



American Pharmacists Association[®]
Improving medication use. Advancing patient care.

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-801

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Proposed Rule

APhA is pleased to submit these comments regarding the Centers for Medicare & Medicaid Services (CMS's) proposed rule regarding changes to the Medicare physician fee schedules and billing requirements for Congressional Year (CY) 2017 (the "Proposed Rule"). 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, physician office practices, community health centers, managed care organizations, hospice settings, and the uniformed services.

APhA supports CMS's ongoing recognition in the Proposed Rule of the significant contributions of physicians in addressing U.S. health care needs. However, physicians and other practitioners are challenged to meet the growing demand for patient care services from the eighty million aging baby boomers, insurance expansion, 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 There are over 300,000 pharmacists in the U.S., many of whom are underutilized in their capacity to contribute to addressing these unmet health care needs.² Pharmacists receive doctoral-level education and training, with some pharmacists furthering their training to become specialists with board certification. Pharmacists' participation on "patient care teams" has been shown

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>

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>

to reduce adverse drug events and improve outcomes for patients with chronic diseases.³ In addition, research has shown that coordinated care models involving other health care practitioners, including pharmacists, are essential for realizing the maximum impact of patient care delivery.⁴ As vital members of patient care teams, APhA strongly believes that better integration of pharmacists into Medicare is necessary as CMS continues to transition toward value-based payments.

Accordingly, APhA's comments focus on the Proposed Rule's provisions that provide additional opportunities to implement policies that maximize the benefits of coordinated team-based care by promoting pharmacists' involvement in patient care—a win for patients and for overall health care quality and cost.⁵ Specifically, APhA offers comments on improving patient participation in chronic care management (CCM); recognizing pharmacists as one of the primary providers of Diabetes Self-Management Training Services (DSMT); expanding the Medicare Diabetes Prevention Program (MDPP); adding medication management to assist behavioral health integration under the Psychiatric Collaborative Care Model (CoCM); aligning Accountable Care Organization (ACO) quality measures with the Quality Payment Program (QPP) measures under the Medicare Access and CHIP Reauthorization Act (MACRA); and increasing transparency by releasing Medicare Advantage (MA) bid pricing data and Part C and Part D Medical Loss Ratio (MLR) data.

I. Improving Patient Participation in CCM

CCM services add value to the health care system through improved patient access and care coordination. APhA appreciates CMS's proposals to address barriers to participation in CCM programs, many of which have been expressed by APhA members and articulated in previous APhA comments to CMS. In line with that stated goal, APhA supports the following proposed modifications to the CCM program for 2017 that include: implementing additional CPT codes for more complex CCM, changing the requirements for electronic sharing of information, modifying the initiating visit requirement for established patients, easing the beneficiary consent process, and expanding the supervision exception under the "incident to" rules to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

- Removing Beneficiary Co-Pays for CCM: While CMS has determined that it does not have the statutory authority to exempt CCM from cost sharing requirements, from pharmacist clinician feedback, the monthly cost sharing fee is a significant burden for beneficiaries and an administrative burden for practitioners. Cost has the potential to be an even greater burden for beneficiaries who receive complex CMM (under a higher fee structure), if it is implemented in 2017.

APhA encourages CMS to explore alternative co-payment relief under existing statute and/or to work with Congress on legislative options. For example, APhA supports the classification of CCM as a preventive service with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF) which would remove the cost sharing

³ 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>

⁴ See Mitchell, Pamela. Et. al. Core Principles & Values of Effective Team-Based Health Care. Institute of Medicine. October 2012. Available at: <https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf>

⁵ 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>

requirement.^{6,7} By addressing the cost barrier, APhA believes patients who can benefit most greatly from CCM services will take advantage of the benefit and consequently, improve their health outcomes and decrease their costs and help lower Medicare costs over the long-term.

- Activating Additional CPT Codes for More Complex CCM Services (pgs. 46205-46207): APhA agrees with CMS “that the resources required to furnish complex chronic care management services to beneficiaries with multiple (that is, two or more) chronic conditions were not adequately reflected in the existing E/M and CPT codes.”⁸ Based on APhA member feedback, the one-size-fits-all CCM codes do not work well for clinicians.

