



American Pharmacists Association®

Improving medication use. Advancing patient care.

April 24, 2017

[Submitted electronically to PartCDcomments@cms.hhs.gov]

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: “2017 Transformation Ideas” in the Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and Final Call Letter

Dear Administrator Verma:

The American Pharmacists Association (APhA) is pleased to submit our comments on the Centers for Medicare & Medicaid Services (CMS’s) “Attachment I. Request for Information” (“RFI”) in the Notice of Methodological Changes for CY 2018 for MA Capitation Rates, Part C and Part D Payment Policies and Final Call Letter (the “Call Letter”). Founded in 1852 as the American Pharmaceutical Association, APhA represents 64,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and the uniformed services.

APhA appreciates CMS’s RFI soliciting suggestions to help it accomplish its goal for MA and Part D benefit flexibility, efficiency and innovation. APhA believes pharmacists are well-poised to make a difference in the care and health of Medicare beneficiaries, including those enrolled in MA and Part D plans. Physicians and other practitioners are challenged to meet the growing demand for health care and services due in part to the increasing number of Medicare beneficiaries, and the growing prevalence of chronic diseases, such as diabetes—thus, creating a mismatch between demand and capacity. Physician practices can greatly increase their capacity to meet patient demand if they reallocate appropriate clinical responsibilities to non-physician practitioners using a coordinated, team-based, patient-centered approach to care.¹ Unfortunately, while there are over 300,000 pharmacists in the U.S., many pharmacists are underutilized in their capacity to contribute to addressing these unmet health care needs because

¹ See Bodenheimer, Thomas. Et. al. Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians. *Health Affairs*. November 2013 vol. 32 no. 11 1881-1886. Available at: <http://content.healthaffairs.org/content/32/11/1881.full?ijkey=cvPTAIQBTEJ0o&keytype=ref&siteid=healthaff>

of coverage restrictions by Medicare and other payors.² What makes this an even greater loss of opportunity is that fact that 91% of Americans live within 5 miles of a pharmacy,³ and already have an established relationship with their pharmacist.

Pharmacists receive doctoral-level education and training, and are allowed by their state scope of practice to provide many patient care services beyond dispensing of medications.⁴ One area in which pharmacists can be better utilized to help patients while addressing a public health need is substance use disorder(s). Depending on state authority, pharmacists in a wide variety of practice settings, and in collaboration with other health care professionals, are being utilized as medication experts to develop treatment plans, order and interpret laboratory tests, and initiate, modify or discontinue medication(s). The misuse and abuse of medication(s), particularly opioids, and the availability of substance use treatment options is of great concern to everyone—policymakers, communities, families and health care providers. If Medicare and other payors covered services provided by pharmacists, patients could likely, and more easily, receive substance use and pain management services, which could help patients better manage pain and prevent addiction.

Additionally, pharmacists' participation on "patient care teams" has been shown to reduce adverse drug events and improve outcomes for patients with chronic diseases.⁵ Overall, research has shown that coordinated care models involving other health care practitioners, including pharmacists, are essential for realizing the maximum impact to patient care delivery.⁶ As vital members of patient care teams, APhA strongly believes that better integration of pharmacists into beneficiary care will help CMS transition the Medicare program toward value-based payment and delivery. We encourage CMS to use any regulatory flexibility to include pharmacists in the provision of care and services in Medicare, including MA, MA-PD and Part D plans—a win for patients and overall health care quality and cost.

I. Facilitate Pharmacists' Involvement in Patient Care

APhA's members are committed to continuous quality improvement and support the development and use of meaningful measures in Medicare that help patients achieve optimal health and medication outcomes. As stated in our comments on the CY 2018 Call Letter, APhA supports the addition of the Medication Reconciliation Post Discharge (Part C) measure to help determine MA-PD's star ratings and looks forward to working with CMS to add it to a broader set of future measures related to care transitions.⁷ For example, CMS should also consider pharmacists' roles in the Notification of Inpatient Admission, Receipt of Discharge Information,

² See Gums, John. Can pharmacists help fill the growing primary care gap? UF News. January 5, 2016. Available at: <http://news.ufl.edu/articles/2016/01/can-pharmacists-help-fill-the-growing-primary-care-gap.php>

³ NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

⁴ Services pharmacists can perform per state scope of practice include: comprehensive medication management, disease management, smoking cessation counseling, health and wellness screenings and services, pain management programs, substance use disorder treatment and care transition services.

⁵ Ibid.

