Pharmacy Health Information Technology Collaborative

Via Electronic Submission to: https://www.regulations.gov

October 5, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
7500 Security Boulevard
Baltimore, MD 21224-1850

Re: [CMS-1734-P] Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Dear Administrator Verma:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments regarding proposed rule *CMS-1734-P Medicare Program, et al.*

The Collaborative has been involved with the federal agencies, including the Office of the National Coordinator (ONC) and the Centers for Medicaid and Medicare Services (CMS), developing the national health information technology (HIT) framework since 2010.

Pharmacists provide essential services to Medicare patients through the Part D prescription drug benefit program and as part of team-based care models in Medicare Part A, B, and C programs. Additionally, pharmacists are users of telehealth and health IT, and in particular, electronic medical record (EMR)/electronic health record (EHR) systems, and those utilizing certified EHR technology (CEHRT). The Collaborative supports the use of these systems, which are important to pharmacists in working with other health care providers to provide needed medications and transmit patient information related to overall patient care,

transitions of care, immunization (historical and administered), immunization registry reporting, medication lists, medication allergies, allergy reactions, patient problem lists, smoking status, reporting to public health agencies, clinical decision support services/knowledge artifacts, drug formulary checking, and electronic prescribing.

The following are our comments regarding the *CMS-1734-P Medicare Program, et al* for proposed areas concerning health information technology (e.g., telehealth, interoperability, electronic prescribing of controlled substances, and prescription drug monitoring programs).

D. Telehealth and Other Services Involving Communications Technology (pages 75-128)

The Collaborative supports the use of telehealth for delivering clinical health and person-centered care, particularly in rural health areas, and especially during times of national, state, and local emergencies, such as the COVID-19 outbreak.

Pharmacists are a part of the health care management teams providing Medicare services and are telehealth providers. Telehealth enables pharmacists to connect with established health care management teams, particularly when questions arise concerning medications prescribed or changes to medications, independent of geography. In many instances, especially in rural and underserved areas where telehealth would be invaluable, pharmacists are the first point of contact by patients and their caregivers.

Although Medicare routinely pays physicians and other health care providers and practitioners (e.g., social workers, dieticians; see 42 C.F.R. §410.73 and §410.134 respectively) for several kinds of services provided via interactive communication technology, the Collaborative and its members believe pharmacists should also be paid for the telehealth services they provide. The Collaborative supports the efforts of the national pharmacy organizations for ensuring payments to pharmacists when billing for telehealth services.

The role of pharmacists in telehealth is expanding. Many types of medication management services (MMS)[1] provided by pharmacists are clinically appropriate for telehealth, including: medication therapy management, chronic care management (e.g., diabetes, hypertension), medication reconciliation, transitions of care, pharmacogenomics, interpretation of diagnostic tests and providing test results, and consultations with patients and health care providers.

Telehealth is a cost-saving option that can expand pharmacist-provided health care services to patients outside of traditional community pharmacy practice settings,

[1] "Medication Management Services (MMS) Definition and Key Points," Joint Commission of Pharmacy Practitioners, https://jcpp.net/wp-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf

while complementing existing pharmacy services and expanding access to the expertise of pharmacists. Telehealth and telepharmacy could also provide cost-savings for hospitals, particularly rural hospitals.[2]

The Bipartisan Budget Act of 2018 modified and removed limitations relating to geography and patient setting for certain telehealth services. Although there may be some statutory restrictions for Medicare telehealth services, we ask CMS to review and consider adding payment codes for those services, noted in the previous paragraph, that pharmacists provide via telehealth to Medicare patients and their health care management teams.

F. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs) (pages 419-558)

The Collaborative supports the continuation of CY 2020 for identifying high priority measures for reporting on quality performance eCQMs for the Medicaid Promoting Interoperability program for 2021.

K. Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (pages 533-545)

The Collaborative supports implementation of EPCS by January 1, 2021 and the use of waivers for those not prepared to implement by 2021.

M. Updates to Certified Electronic Health Record Technology due to the 21st Century Cures Act Final Rule (pages 558-580)

2. Updates to Certified Electronic Health Record Technology Requirements in the Promoting Interoperability Program and Quality Payment Program due to the 21st Century Cures Act Final Rule

The Collaborative supports requiring health care providers participating in the Promoting Interoperability Program or Quality Payment Program (QPP) to use only technology that is considered certified under the ONC Health IT Certification Program as finalized in the Cures Act final rule. Additionally, the Collaborative supports the proposed revisions of two definitions. Under the definitions of CEHRT and Meaningful User for MIPS, replacing the reference to "Advancing Care Information" with "Promoting Interoperability" to reflect the category name changes CMS made previously.