APhA had previously supported CMS’s proposal to create add-on codes to take the complexity of a patient’s condition into account when billing for CCM services. Although, since CMS’s establishment of CPT code 99490,⁹ many practitioners in a number of forums and in public comments to the CY 2016 PFS final rule, have stated that the CCM service elements and billing requirements “are burdensome, redundant and prevent them from being able to provide the services to beneficiaries who could benefit from them.” Additionally, practitioners have stated that the code is underutilized because it is underpaid relative to the resources involved in furnishing the services. Therefore, APhA supports CMS’s proposal to allow for separate payments using CCM CPT codes 99487, 99489, and 99490, as appropriate, and hopes CMS continues to pursue ways to decrease the administrative burden associated with CCM and other Medicare services’ billing requirements.

Additionally, APhA requests clarification of, or changes, to account for the practitioner’s time spent with a beneficiary that is greater than 20 minutes, but under one hour. It is important to note that the Relative Value Scale Update Committee’s (RUC) original CCM code recommendation to CMS was for 1 hour of non-face-to-face services, but CMS only approved 20 minutes of services per month in the 2015 physician fee schedule final rule.¹⁰ As currently proposed, CPT code 99487 would require 60 minutes of clinical staff time as compared to the minimum of 20 minutes under 99490. Therefore, APhA requests that CMS allow for the billing of services between 20 and 60 minutes. Mechanisms could include allowing 99490 to be used more than once or by allowing the use of 99489 alone and/or with 99490, not just as an add-on service with CPT code 99487. APhA also

⁶ See F.R. 78, 74424. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf>. Also, See F.R. 79, 67718. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf>

⁷ See §1861(ddd)(1)(A). Available at: https://www.ssa.gov/OP_Home/ssact/title18/1861.htm

⁸ CMS states that “medical practice and patient complexity required physicians, other practitioners and their clinical staff to spend increasing amounts of time and effort managing the care of comorbid beneficiaries outside of face-to-face E/M visits, for example complex and multidisciplinary care modalities that involve regular physician development and/or revision of care plans; subsequent report of patient status; review of laboratory and other studies; communication with other health care professionals not employed in the same practice who are involved in the patient’s care; integration of new information into the care plan; and/or adjustments of medical therapy.”

⁹ At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month (30 day time frame), with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised or monitored.

¹⁰ See AMA. Comments on Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 Final Rule. November 13, 2014. Pg. 146. Available at: <https://www.regulations.gov/document?D=CMS-2015-0081-2303>

requests that CMS clarify that a practitioner can bill for more than one 30-minute service (99489) provided beyond 60 minutes each month which we believe is consistent with CMS's intent to better meet the needs of beneficiaries with chronic diseases.¹¹

Furthermore, APhA requests that CMS recognize the team-based nature of CCM in the use of the proposed temporary GPPP7 code for initiating visits. While we recognize the importance of incentivizing physician time in the development of the patient's care plan, the entire patient-care team (including pharmacists) is typically involved in the development of the plan. Therefore, APhA recommends CMS change the term "personally performs" to "supervises" under the provision that states, "when the billing practitioner initiating CCM personally performs extensive assessment and care planning outside of the usual effort described by the billed E/M code."

Clarifying the ability to factor complexity into the codes should make it financially feasible for health care practitioners to provide the services to those who need and would benefit from CCM the most—patients with complex conditions. In addition, due to the fact that a significant percentage of CCM services are medication-related, engaging pharmacists, the medication experts on the health care team, in the provision of CCM services will be vital to ensuring successful patient outcomes.

- Changing Electronic Information Sharing Requirements (pgs. 46209-46211): APhA supports CMS's proposals to ease electronic documentation and information sharing requirements for CCM. This includes the Proposed Rule's change from requiring CCM providers to have 24/7 access to an electronic care plan to requiring that providers electronically capture care plan information and share it in a timely manner, including via fax. Allowing flexibility will help to facilitate participation in CCM by providers, who are working toward implementation of electronic health records (EHRs), but have not fully implemented them yet. In addition, it will provide an opportunity for greater participation in CCM by pharmacists in different practice settings because many pharmacists, outside of those participating in integrated care models, lack the incentives to implement EHRs, or do not have the ability to access and exchange clinical information through EHRs. Increasing access and bi-directional communication by, and between, all members of the health care team is critical to maximize the contributions of all of the health care practitioners on patients' care teams, and to continue CMS's movement to value-based care.

