December 20, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9962-NC
7500 Security Boulevard
Baltimore, Maryland 21244

Subject: CMS-9962-NC; Request for Information regarding Health Care Quality for Exchanges

The Academy of Managed Care Pharmacy (AMCP) is pleased to provide recommendations to the Centers for Medicare & Medicaid Services (CMS) on the request for information (RFI) for health care quality in the Exchanges, published in the Federal Register on November 27, 2012.

AMCP is a national professional association of pharmacists with more than 6,000 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.

The RFI seeks input regarding 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 beginning in 2016. 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. 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 PDP performance in 50 different areas, including measures that impact pharmacists and adherence. AMCP recommends that CMS evaluate the experiences of plans and PDPs under the star ratings program to select measures that improve quality and to eliminate measures that do not improve quality before incorporating these measures in the Exchanges.

1 CMS. Choose higher quality for better health care.
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. AMCP has offered comments and suggestions in many of these areas, and many are included in these recommendations.

These comments focus on the role that pharmacists play as health care professionals and provide responses to the relevant questions posed by CMS in the RFI. AMCP supports incorporation of pharmacists as meaningful users of electronic health records (EHRs). Incorporating pharmacists as meaningful users will allow medication information exchange beyond e-prescribing. This allowance will ensure that pharmacists’ interventions may be fully measured and documented in any health care system. To this end, AMCP also supports comments submitted by the Pharmacy e-Health Information Technology (eHIT) Collaborative that focus on the HIT issues raised in the RFI.

**Role of Pharmacists in Promoting Quality in Exchanges**

The Academy 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. In many cases, pharmacists are not mentioned as specific members of the health care team, but should be encouraged to participate in all health care systems. 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*\(^1\) 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.\(^2\) Additional evidence demonstrating the need for pharmacists is analyzed below.

In 2006, 71 percent of physician visits resulted in at least one prescription medication order.\(^3\) 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.\(^4\) 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.\(^5\) 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.\(^6\)

Over the past twenty-five years, studies have demonstrated that pharmacists participating in team-based care models have made positive contributions to patient care and safe medication use. 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. As clinical experts working as part of an interdisciplinary team, pharmacists can assess whether

---


\(^4\) Ibid.

\(^5\) Ibid.

\(^6\) Ibid at 3.
medication use is contributing to unwanted effects and can help achieve desired outcomes from medication use.

Pharmacist-provided care can reduce drug expenditures, hospital readmissions and lengths of stay, and emergency department visits. Pharmacists in community settings, hospitals and managed care organizations are already actively involved in communications with prescribers and patients that are intended to improve quality and appropriateness of care. Incorporating pharmacists within the health care team will be essential to achieving quality improvement benchmarks.

Organizations across diverse care settings are already implementing pharmacy services, including medication management. For example, pharmacists already provide services in drug therapy management clinics. Such clinics address anticoagulation, transplant programs, human immunodeficiency virus (HIV), hepatitis C, psychiatric and lipid management to ensure that patients are taking their medications correctly and that drug-related problems are identified and managed.

Pharmacists are uniquely positioned to help patients optimize appropriate medication use, reduce medication related problems, and improve health outcomes through the delivery of patient care services such as medication therapy management, health promotion, education, and disease prevention and mitigation. For these reasons, health plans in the Exchanges should utilize pharmacists’ services and should be encouraged to develop evidence-based, innovative approaches for implementing these services.

**AMCP Response to Specific Questions Posed by CMS**

*Understanding the current landscape*

**Question 1: What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reduced medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?**

AMCP’s comments focus on quality initiatives implemented by various organizations to improve medication management. These comments provide an overview of the existing standards and AMCP’s previous comments on these areas.

- URAC has several measures for plan accreditation supported by AMCP that should be incorporated as measures in health Exchanges. Some of these measures have been approved by the Pharmacy Quality Alliance (PQA), the primary consensus organization that collaboratively promotes appropriate medication use and develops strategies for measuring and reporting performance information related to medications. These measures are:
  - **Generic dispensing rates.** Measures the percentage of all generics dispensed by examining the percentage of all prescriptions that were dispensed as generics, branded generics, or brands for which members paid the generic copay; and the percentage of all prescriptions available as generics that were dispensed as generics. The Academy supports this as an appropriate leading efficiency measure.
  - **Proportion of days covered (PDC) rates by therapeutic category.** Measures the percentage of patients 18 years and older who met the PDC threshold of 80% during the measurement year (medication adherence). A performance rate is calculated separately for the following

---

medication categories: beta-blockers, angiotensin-converting enzyme inhibitor/angiotensin-receptor blockers, calcium channel blockers, diabetes medications, and statins. The Academy supports this PQA-developed and National Quality Forum (NQF)-endorsed measure.

