer (OHD) / Use of Opioids from Multiple Providers in Persons without Cancer (OMP) / Initial Opioid Prescribing -Long Duration (IOP-LD) (Part D).
APhA supports CMS applying continuous enrollment (CE) for the 2025 measurement year to align with the PQA measure specifications.

Poly-CNS / Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-ACH) / Concurrent Use of Opioids and Benzodiazepines (COB) / OHD / OMP (Part D).
If the PQA Quality Metrics Expert Panel (QMEP) vote on the removal of the anchor date in early 2024, then CMS will also not implement the anchor date to the applicable measures. Regarding COB, pharmacists should be able to dispense both opioids and benzodiazepines where clinically appropriate, appropriately dosed, and through communication with the beneficiary's physician. In addition, pharmacies should not be penalized as high dispensers of opioids due to their patient mix, or the fact that they are near pain clinics alone. APhA urges CMS and plans to monitor the COB measure for unintended consequences. For example, neither of these drug

classes can be stopped immediately and must be tapered gradually. CMS should also ensure that Part D plan measures do not encourage providers to get a patient off of one medication, or the other quickly simply to improve their quality scores.

Potential New Measure Concepts and Methodological Enhancements for Future Years

Medicare Plan Finder Drug Pricing Measure (Part D).
APhA supports CMS considering a new measure, similar to the MPF - Stability display measure, to evaluate the accuracy of sponsors' pricing data displayed on the Medicare Plan Finder (MPF) tool. APhA shares CMS' concern that some plans may be submitting artificially high or low prices to display on the MPF during the Annual Enrollment Period (AEP) and the need to evaluate MPF prices for drugs following AEP. Similarly, APhA encourages CMS explore examining whether Part D and MA-PD plans and their affiliated pharmacy benefit managers (PBMs) may be submitting inaccurate plan information on compliance with § 423.120 Access to covered Part D drugs which requires "[a]t least 70 percent of Medicare beneficiaries, on average, in rural areas served by the Part D sponsor [must] live within 15 miles of a network pharmacy that is a retail pharmacy." It's 90 percent, on average, within 2 miles of a network pharmacy for urban areas and 90 percent, on average, within 5 miles for suburban areas. Data from APhA members reflects that with PBMs' 2024 underwater contracts and ongoing pharmacy closures across the country, it is not feasible that many of the Part D plans are still in compliance with § 423.120 that are listed in MPF. If pharmacies continue closing down and many Part D plans are, in fact, noncompliant with § 423.120 then not only will seniors lose access to their necessary pharmacies, they will also lose access to compliant Part D plans.

Thank you for the opportunity to provide comments. APhA supports CMS' ongoing efforts to continue to improve Medicare's prescription drug programs and looks forward to continuing to work with CMS to reach that goal. If you have any questions or require additional information, please contact APhA at mbaxter@aphanet.org.

Sincerely,

Michael Baxter

Michael Baxter
Vice President, Federal and State Legislative Affairs