March 1, 2014

[Submitted electronically to http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/]

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Request for Information: Evolution of ACO Initiatives at CMS

Dear Sir/Madam:

APhA is pleased to submit these comments regarding the Center for Medicare & Medicaid Innovation’s (“CMMI’s”) Request for Information (“RFI”) related to innovations for accountable care organizations (“ACOs”). Founded in 1852 as the American Pharmaceutical Association, APhA represents more than 62,000 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, managed care organizations, hospice settings, and the uniformed services.

We thank CMS for the opportunity to comment on new ACO models that encourage greater care integration and financial accountability. APhA considers patient-centered, coordinated care to be the gold standard. Thus, we fully support the transition of the U.S. health system to ACO and other integrated care delivery models that improve outcomes and contain costs. As stated in the RFI, one of CMMI’s primary goals is to give providers more tools and resources to improve care outcomes and efficiency. APhA strongly believes that better integration of the Part D prescription drug benefit, especially medication therapy management services (“MTM”), into ACOs is necessary achieve the goal of improved outcomes and efficiency.

Medications play a critical role in the prevention and management of chronic conditions, and the exclusion of Part D medications and related services from Medicare ACOs prevents ACOs from having full oversight over, and coordination of, a significant aspect of patients’ health care. In addition, the Part D MTM benefit is siloed and not well coordinated with the clinical services of other health professionals on a patient’s health care team. Better integration of MTM services, and the pharmacists who provide them, with the rest of the health care team would help align clinical goals for the patient, better coordinate the care provided, avoid confusion, and ultimately contribute to more efficient and effective care. As demonstrated by the successes in longstanding integrated-care delivery programs like Kaiser Permanente, the Veterans Administration, and Geisinger Health System,
including MTM services delivered by pharmacists as part of team-based care results in improved health outcomes for patients.

APhA strongly advocates the full integration of MTM services and pharmacists into the Medicare ACO infrastructure. Pharmacists are the medication experts of the health care team, and without their participation, ACOs are unlikely to reach their cost and quality goals. While we strongly recommend the full incorporation of pharmacist services into ACO models, at present there are number of barriers to the most full and effective integration. We address these issues below.

I. Pharmacists Are Left Out of the ACO “Care Team”

The inclusion of pharmacists on the care team, including ACO care teams, can have a profound impact on overall quality of care.1 APhA’s member pharmacists who participate in ACOs have indicated to us that the opportunity to work with other health professionals on the care team on a regular basis improves communication and coordination and provides an often missing in-depth focus on medications by the pharmacist that leads to improved care for patients.2 One member noted that as the pharmacist on the care team, she often caught medication errors and patient adherence issues, resulting in better patient outcomes.

To promote the inclusion of pharmacists in ACOs, APhA supports both integration of pharmacists within the ACO infrastructure (which can be complicated by payment constraints—see Section II below) and contracting between community pharmacies and ACOs. Direct contracting between an ACO and a community pharmacy(ies) may provide additional patient access to services, particularly in rural and underserved areas. Pharmacists practicing in a community pharmacy setting can provide MTM, medication reconciliation, and assistance with care transitions to help manage medication use issues and avoid adverse drug events. We encourage CMMI to explore and implement strategies for integrating medication management services through contracts with community pharmacists and pharmacies.3

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2 For additional background information on the issue of pharmacist participation in ACOs, we have attached a forthcoming APhA Issue Brief on the Topic. Because this is not yet public, we ask that CMMI treat it as confidential (Addendum 1).

3 Some ACOs are already contracting with community pharmacies, with good results. UnityPoint’s Trinity ACO in Iowa is currently engaged in a project incorporating community pharmacists in its care teams. Under the Trinity model, MTM services will be provided by a team comprised of ACO personnel and pharmacists in participating community pharmacies.
As value-based health care becomes the norm, greater emphasis is placed on meeting quality metrics. Of CMS’s thirty-three ACO metrics, twelve are directly related to medications.\(^4\) Alignment of MTM services between Part D and ACOs will allow ACOs to optimize medication use in an efficient and effective manner, which makes practical and financial sense.