[2] Health IT News, January 2018, https://www.healthcareitnews.com/news/telepharmacy-rural-hospitals-provides-big-savings-quality-improvements

3. Proposed Changes to Certification Requirements under the Hospital IQR Program due to the 21st Century Cures Act

The Collaborative supports allowing hospitals the flexibility to use either: 1) technology certified to the 2015 Edition criteria for CEHRT as previously finalized in the FY 2019 IPPS/LTCH final rule or 2) technology certified to the 2015 Edition Cures Update standards as finalized in the 21st Century Cures Act final rule.

(4) Promoting Interoperability (pages 670-694)

(b) Promoting Interoperability Performance Period

The Collaborative supports establishing a reporting period of a minimum of a continuous 90-day period for the 2024 MIPS payment year and each subsequent MIPS payment year.

(i) Proposed Changes to Query of Prescription Drug Monitoring (PDMP) Measure under the Electronic Prescribing Objective

The Collaborative supports continuing to include this measure as optional for the performance period in CY 2021. As the PDMP landscape is still maturing, and there are variations across the country as to how providers and states are implementing and integrating PDMP queries into health IT, the Collaborative agrees with the proposed CMS approach for the PDMP measure. The Collaborative also supports using CEHRT to conduct a query of PDMP for prescription drug history.

2. Health Information Exchange Objective
b. Engagement in bi-directional exchange through Health Information Exchange (HIE)

The Collaborative supports including the new measure, Health Information (HIE) Bi-Directional Exchange measure, under the HIE objective beginning with the performance period in 2021 and requiring that eligible clinicians use CEHRT to engage in bi-directional exchange.

Additionally, we believe CMS needs to look at this more broadly to ensure that the electronic exchange of information via HIEs between pharmacists and these plans, as well as between pharmacists and eligible clinicians, eligible hospitals, and eligible CAHs occurs in an interoperable two-way process (bidirectional communication/exchange). For long-term and post-acute care settings, a three-way process is needed to include pharmacy, prescriber, facility/home care systems, and these plans.

(f) Future Direction of the Promoting Interoperability performance category

The Collaborative agrees that CMS should look at other potential areas, including information blocking, growth of PDMP, the use of United States Core Data for Interoperability (USCDI), Health Level Seven's (HL7) Fast Healthcare Information Resource (FHIR), and updates to 2015 Edition health IT certification and the ONC Health IT Certification Program.

Additionally, the Collaborative encourages CMS to review the Pharmacist Care Plan Initiative. This joint project between the National Council of Prescription Drug Programs (NCPDP) and HL7, which is fully supported by the Collaborative, will serve as a "standardized, interoperable document exchange of consensus-driven prioritized medication-related activities, plans, and goals for an individual needing care."[3]

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The Pharmacy HIT Collaborative comprises the major national pharmacy associations, representing 250,000 members, including those in pharmacy education and accreditation. The Collaborative's membership is composed of the key national pharmacy associations involved in health information technology (HIT), the National Council of Prescription Drug Programs, and 13 associate members encompassing e-prescribing, health information networks, pharmacy quality development organizations, pharmacy companies, system vendors, and other organizations that support pharmacists' services.

As the leading authority in pharmacy health information technology, the Pharmacy HIT Collaborative's vision and mission are to ensure the U.S. health IT infrastructure better enables pharmacists to optimize person-centered care. Supporting and advancing the use, usability, and interoperability of health IT by pharmacists for person-centered care, the Collaborative identifies and voices the health IT needs of pharmacists; promotes awareness of functionality and pharmacists' use of health IT; provides resources, guidance, and support for the adoption and implementation of standards driven health IT; and guides health IT standards development to address pharmacists' needs. For additional information, visit www.pharmacyhit.org.

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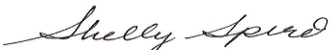
On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on *CMS-1734-P Medicare Program, et al.*

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

[3] https://www.healthit.gov/techlab/ipg/node/4/submission/1376

Respectfully submitted,



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