⁶ See Mitchell, Pamela. Et. al. Core Principles & Values of Effective Team-Based Health Care. Institute of Medicine. October 2012. Available at: <https://www.nationalahecc.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf>

⁷ Inclusion of the medication reconciliation post-discharge measure in the MA-PD star ratings program is consistent with measures used in other CMS programs such as the ACO measures in the Medicare Shared Savings Program (MSSP) and the quality measures in the Merit-based Incentive Payment System (MIPS) within the Quality Payment Program (QPP).

and Patient Engagement after Discharge indicators. As the first health care practitioner patients often encounter post-discharge and the provider generally responsible for coordinating medication-related information between the hospital and primary care physician, patients could benefit greatly if pharmacists were better included in the sharing of pertinent clinical information. Accordingly, APhA strongly urges CMS to implement policies that facilitate pharmacists' involvement in a patient's care coordination process. Better, as well as earlier, incorporation of pharmacists and their medication expertise in patient care is consistent with the movement to coordinated care^{8,9} and other team-based care models to more effectively maximize the members of the health care team and benefit patients.

As CMS and its contractors¹⁰ consider the activities and measures that best represent new and existing care coordination for MA and MA-PD plans, APhA also requests that CMS consider examining the contributions of pharmacists to appropriate care coordination, especially as it relates to optimizing medication therapies. Medication-related problems often occur due to lack of care coordination, and pharmacists can play an important role in managing medications across multiple providers, including communicating medication information and exchanging reconciled medication lists. APhA believes it is important to be able to measure and quantify the contributions of pharmacists and other health care providers so successful practices can be highlighted and replicated.

II. Facilitate the Electronic Exchange of Clinical Information Between Pharmacists and Other Health Care Providers to Improve the Delivery of Coordinated, Team-Based Care and Benefit Patients

Pharmacists regularly provide services to improve safe and appropriate medication use; adherence for the elderly and other populations; medication reconciliation; wellness and prevention; chronic disease management programs; and case management for beneficiaries with multiple medications that require complex medication dosing regimens. However, pharmacists are frequently blocked from the electronic exchange of relevant clinical information, which is critical to maximize the benefit of coordinated team-based care. Therefore, we encourage CMS to establish policies that encourage and facilitate the electronic exchange of clinical information between pharmacists and other health care providers to improve the delivery of coordinated, team-based care and to benefit patients.

III. Reduce the Cost Threshold to Receive MTM Services

APhA appreciates CMS's continued support for MTM programs, which improve medication-related and overall health outcomes. Studies indicate that for every \$1 spent on MTM services, anywhere from \$4 up to \$12 is saved—in addition to cost savings, patients also realize significant improvements in key health measures.¹¹ Despite clear evidence supporting the value of pharmacist-led MTM services, these programs continue to be significantly underutilized. As APhA has previously stated, we strongly encourage CMS to revisit the cost threshold, as the

⁸ See, The Patient-Centered Primary Care Collaborative. "Integrating Comprehensive Medication Management to Optimize Patient Outcomes." June 2012. Available at: <https://www.pcpcc.org/guide/patient-health-through-medication-management>

⁹ See, American College of Physicians (ACP) – Practice Advisor. Collaborative Medication Management. Module. 2017. Available at: <https://www.practiceadvisor.org/Modules/improving-clinical-care/collaborative-medication-management/login>

¹⁰ Impaq International. CMS Awards IMPAQ Contract to Support Quantifiable Care Coordination Measures for Medicare Advantage Plans. November 10, 2015. Available at: <http://www.impaqint.com/media-center/press-releases/cms-awards-impaq-contract-support-quantifiable-care-coordination>

¹¹ Isetts, BJ. Et. al. Clinical and economic outcomes of medication therapy management services: the Minnesota experience. J Am Pharm Assoc. 2008; 48(2):203–11. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/18359733>

current \$3,967 excludes many beneficiaries with complex conditions, but smaller drug spends, who could benefit from MTM services. This point is reinforced by the fact that the United States spends \$300 billion annually on medication-related problems.¹² While APhA appreciates CMS's ongoing efforts to expand and enhance MTM, including the implementation of the Enhanced MTM Model test, we hope that CMS will continue to work collaboratively with pharmacists, plans, and beneficiaries to improve and streamline MTM eligibility criteria (including the number of medications and chronic conditions) in order to maximize the services' benefits to both patients and the larger health care system.