**II. Payment for Pharmacists Is Not Sufficient in Current ACO Models**

Pharmacists have the potential to help ACOs reach their cost and quality goals—yet in discussions with our members who are trying to participate in ACOs, lack of pharmacists’ Medicare Part B fee-for-service payment is a barrier, especially in ACOs that have not moved to fully capitated payment systems. For pharmacists embedded in physician office practices, “incident to” billing under Medicare Part B is an option in some cases, but by itself is not sufficient to support a pharmacist’s practice. For pharmacists not practicing directly in a physician office practice (i.e., community pharmacists, consultant pharmacists), there are few, if any, payment options to support a pharmacist as part of team-based care in an ACO. The medication management and other services pharmacists can provide improve care quality and patient outcomes, but the current Pioneer ACO payment model not only fails to incentivize pharmacist participation, it creates a substantial barrier to pharmacist inclusion on care teams. We encourage CMS and CMMI to consider payment methodologies that expand opportunities for pharmacists to actively engage in ACOs so that ACOs can capitalize on pharmacists’ patient care services, including medication management services.

**III. Pharmacists Are Not Included as Providers Under Section 1899 of the Social Security Act**

As discussed above, if pharmacists are not included in ACOs and other integrated care delivery models, it will be difficult to reach the goal of fully coordinated care. Because pharmacists are not included in the statutory definition of “ACO Professionals”, they are effectively limited from full participation in Medicare ACOs.\(^5\) Thus, Medicare ACOs can make arrangements with pharmacists for their participation in ACOs, but currently pharmacists are not a recognized and required member of the ACO health care team.

Members of Congress have expressed their support for the inclusion of pharmacists in the ACO statute. During the Sustainable Growth Rate discussions of 2013, Senators Grassley (R-IA) and Carper (D-DE) proposed an amendment to “include licensed pharmacists as providers of services in team-based or integrated care activities with one or more of the other defined groups and suppliers”, which would have promoted the inclusion of pharmacists in ACOs.\(^6\) Ultimately the amendment was not offered due to time constraints, but the idea has many supporters in the clinical and legislative arenas.

We strongly encourage CMMI to work with CMS to clarify that pharmacists can and should participate in Medicare ACOs. By including pharmacists as part of the patient’s health care team,

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\(^4\) For additional information on medication use in ACOs, we have attached APhA’s Issue Brief on the topic (Addendum 2).


patients, communities and the health care system will benefit through better health outcomes, care, and reduced overall health care cost.

IV. Pharmacists Do Not Have the Necessary Access to Electronic Health Records

Pharmacists working in contracted arrangements with ACOs have indicated to APhA that they do not always have optimal access to health information technology (“HIT”). For instance, one group we spoke with does not have full read/write access to patients’ electronic health records (“EHR”), and, as a result, is forced to rely on faxes for the transmission of information necessary for MTM services. The faxed information is often incomplete, which makes effective and efficient medication management difficult, especially during care transitions, where lag time and incomplete clinical information can have a profound impact on patient readmissions. Given the considerable focus on HIT upgrades in both the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act of 2010, reliance on faxes for sharing information with other providers seems antiquated and burdensome. Thus, we recommend that CMMI work with ACOs to ensure that as pharmacists are integrated into care teams, they are provided read/write EHR access, and that, where available, HIT systems integrate pharmacists’ medication management services into the patient’s overall care record.

It is also important to note that in many cases, pharmacists are told that they cannot have access to EHR systems due to Health Information Portability and Accountability Act (“HIPAA”) compliance concerns. This type of information sharing is explicitly covered by HIPAA, so we encourage CMMI to work with the U.S. Department of Health and Human Services (“HHS”) to ensure that all providers are well-versed on HIPAA legal requirements so that the information-sharing necessary for effective coordinated care is not compromised.

In conclusion, pharmacists offer many services, including MTM, which improve care quality and patient outcomes in a cost-conscious manner. However, there are currently a number of barriers, including payment, HIT and EHR access, and provider status, to effective integration of pharmacists in ACOs. As CMMI continues to explore new ACO initiatives, we hope you will use APhA as a resource. We look forward to working with CMMI and other ACO stakeholders to find innovative solutions to full and effective care coordination across the entire spectrum of providers and the health system as a whole.

Thank you for the opportunity to provide information on this important issue. If you have any questions or require additional information, please contact Jillanne Schulte, JD, Director of Regulatory Affairs, at jschulte@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
    Anne Burns, Senior Vice President, Professional Affairs

7 See 45 C.F.R. § 164.506.