



**American Pharmacists Association**<sup>®</sup>  
Improving medication use. Advancing patient care.

December 19, 2016

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Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services  
Attention: CMS-5517-FC  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Re: Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Final Rule**

Dear Acting Administrator Slavitt:

The American Pharmacists Association (APhA) is pleased to submit these comments regarding the Centers for Medicare & Medicaid Services (CMS's) final rule for the Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Physician Fee Schedule ("PFS"), and Criteria for Physician-Focused Payment Models (the "Final 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, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and the uniformed services.

APhA appreciates CMS's acknowledgement in the Final Rule that "because pharmacists are neither MIPS eligible clinicians nor required practitioners under APMs, pharmacist expertise and contributions may be underutilized and/or unavailable to certain patients." We also applaud CMS recognizing that improving the exchange of clinical information between pharmacists and physicians and other health care practitioners would create opportunities for patients to interact with providers to maximize coordinated and team-based care. While CMS also stated that they "do not have discretion under the statute to include clinicians who do not meet the definition of a MIPS eligible clinician," CMS expressed appreciation for pharmacists' suggestions related to better inclusion of pharmacists within MACRA. As CMS and Congress continue discussions related to MACRA, APhA encourages policymakers to recognize the role of the pharmacist in maximizing the benefits of coordinated team-based care—a win for patients and overall health care quality and cost. Statutes and laws tend to change less frequently and often do not reflect current roles and responsibilities of health care practitioners. Therefore, absent legislative action, APhA hopes CMS will seek meaningful ways to support pharmacists' opportunities in its policies, particularly related to innovative payment and care

delivery models. For example, we look forward to CMS using its “authority under section 1848(q)(1)(C)(i)(II) [of the Social Security Act] to expand the definition of MIPS eligible clinician to include additional eligible clinicians (as defined in section 1848(k)(3)(B) of the Act) through rulemaking in future years,”<sup>1</sup> and request that CMS consider pharmacists in any expansion.

APhA and CMS share the same goal—to increase access to quality care and better health. One way to accomplish this goal would be to use CMS’s regulatory flexibility to remove the barriers to allow beneficiaries to access the skills and expertise of the pharmacist, often an underutilized resource with extensive education and training,<sup>2</sup> in achieving its objectives of better care for patients, improved health for communities, and lower costs. For example, CMS has already allowed lifestyle coaches, who directly furnish Medicare Diabetes Prevention Program (MDPP) services,<sup>3</sup> to receive National Provider Identifiers (NPIs) and reimbursements through MDPP suppliers in the final PFS rule.<sup>4</sup> 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. While APhA supports this type of regulatory approach to increase the availability of and patients’ access to services like those within the MDPP, additional regulatory changes to allow for increased pharmacists’ participation as part of a coordinated approach would also be incredibly impactful. The current MDPP model provides federal funding to YMCAs, however, these facilities are not available in every community. In contrast, nearly 91% of Americans live within five miles of a community pharmacy, 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, CMS should establish similar mechanisms in future rule-making to appropriately expand the type of practitioner eligible and attribute the role that pharmacist services and pharmacists play in improving care under the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative payment models (APMs)

As APhA has previously stated, pharmacists are 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 Medication Therapy Management (MTM) services in Medicare Part D; the modified incident to physician supervision requirements for transitional care management (TCM) services and chronic care management (CCM); and the inclusion of metrics in the Final Rule that specifically mention pharmacists—medication reconciliation post-discharge and population management of medications. While the law and corresponding Final Rule primarily address physician payments, MACRA does offer the potential to incentivize the inclusion of pharmacists as part of patients’ care delivery teams. For example, many of the 290+ measures in the quality category (e.g., outcomes, patient safety, care coordination, patient experience) can be impacted by pharmacists working in partnership with physicians to improve the quality of patient care. A significant number of MIPS quality measures are

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<sup>1</sup> See CMS. Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. Proposed Rule. 81 FR 28173. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf>

<sup>2</sup> 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>

<sup>3</sup> 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>

<sup>4</sup> 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.”

related to or impacted by medications, and scores on these measures would benefit from appropriate medication use. APMs also offer additional opportunities for pharmacist involvement as Medicare continues its transition to value-based care. Because of pharmacists' ability to positively affect health care quality, outcomes and costs, they can play a critical role in contributing to the continued growth and success of APMs given their unique access to, and relationship with, the patient community. Pharmacists' participation as part of coordinated health care teams in a variety of outpatient settings can also help to fill gaps in care through their disease management, medication management, and prevention and wellness services. As CMS is aware, the number and complexity of medications continues to rise, thereby increasing the importance and impact of services related to medications, such as medication management, in optimizing patient outcomes. Given the potential positive influence of pharmacists' services on patients and the health care system generally and the fact that no other health care practitioner has more medication-related experience than pharmacists, APhA continues to strongly encourage CMS to recognize the contributions of pharmacists and their services in its policies, including those related to MIPS and APMs.

Thank you for the opportunity to provide feedback on the Final Rule and for your consideration of our comments. We continue to encourage CMS to use pharmacists in new payment and delivery mechanisms to improve the quality of care provided to Medicare beneficiaries. If you have any questions or require additional information, please contact, Michael Baxter, Director of Regulatory Affairs, at [mbaxter@aphanet.org](mailto: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