While APhA is supportive of easing the documentation and information sharing requirement for CCM providers, APhA members have encountered third-party vendors who consider up to 90 days to be "timely." Therefore, APhA requests that CMS better define the term "timely" when referring to providers inputting and receiving CCM information.

- Modifying the Initiating Visit Requirement for Established Patients (p. 46208): APhA strongly supports CMS's proposal to ease the requirement for "all beneficiaries" to receive CCM initiating visits to only "new patients or patients not seen within one year."

¹¹ The Proposed Rule states that all three codes (99487, 99489, 99490) may "only be reported once per service period," and "only by the single practitioner who assumes the care management role with a particular beneficiary period." Yet, the proposed rule also mentions billing for "each unit of CPT code 99489."

We support CMS’s approach that “allows practitioners with existing relationships with patients who have been seen relatively recently to initiate CCM services without furnishing a potentially unnecessary E/M visit.” In addition, APhA is very pleased that CMS is allowing transitional care management (TCM) services (CPT 99495 and 99496) to serve “as a “comprehensive” visit for CCM initiation.”

- Easing the Beneficiary Consent Process (p. 46210): APhA members have indicated that the consenting process, which occurs as part of a longer visit, can be quite onerous. Accordingly, APhA generally supports CMS’s proposal to ease the beneficiary consent process by no longer requiring and documenting the beneficiary’s written consent to participate in CCM services, and instead, allowing practitioners to document that consent was given in the beneficiary’s medical record—a change that should help in the initiation process. However, APhA members are concerned about the impact that easing the consent mechanism may have on beneficiary understanding of the benefits and requirements of CCM services, and the accompanying copays. Therefore, APhA strongly recommends that CMS also target appropriate resources towards increasing the public’s awareness and understanding of CCM (e.g., through patient education programs, public outreach, etc.).¹²
- Applying General Supervision for CMM and TCM at RHCs and FQHCs (pgs. 46211, 46377-78): In previous comments, APhA has requested that CMS develop a CCM framework for FQHCs to allow auxiliary personnel, including pharmacists, to provide CCM services. Due to their unique regulatory requirements, FQHCs have been prevented from utilizing pharmacists for some services that pharmacists can provide in other health care settings (e.g., Annual Wellness Visits). Accordingly, APhA appreciates the Proposed Rule’s provision to permit general supervision instead of direct supervision for all health care team members (including pharmacists as “auxiliary personnel”) providing CCM and TCM services in FQHCs and RHCs.

Finally, APhA encourages CMS to explore mechanisms to effectively measure the quality of CCM services, including the identification of meaningful quality metrics. As in other value-based programs, it will be important to measure the impact of CCM on patient outcomes and the health care system in general.

II. Enrolling Pharmacists as Certified DSMT Providers and Including Pharmacies as DSMT Locations (pgs. 46215-46216)

APhA appreciates CMS’s recognition of pharmacists as instructors “who actually furnish DSMT services...,” however, as CMS states, pharmacists “do not qualify to enroll in Medicare as certified providers, as that term is defined at section 1861(qq)(2)(A) of the [Social Security] Act, and codified in our regulations at § 410.140 as approved entit(ies).” Yet, § 1861(qq)(2)(A) states that DSMT services can be provided by “certified providers,” which include “individual[s]” who meets “quality standards established by the Secretary...” “...for furnishing these services.” While pharmacists and their services are not listed under § 1861 and therefore, are not eligible to directly bill for DSMT services, accredited pharmacies are able to provide such services upon meeting certain requirements.

¹² Section 103 of MACRA also requires CMS to assess and report to Congress, by December 31, 2017, on access to CCM services by underserved rural, racial and ethnic minority populations and to conduct an outreach/education campaign.