IV. Require Part D Plans Contract with Any Pharmacy Willing to Accept Their Contractual Terms and Conditions

APhA advocates for increasing patient access to affordable medications. APhA remains concerned Medicare beneficiaries are not able to receive medications and services from the pharmacy of their choice because of often overly-restrictive networks by Part D plans. APhA believes patient outcomes and satisfaction will result if Medicare beneficiaries are able to go to their pharmacy of choice. Accordingly, in order to help facilitate "individual preferences," as stated in the RFI, APhA emphasizes the need for Part D plans to contract with any pharmacy willing to accept their contractual terms and conditions.

APhA would also like to take this opportunity to advise CMS that a number of our members are encountering increases in the direct and indirect remuneration rate (DIR) that further threaten patient access. In many cases, the increases in the DIR fees for brand medications result in the pharmacy returning more money to the plan than the pharmacy receives in actual reimbursement for the medication. Pharmacies are seeing a similar trend for generic medications as well. Accordingly, APhA encourages CMS's help in preventing Part D plans' use of DIR or other fees as a mechanism to unfairly reduce reimbursement to pharmacists and pharmacies, and negatively impact patient access. Despite a firm commitment to patient access, the financial realities associated with very high DIR fees may force many pharmacies to withdraw from networks, further constricting service and accessibility in certain areas.

V. Replicate CMS's Use of Regulatory Flexibility

APhA is very grateful for CMS's continued recognition of the value of pharmacists and implementation of policies that promote pharmacists' involvement in patient care, such as pharmacists' inclusion in payment and care delivery models tested through CMS's Center for Medicare and Medicaid Innovation (CMMI); recognition of pharmacists as providers of MTM services in Medicare Part D; and the modified incident to physician supervision requirements for transitional care management (TCM) services and chronic care management (CCM). We appreciate CMS's willingness to use its regulatory flexibility to remove barriers preventing the efficient and effective delivery of care and medications to Medicare beneficiaries. As previously mentioned, there are legislative and regulatory barriers limiting beneficiary access to the skills and expertise of the pharmacist,¹³ and the potential for better care for patients, improved health for communities, and lower overall costs.

¹² NEHI. Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Adherence for Chronic Disease. August 2009. Available at: http://www.nehi.net/writable/publication_files/file/pa_issue_brief_final.pdf

¹³ See Avalere Health. Exploring Pharmacists' Role in a Changing Healthcare Environment. May 2014. Available at: <http://avalere.com/expertise/life-sciences/insights/exploring-pharmacists-role-in-a-changing-healthcare-environment>

One way to remove a barrier for Medicare beneficiaries to access pharmacists' services would be to take an approach similar to the CY 2017 Physician Fee Schedule (PFS) final rule,¹⁴ which expanded the types of individuals who can directly furnish and receive reimbursement for Medicare Diabetes Prevention Program (MDPP) services to "lifestyle coaches."¹⁵ Like pharmacists, lifestyles coaches are also not recognized as "eligible professionals" under §1848(k)(3)(B) or "practitioners" under §1842(b)(18)(C) of the Social Security Act. APhA supports the use of CMS's regulatory flexibility to increase the availability of and patients' access to appropriate care and services, especially for populations who needs are not being met, and encourages similar changes for pharmacists. Medicare coverage of pharmacists' services is even more impactful for medically underserved patients with chronic conditions because of the requirement for long-term management and monitoring and the importance of having care accessible.

Thank you for the opportunity to provide comments to the RFI regarding immediate changes that CMS can make regarding the benefit design, flexibility and/ or network composition of the MA-PD and Part D plans through the better incorporation of pharmacists and pharmacist services to improve the delivery and overall quality of patient care. We support CMS's ongoing efforts to improve Medicare's prescription drug programs and look forward to continuing to work with CMS to reach that goal. If you have any questions or require additional information, please contact Michael Baxter, Director of Regulatory Affairs, at mbaxter@aphanet.org or by phone at (202) 429-7538.

Sincerely,



Thomas E. Menighan, BSPHarm, MBA, ScD (Hon), FAPhA
Executive Vice President and CEO

cc: Stacie S. Maass, RPh, JD, Senior Vice President, Pharmacy Practice and Government Affairs, APhA
The Honorable Tom Price, M.D., Secretary, U.S. Department of Health and Human Services

¹⁴ See CMS. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017. Final Rule. November 15, 2016. 81 FR 80170. Available at: <https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>

¹⁵ See 81 FR 80478. "Because 45 CFR 160.103 specifies that health care includes preventive services, we believe MDPP coaches provide health care and are therefore health care providers under 45 CFR 160.103 and eligible to obtain NPIs."