- Medication therapy for persons with asthma [suboptimal asthma control (SAC) and absence of controller therapy (ACT)]. Measures (1) the percentage of patients with persistent asthma who are dispensed more than three canisters of a short-acting beta 2 agonist inhalers during the same 90-day period, and (2) the percentage of patients with asthma during the measurement period dispensed more than 3 canisters of short acting beta 2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.

- AMCP also recommends maintaining the following measures adopted by CMS for ACOs.

  - Medication reconciliation after discharge from an inpatient facility. AMCP also recommends an expanded definition of medication reconciliation as described below in response to Question 5.
  - Percentage of primary care physicians who are successful electronic prescribers under the eRx incentive program
  - Preventive health
    - Influenza immunization
    - Pneumococcal vaccination
    - Tobacco use assessment and tobacco cessation intervention
    - Depression screening
    - Blood pressure screening for patients aged 18 and older.
    - AMCP also suggests the addition of cholesterol screening.
  - Diabetes
    - These measures include screening for hemoglobin A1c control, low density lipoprotein (LDL) measurement, blood pressure monitoring, and aspirin use.
  - Heart Failure
    - Measuring use of beta blockers
    - Use of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy
    - Use of warfarin therapy for patients with atrial fibrillation.
  - Coronary Artery Disease (CAD)
    - Use of oral antiplatelet therapy prescribed for patients with CAD
    - Drug therapy for lowering LDL-cholesterol
    - Beta-blocker therapy for CAD patients with prior myocardial infarction (MI).

- Finally, AMCP recommends adoption of the following HEDIS® measures adopted by the National Committee for Quality Assurance (NCQA)8:

  - Pharmacotherapy management of COPD;
  - Appropriate medication management, medication management, and medication possession ratios for people with asthma;
  - Cholesterol management for people with cardiovascular conditions;
  - Controlling high blood pressure;
  - Use of beta blockers after heart attack
  - Comprehensive diabetes care, specifically management of A1c levels;
  - Antidepressant medication management;
  - Annual monitoring for patients on persistent medications;

---

Applicability to the Health Insurance Exchange Marketplace

Question 5: What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?

AMCP members can help to improve quality through pharmacists’ involvement as members of the interdisciplinary health care team. This involvement is described above. In addition to the general role of the pharmacist as described above, AMCP encourages CMS to adopt the following definition of medication reconciliation as approved by the Joint Commission\(^9\) and supported by the Agency for Health Quality Research:

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.

By implementing an effective medication reconciliation strategy during transitions of care, health care quality may be improved significantly by reducing morbidity and mortality that occurs during these transitions, particularly from adverse drug events (ADEs) that occur because lack of appropriate medication coordination efforts.\(^{10}\)

Question 6: What quality measures or measure sets currently required or recognized by states, accrediting agencies, or CMS are most relevant to the Exchange marketplace?

AMCP reiterates support for measures that promote safe and effective medication utilization and reduce the potential for ADEs. As noted above, a growing body of research, including from CBO, indicates that appropriate medication utilization reduces health care costs in other areas. Capturing information related to medication utilization is critical to ensuring quality in the Exchanges. However, plans should utilize existing measures that are shown to be effective and not develop new measures that would create confusion or inconsistencies that could result in reduced quality, reporting errors, or increased costs. Plans should look to measures developed and approved by PQA and NQF and those implemented by ACOs and PCMHs and effective Medicare Advantage and PDP star ratings quality reporting system.

---


Question 10: What are the priority areas for quality rating in the Exchange marketplace? Should these be similar to or different from the Medicare Advantage 5-star quality rating system?

To the extent possible, quality measurement should be consistently aligned among all programs, and the goals should be similar. However, the health care system must recognize that different measures may be more important in some populations compared to others. These differences occur 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. For example, plans with younger populations may have fewer individuals using medications for chronic diseases; therefore, some measures related to medication utilization may not sufficiently determine the quality of a plan. In these plans, other measures, such as prevention or a focus on other diseases or conditions might be given more weight.

Aligning measures across programs also provides for more economic efficiency 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.

Information must not only be aligned, but must also be provided in a timely manner. Based on AMCP’s member experience with the star ratings, delays in communication from CMS to PDPs related to prescription drug event (PDE) data result in the inability to effectively measure adherence in a timely manner. This is just one example of situations that may occur when communications among health care entities, the government, and health plans are not timely. This situation reinforces the need for a comprehensive, interoperable HIT network with the participation of pharmacists and the proper support and funding from the federal government to ensure implementation.

The Academy 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 develops formal proposals. 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