However, APhA members experience barriers to providing DSMT services due to lack of awareness that accredited pharmacies can bill for DSMT services and that pharmacists are recognized DSMT instructors. For example, it took one community pharmacy 9 months to receive a National Provider Identifier (NPI) to bill for DSMT services primarily because of processor assertions that a pharmacy should only be requesting an NPI for Part D services. In addition, our members have had claims rejected when submitting bills from a DSMT accredited pharmacy because a pharmacist signed the billing paperwork and not a Part B DSMT certified provider.¹³ Policies that allow a pharmacist to be an instructor for an accredited DSMT pharmacy but not sign the bills for DSMT services, not only seems illogical, it is inconsistent with CMS's policies and desire to make such services accessible to patients. In many cases, the pharmacist is the most accessible health care provider in a community and may be the sole instructor for DSMT. Furthermore, when pharmacists inquire about DSMT billing problems to CMS or Medicare Administrative Contractors, staff are not aware of pharmacists and pharmacies' roles in DSMT. Therefore, APhA requests that CMS clarify the ability of pharmacists and pharmacies to provide DSMT services in education and training materials for staff and in information for patients and other stakeholders about the program and its benefits. This acknowledgement and awareness will address concerns expressed in the Proposed Rule, that "claims have been rejected or denied because of confusion about the credentials of the individuals who furnish DSMT services," and help address the "issues that may contribute to the low utilization of these services." APhA also asks CMS to clarify that a DSMT accredited pharmacy can bill for services without sign-off from a Part B DSMT accredited provider—a position reinforced by the fact that CMS and national accreditation organizations (NAOs) allow pharmacists to be DSMT certified instructors.

Similarly, while APhA appreciates CMS reiterating the settings and locations where DSMT services may be provided in the Proposed Rule,¹⁴ APhA also strongly recommends that CMS clarify in the Medicare Benefit Policy Manual, Chapter 15, Section 300¹⁵ that DSMT services are already permitted at pharmacies that meet CMS's and NAO's requirements.¹⁶ Moreover, to truly maintain the viability of DSMT programs, APhA urges CMS to update the outdated terminology and design of the benefit. APhA recommends that CMS adopt the updated terminology defined in the 2016 Standards of Medical Care in Diabetes, "diabetes self-management education and support" or "DSME/S." This terminology reflects the continuous support that diabetes patients need in managing their chronic condition as patients may require intensified re-education and self-management planning and support that often go beyond the current DMST benefit. In addition, CMS should also consider allowing additional hours of DSMT for beneficiaries, similar to the Medical Nutrition Therapy (MNT) benefit,

¹³ See § 1848(k)(3)(B) and 1842(b)(18)(C). Available at: https://www.ssa.gov/OP_Home/ssact/title18/1848.htm

¹⁴ See 81 Fed. Reg. 46216 – which states "In the case of DSMT services furnished by an entity that submits professional claims to the A/B Medicare Administrative Contractor (MAC), such as a physician's office or an RD's practice, DSMT services may be furnished at alternate locations used by the entity as a practice location; and (b) when the DSMT services are furnished by an entity that is a hospital outpatient department (HOPD), [that] these DSMT services must be furnished in the hospital (including a provider-based department) and cannot be furnished at alternate non-hospital location."

¹⁵ See CMS. Medicare Policy Benefit Manual. Section 300. May 13, 2016. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>

¹⁶ In accordance with § 410.144, a CMS-approved NAO may accredit an individual, physician or entity to meet one of three sets of DSMT quality standards: CMS quality standards; the National Standards for Diabetes Self-Management Education Programs (National Standards); or the standards of an NAO that represents individuals with diabetes that meet or exceed our quality standards. Currently, CMS recognizes the American Diabetes Association and the American Association of Diabetes Educators as approved NAOs, both of whom follow National Standards. Medicare payment for outpatient DSMT services is made in accordance with §414.63.

during the four critical times¹⁷ identified in the Joint Position Statement of the American Association of Diabetes Educators (AADE), the American Diabetes Association (ADA) and the Academy of Nutrition and Dietetics (AND).¹⁸ Investing in a more robust service for certain high-risk diabetes patients can help improve their quality of life and health outcomes, and prevent high-cost services and procedures.

APhA also recommends that CMS increase payments for the G0108 and G0109 codes. Lower reimbursement rates have resulted in lower utilization of DSMT services. These services will have no impact on patients if there is not a sustainable business model for providers.¹⁹ APhA also requests that CMS consider allowing DSMT to be provided on the same day as other provider visits. Transportation is a significant barrier for many patients, and APhA members have indicated that allowing DSMT on the same day as other visits, and virtual DSMT visits, would help to alleviate the transportation barrier to participate in DSMT.

