AMCP Academy of Managed Care Pharmacy®

January 24, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3288-NC
7500 Security Boulevard
Baltimore, Maryland 21244

Subject: CMS-3288-NC; *Patient Protection and Affordable Care Act* (ACA); Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology

The Academy of Managed Care Pharmacy (AMCP) is pleased to provide recommendations to the Centers for Medicare & Medicaid Services (CMS) regarding its notice related to the quality ratings system, framework and methodology on qualified health plans (QHPs) in exchanges. AMCP is a national professional association of pharmacists with nearly 7,000 members who provide services on behalf of the more than 200 million Americans served by managed care organizations, including health plans and pharmacy benefit management companies. Our members are responsible for managing prescription drug benefits on behalf of clients of the managed care organizations that employ them. They are responsible for implementing a broad and diversified range of clinical, quality-oriented services and strategies whose objective is to assure that individual patients receive the appropriate drug at the right time in a convenient, cost-effective manner.

CMS seeks input on the manner in which health insurer issuers offering qualified health plans (QHPs) in the Exchanges foster and promote quality, including quality improvement strategies, enhancement of patient safety, and public reporting. AMCP members have been actively involved with the "Star Ratings" quality improvement and measurement strategies for prescription drug plans (PDPs) under the Medicare Advantage program and Medicare Part D program.[1] The Stars Rating system is one of the first national programs to use quality metrics for health care services. The stars' program measures Medicare Advantage plan and Medicare Part D prescription drug plan (PDP) performance in 50 different areas, including measures that impact pharmacists and adherence. For selection of medication measures in the QHPs, AMCP recommends that CMS evaluate the experiences of plans and PDPs under the Star Ratings program and other measures to select measures that improve quality and to eliminate measures that do not improve quality before incorporating these measures in the Exchanges. AMCP also suggests that CMS consider the measurements used to evaluate accountable care organizations (ACOs), patient-centered medical home (PCMH) models, and other innovative delivery systems when developing measures for use in the Exchanges.

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[1] CMS. Choose higher quality for better health care. http://www.medicare.gov/Publications/Pubs/pdf/11226.pdf (accessed January 20, 2014).

AMCP emphasizes the need to align measures across programs to promote consistency, economic efficiency, and quality across the health care system. If providers and health systems must implement multiple measurement systems, the administrative and technology costs will increase; and thus, overall costs to the health care system will increase. This situation would undermine the goals of improving quality and lowering costs in the health care system.

AMCP provides general comments on the measures selection process used by CMS and also provides comments on certain measures related to pharmacists and pharmacy. AMCP's comments emphasize the role of pharmacists in improving and promoting quality of care using evidence-based medicine.

AMCP General Comments on Measures Selection and Update Process

CMS notes its intent to continually monitor the QRS and make necessary adjustments to ensure that the methodology and measures remain consistent with the intended goals and principles of the QRS. As advancements in health plan quality measurement and reporting are made, CMS will consider ways in which the QRS may evolve (such as the potential selection of measures that are reportable through disease registries or all-payer claims databases). AMCP reiterates the importance of ensuring that this process provides the opportunity for health insurers and their provider networks to respond in a timely manner to changes in evidence-based guidelines or other changes that may result in updates to quality measures during a plan year or other period of time that would result in changes to metrics during that period and would impact the measurement process. For example, CMS' notice contains a measurement of low density lipoprotein (LDL) cholesterol levels that are now in direct conflict with new evidence-based guidelines. CMS must establish a clear process to resolve these issues as they occur and to not penalize health insurers and provider networks for following current guidelines.

As stated above, AMCP also supports aligning quality measurement standards across all programs and to ensure similar goals among all programs. However, the health care system must recognize that different measures may be more important in some populations compared to others. This occurs because of differing health issues among patients across the country and the differences among the Medicare population and those in the Exchanges. The population of individuals in the Exchanges will primarily include non-elderly and disabled individuals, but the overall goals remain similar to the Medicare population: preventing disease or chronic conditions; managing long-term conditions; and ensuring that plans are effectively managing care and providing a positive experience. To that end, the quality measurements must accommodate differences in the populations and should not penalize plans with differing patient populations. The QRS for the Exchanges must take into account difference in average age, risk scores, and diseases for the affected population in the exchange and not make direct comparisons to the Medicare program when not appropriate. Furthermore, if necessary, the QRS should account for regional variations in standards and include risk adjustments as necessary. For example, NQF and others recommend risk-standardization and peer-grouped rates for readmissions. AMCP supports the consideration of this approach for other measures, including drug-related measures, using peer groups in addition to national averages.

AMCP Comments on Individual Measures for QRS and Child-Only QRS (*Section II. B)*

AMCP supports CMS' incorporation of the following pharmacy measures and provides recommendations for some of these measures.