III. Supporting Pharmacists Inclusion in the Medicare Diabetes Prevention Program (MDPP) Model

The clarification of pharmacists and pharmacies' roles under DSMT may also help with pharmacists' participation under CMS's proposed expansion of the MDPP model. The MDPP is yet another program that may benefit from the increased participation of pharmacists as part of a coordinated approach to help prevent diabetes. For example, while the current MDPP model provided federal funding to YMCAs, these facilities are not available in every community. In contrast, nearly 86% of Americans live within five miles of a community pharmacy,²⁰ and the inclusion of pharmacists as part of patients' health care teams can have a profound impact on access, quality, health outcomes and costs, particularly in medically underserved communities.

Accordingly, APhA supports the provision in the Proposed Rule that permits MDPP suppliers (including Lifestyle Coaches and Diabetes Prevention Coordinators) with preliminary or full recognition from the Center for Disease Control (CDC) Diabetes Prevention Recognition Program,²¹ "who are not already enrolled in Medicare (on the basis of being an existing Medicare provider or supplier) to apply to enroll any time on or after January 1, 2017." Under CDC's current "eligibility" requirements, it states that "Lifestyle coaches may have credentials (e.g., RD, RN), but credentials are not required." As all pharmacists are already licensed, have extensive education and training, and provide a broad array of prevention and wellness services,²² pharmacies could potentially serve in a

¹⁷ The Joint Statement identified for critical times for allowing additional hours of DSMT: 1. New diagnosis of type 2 diabetes; 2. Annually for health maintenance and prevention of complications; 3. When new complicating factors influence self-management; and 4. When transitions in care occur.

¹⁸ Powers, Margaret. Et. al. A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. Diabetes Self-management Education and Support in Type 2 Diabetes. 2015. Available at: https://www.diabeteseducator.org/docs/default-source/practice/practice-resources/position-statements/dsme_joint_position_statement_2015.pdf?sfvrsn=0

¹⁹ According to AADE comments, "Medicare payment for G0109 has decreased 23% from 2011 to 2016 (2011 was \$18.69 and 2016 is \$14.32). Correlating with decreased reimbursement, Medicare claims data show that G0109 also had a 23% decrease in utilization. G0109 had \$136,103 in claims in 2011, and with the latest available data being 2014 – it had decreased to \$105,116."

²⁰ NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

²¹ CDC. Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. January 1, 2015. Available at: <http://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf>

²² 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>

valuable role as sites for MDPP. Pharmacists could either function as, or oversee pharmacy technicians, as Lifestyle Coaches/Diabetes Prevention Coordinators. APhA is also encouraged by the Proposed Rule's provisions to "allow MDPP suppliers to provide MDPP services via remote technologies." Accordingly, APhA recommends that CMS state that pharmacies qualify as "virtual...site[s] of the service in codes included on claims submitted for payment." In addition, we encourage CMS to evaluate provider participation in and patient utilization of services through the MDPP model and make changes, as necessary, to make certain the model is sustainable to achieve its intended goal of benefitting patients.

IV. Including Pharmacists Under CoCM Models to Evaluate All Beneficiaries' Medications (pgs. 46203-46205)

In order to increase patient access to Psychiatric CoCM medication management services, APhA urges CMS to highlight pharmacists' participation in CoCM education and information materials, and to reach out to pharmacists to facilitate their participation in providing these services.²³ As stated in the Proposed Rule, CMS plans to use "psychiatric consultants," "whose consultative services are furnished incident to services of the treating physician or other qualified health care professional. Patients who are appropriate candidates to participate in the psychiatric CoCM²⁴ may have newly diagnosed conditions, need help in engaging in treatment, have not responded to standard care delivered in a non-psychiatric setting, or require further assessment and engagement prior to consideration of referral to a psychiatric care setting." These "psychiatric consultants," must be medical professionals "trained in psychiatry and qualified to prescribe the full range of medications..." and they would make "...recommendations, as needed, for psychiatric and other medical care, including psychiatric and other medical diagnoses, treatment strategies including appropriate therapies, medication management, medical management of complications associated with treatment of psychiatric disorders, and referral for specialty services, that are communicated to the treating physician or other qualified health care professional, typically through the behavioral health care manager." When it comes to conducting CMM,²⁵ psychiatric and neurologic pharmacists can provide "psychiatric consultant" services, outside of diagnoses, and could serve a valuable role working with mental health providers as members of behavioral patient care teams. Additionally, the models that CMS cites in the Proposed Rule focus on depression and anxiety—which are only part of a much larger array of behavioral health conditions that may require participation in a CoCM. Accordingly, to increase the availability of these important services, we strongly urge CMS to perform outreach out to psychiatric and neurological pharmacists, as well as pharmacists with proper training, to help facilitate their awareness of and participation in CoCM models. More generally, whether in the Psychiatric CoCM or other coordinated care models, APhA recommends that CMS continue to

²³ As stated by CMS, "CoCM typically is provided by a primary care team, consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate."

²⁴ CPT has approved three codes that describe services furnished consistent with the psychiatric CoCM, but that they will also not be ready in time for valuation in 2017. To facilitate separate payment for these services furnished to Medicare beneficiaries during 2017, CMS is proposing to make payment through the use of three temporary G codes (GPPP1, GPPP2, and GPPP3), as well as a fourth temporary G code (GPPPX) to describe services furnished using a broader application of behavioral health integration in the primary care setting (extensive conversations between primary care physicians and specialists).

²⁵ 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>

develop policies encouraging the integration of pharmacists so that beneficiaries receive optimal care and avoid medication-related problems.

V. **Aligning ACO and QPP Quality Measures to Recognize Pharmacists and Other Health Care Practitioners' Contributions to Quality (p. 46420)**

APhA supports CMS's proposed revisions to the ACO quality measure set in order to better align CMS quality reporting initiatives and reduce their burden on providers. Requiring the Medication Reconciliation Post-Discharge measure (ACO-12) in place of the current Documentation of Current Medications measure (ACO-39), as recommended by the Core Quality Measures Group, will better align the Shared Savings Program quality measure set with the Quality Payment Program (QPP) under the recently proposed MACRA rule. Generally, APhA supports the Medication Reconciliation Post-Discharge measure because of the significant medication-related problems encountered during care transitions. However, this measure is narrowly focused on care transitions, and medication-related problems span the health care continuum. Accordingly, APhA encourages CMS to continue to seek and implement medication-related measures that have a meaningful impact on optimizing medication use throughout the health care system.

Multiple studies have found evidence that pharmacist-led processes could prevent medication discrepancies and potential Adverse Drug Events (ADEs) after discharge.²⁶ However, as stated in pharmacy organizations' joint comments on MACRA,²⁷ because pharmacists are not Merit-Based Incentive Payment System (MIPS) "eligible clinicians,"²⁸ or "ACO professionals,"²⁹ it difficult to quantify the attribution of a pharmacist's contributions in these payment models. As the complexity and use of medications continues to increase, so will the role that proper medication management will play under MIPS, APMs, and Advanced APMs. Consequently recognizing the unique and essential contributions of pharmacists, the medication experts on the health care team, is fundamental to assisting CMS to meet its goals of improving the quality of care and reducing costs.³⁰ Therefore, APhA strongly urges CMS to seek mechanisms to appropriately attribute the role that pharmacist

²⁶ See Kilcup, M. Et. al. Postdischarge pharmacist medication reconciliation: impact on readmission rates and financial savings. *Journal of the American Pharmacists Association*. 2003. 2013 Jan-Feb; 53(1). Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23636160>. See Mueller, SK. Et.al. Hospital-based medication reconciliation practices: a systematic review. *Arch Intern Med*. 2012;172:1057-1069. Available at: <https://psnet.ahrq.gov/resources/resource/24689>. Also, See Shekelle, PG. Et al. Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices. Rockville, MD: Agency for Healthcare Research and Quality; March 2013. AHRQ Publication No. 13-E001-EF. Available at: <https://psnet.ahrq.gov/resources/resource/25758>

²⁷ Joint Pharmacy Organizations. Comments to CMS on MACRA Proposed Rule Final. June 27, 2016. Available at: <https://www.regulations.gov/document?D=CMS-2016-0060-3474>

²⁸ See Section 1848(k)(3)(B) - uses the term "eligible professional." Both eligible clinician and eligible professional mean any of the following: (i) A physician. (ii) A practitioner described in section 1842(b)(18)(C). (iii) A physical or occupational therapist or a qualified speech-language pathologist. (iv) A qualified audiologist (as defined in section §1861(l)(3)(B)). §1842(b)(18)(C) of the Social Security Act defines a "practitioner" as any of the following: (i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)). (ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)). (iii) A certified nurse-midwife (as defined in section 1861(gg)(2)). (iv) A clinical social worker (as defined in section 1861(hh)(1)). (v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)). (vi) A registered dietitian or nutrition professional. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1848.htm