- Annual monitoring for patients on persistent medication (not National Quality Forum (NQF) endorsed)
    - AMCP recommends that this measure incorporate both an adherence component and laboratory values when necessary. Laboratory values are important in some cases to determine whether medication therapy is appropriate and at the correct level. In addition, adherence may not be the most comprehensive measure, but using both types of measures creates the ability to more fully assess medication therapy.
- Antidepressant medication management (NQF ID 0105)
    - Managed care pharmacy prefers the portion of days covered (PDC) approach as compared to the adherence approach used for Part D, but understands given the multiple indications for the antidepressant class of drugs that diagnoses are needed to target the appropriate population.
- Appropriate treatment for children with upper respiratory infection (NQF ID 0069);
- Avoidance of antibiotic treatment in adults with acute bronchitis (NQF ID 00580;
- CAHPs—Aspirin use and discussion (not NQF endorsed);
- CAHPS flu shot for adults (NQF 0039); childhood immunization status (NQF 0038); HPV vaccination for female adolescents (NQF 1959); and, immunization for adolescents (NQF 1407)
    - AMCP members find that these measures are resource-intensive for health plans to conduct chart review for health effectiveness and data information set (HEDIS). NCQA is moving away from manual review measures and seeking electronic solutions that allow seamless, bi-directional communication among and between prescribers, health care providers, and health plans. Furthermore, vaccine registries create unnecessary work for all entities because this information should be readily available and accessible in the patient electronic health record (EHR) and pharmacy claims.
- Cholesterol management for patients with cardiovascular conditions, (LDL-C control (<100 mg/dl) (not NQF endorsed)) and diabetes care: HbA1c control (<8.0%) (NQF 0575)
    - As stated previously, the LDL-C recommendation is now not consistent with current evidence-based guidelines and should be revised as necessary to ensure conformance with the most current clinical evidence. AMCP also recommends that these measures include both adherence monitoring and laboratory values because using both types of measures creates the ability to more fully assess management of medication therapy.
    - Controlling high blood pressure (NQF 0018)
        - Again, AMCP recommends that these measures include both adherence monitoring and blood pressure clinical measurement because using both types of measures creates the ability to more fully assess management of medication therapy.
- Follow-up care for children prescribed ADHD medication: initiation phase and continuation and maintenance phase (NQF ID 0108)

    - Some pharmacists are responsible for follow-up ADHD assessment and therefore AMCP supports the inclusion of pharmacists in the numerator for this measure.
- Medication management for people with asthma and for children with asthma (ages 5-18) (NQF 1799);
- Plan all-cause readmissions (NQF ID 1558). Similar to NQF, AMCP supports that all-cause readmissions need to be for unplanned readmissions, be risk-adjusted, reported at a peer group level, and consider clinical cohorts (e.g. medicine, surgery/gynecology, cardiorespiratory, cardiovascular, and neurology). AMCP supports further testing of the measure, including appropriate levels to target.

In addition to the measures proposed by CMS, AMCP also recommends the addition of *post-discharge medication reconciliation*; with pharmacist involvement to the list of measures.Quality of care is improved through pharmacists' involvement as members of the interdisciplinary health care team. Given this, AMCP encourages CMS to adopt the following definition of medication reconciliation as approved by the Joint Commission[2] and supported by the Agency for Health Research Quality:

> Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care. This process comprises five steps: (1) develop a list of current medications; (2) develop a list of medications to be prescribed; (3) compare the medications on the two lists; (4) make clinical decisions based on the comparison; and (5) communicate the new list to appropriate caregivers and to the patient.

Role of Pharmacists in Promoting Quality

In addition to pharmacists' role in the medication reconciliation process, AMCP recognizes the essential role that pharmacists will play as interdisciplinary partners in delivering health care in the Exchanges and in other areas of health care. Pharmacists will be needed to work with other providers to achieve appropriate medication management and prevent complications that could result in negative outcomes for patients whose medication is not managed appropriately. Growing evidence suggests that including pharmacists as a member of the interdisciplinary team to improve medication utilization benefits improves quality in the health care system as a whole. A recent Congressional Budget Office (CBO) report, *Offsetting the Effects of Prescription Drug Use on Medicare's Spending for Medical Services*[3] concludes that appropriate medication adherence under Medicare Part D lowers health care costs in other areas, and other research suggests the same impact in other patient populations.[4] Additional evidence demonstrating the need for pharmacists is analyzed below.

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[2] The Joint Commission. Medication reconciliation. sentinel event alert, Issue 35. 2006. http://www.jointcommission.org/sentinel_event_alert_issue_35_using_medication_reconciliation_to_prevent_errors/. (accessed January 20, 2014.)

[3]CBO. *Offsetting the Effects of Prescription Drug Use on Medicare's Spending for Medical Services.* http://www.cbo.gov/publication/43741 (accessed January 20, 2014)

[4] Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. . *Health Aff. 2011; 30: 91-99.*

In 2006, 71 percent of physician visits resulted in at least one prescription medication order.[5] Approximately 32 percent of adverse events leading to hospitalization are due to medications, and only 33 to 50 percent of patients with chronic conditions adhere to their prescribed medication therapies.[6] The Institute of Medicine has suggested that while only 10 percent of total health care costs are spent on medications, their ability to control disease and impact overall morbidity, productivity and costs, when used appropriately, is enormous.[7] However, 58 percent of physicians state that their patients have difficulty affording their medications, thus revealing an opportunity for pharmacists to play an important role in achieving desired therapeutic outcomes while promoting cost-effective medication use.[8]

Pharmacists are well trained in pharmacotherapeutics and are uniquely positioned in the health care system to help optimize appropriate medication use, reduce medication related problems and improve health outcomes; yet, they are often underused. Incorporating pharmacists within the health care team will be essential to achieving quality improvement benchmarks.

AMCP appreciates the opportunity to provide input related to the development of quality standards in the Exchanges. We look forward to working with CMS as it continues to develop formal proposals in this area. If you have questions regarding our comments or require any additional information, please do not hesitate to contact me at (703) 683-8416 or at erosato@amcp.org.

Sincerely,

Edith A. Rosato, R.Ph., IOM
Chief Executive Officer

[5] Smith M, Bates DW, Bodenheimer T, Cleary P. Why pharmacists belong in the medical home. *Health Aff.* 2010; 29(5):906-913.
[6] *Ibid*.
[7] *Ibid*.
[8] *Ibid* at 3.