²⁹ See §1899(h) "(1) ACO PROFESSIONAL.—The term 'ACO professional' means— (A) a physician (as defined in section 1861(r)(1)); and (B) a practitioner described in section 1842(b)(18)(C)(i)." Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

³⁰ HHS. National Strategy for Quality Improvement in Health Care. Report to Congress. Agency for Healthcare Research and Quality (AHRQ). March 2011. Available at: <http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf>

services and pharmacists play in relevant quality measures and payment codes in its forthcoming final rules. Furthermore, APhA urges CMS to work with Congress on Medicare improvements that require legislative changes,³¹ especially efforts to increase health care access for medically underserved beneficiaries.

VI. Reporting MTM in MA Bid Pricing and Part C and Part D MLR Data (pgs. 46396-46406)

APhA was very pleased that the 2013 final rule for Medicare Part D and MA-PD plans allowed costs from MTM programs to count as quality improvement activities (QIAs) under these plans' MLR calculations.³² The MLR provides a financial incentive for health insurers to reduce administrative costs and spend more on health care QIAs. As CMS knows, MTM is not an administrative task provided by non-health care professionals.³³ MTM is medical care, provided by pharmacists, whose aim is to improve drug therapy and therapeutic outcomes for patients.³⁴ Considering MTM a health care QIA makes plans more likely to invest in and offer this service—which relies on pharmacists to improve medication use and adherence and reduce the risk of adverse events (medication errors)—which enhances patient safety and promotes health and wellness. As the costs of MLR QIAs are included in the bids that MA-PD plans submit to CMS, releasing aggregate MA-PD bid pricing data (5 years prior to the current year), and Part C and Part D MLR data could represent an opportunity to improve the public's understanding of these programs. However, the Proposed Rule bid release only applies to MA plans and specifically excludes “information pertaining to the Part D prescription drug bid amount for an MA plan offering Part D benefits, specifically the information required for Part D bid submission at § 422.254(b)(1)(ii), (c)(3)(ii), and (c)(7).”

Generally, APhA is supportive of CMS's ongoing transparency efforts and its desired goal in the Proposed Rule to “use such information for [the] purposes of improving public health through research on the utilization, safety, effectiveness, quality and efficiency of health care services.” As CMS has recognized the value of MTM and advocated for its use beyond statutory requirements, APhA continues to advocate for better transparency regarding MTM services within MA-PD and Part D plans. Ultimately, APhA believes additional transparency of data related to MTM services and utilization will benefit beneficiaries and the program by better identifying the impact of particular MTM service components.

³¹ See (H.R. 592/S. 314). The Pharmacy and Medically Underserved Areas Enhancement Act. Introduced January 28, 2015. Available at: <https://www.congress.gov/bill/114th-congress/house-bill/592/text?q=%7B%22search%22%3A%5B%22%5C%22hr592%5C%22%22%5D%7D&resultIndex=1> : <https://www.congress.gov/bill/114th-congress/senate-bill/314/text>

³² See F.R. 78, 31294 – which states “...so long as the MTM activities meet the requirements set forth in § 422.2430 and § 423.2430, they would qualify as a QIA.” Available at: <https://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf>

³³ APhA. Comments on the Proposed Rule for the Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs. April 16, 2013. Available at: <http://www.pharmacist.com/sites/default/files/files/APhA%20Comments%20to%20CMS%20on%20MA%20%20Part%20D%20MLR%20Requirements%20Final%20041613%5B2%5D.pdf>

³⁴ APhA and the National Association of Chain Drug Stores Foundation. Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model. Version 2.0. March 2008. Available at: http://www.pharmacist.com/sites/default/files/files/core_elements_of_an_mtm_practice.pdf

Once again, thank you for the opportunity to provide feedback on the Proposed Rule and for your consideration of our comments. As pharmacists continue to work in collaboration with our physician colleagues as vital members of patient care teams, we are happy to facilitate discussions between our members who currently provide medication management, CCM, TCM and incident to physician services, and CMS, if that would be helpful. 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,



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