NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Mary T. Bassett, MD, MPH
Commissioner

January 10, 2018

via electronic submission

Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program
[CMS–4182–P] RIN 0938–AT08 (82 FR 56336)

To Whom It May Concern:

The New York City (NYC) Department of Health and Mental Hygiene (DOHMH) appreciates the opportunity to comment on the above-referenced proposed changes to the Medicare Program, and particularly to the Medication Therapy Management and E-Prescribing standards under Medicare Part D. The Primary Care Information Project (PCIP), a bureau within the DOHMH Division of Prevention and Primary Care, works with providers and pharmacies in NYC to help them improve their quality of care. PCIP operates NYC's federally designated Health Information Technology Regional Extension Center, NYC REACH, which has supported over 15,000 New York City providers in achieving Meaningful Use, and now provides technical assistance to NYC providers participating in the Merit-based Incentive Payment System (MIPS) through the QPP Small Underserved and Rural Support program.

DOHMH Supports Designating Medication Therapy Management Programs (MTMPs) as Quality Improvement Activities (QIA) [FR 56458]

The evidence shows that MTMPs improve patient care and save lives. DOHMH actively encourages our partner medical practices and pharmacies to engage in MTM, and we applaud CMS's move to encourage Part D Sponsors to do the same. MTM is not a mere administrative function, but part of the care that the Part D Sponsor is making available to its members. It is therefore appropriate to clarify that MTMPs are QIA by definition, and may be counted in the numerator of a Part D Sponsor's Medical Loss Ratio.

In our work among providers in New York City, we have observed that patients who might benefit from participation in an MTMP are not always enrolled in one; patients who are enrolled do not always complete the program. Insurers can help ensure that the right patients enroll in and complete appropriate MTMPs, but the same insurers have a financial disincentive to promote their MTMPs as long as MTMP expenses may be excluded from their MLR numerator. The issue that CMS seeks to address is real. We agree that this proposed change could be sufficient to change the behavior of Part D Sponsors in making their MTMPs available to more patients. For that reason, we believe that this change is not only appropriate, but necessary.

DOHMH supports adopting NCPDP SCRIPT 2017071 as the official Part D e-prescribing standard for transmitting prescriptions and prescription-related information [FR 56440]

NCPDP SCRIPT 2017071 includes several elements not present in the existing NCPDP SCRIPT 10.6 standard, particularly patient primary language and diagnosis. We support adopting the updated standard, to be codified as 42 CFR § 423.160(b)(1)(v), because we believe these additions will contribute to improved patient safety.

E-prescriptions sent using NCPDP SCRIPT 2017071 will contain a structured field indicating a patient's primary language, the "language name code". The pharmacists we work with serve a diverse patient community. Often, English is not these patients' first language. Many of these patients would better

understand medication labels and instructions printed in their own primary language, instead of English. The language field included in NCPDP SCRIPT 2017071 e-prescriptions will allow a prescriber to identify patients with limited English proficiency, so a pharmacist can print the label and other materials in the patient's preferred language.

We hope that future versions of NCPDP SCRIPT will make "language name code" a mandatory field for all e-prescriptions, to ensure that all prescriptions will be printed in the best language for each patient.

NCPDP SCRIPT 2017071 also now allows a prescriber to indicate a patient's diagnosis in each e-prescription. Pharmacists need this information to confirm whether the medication prescribed is appropriate to the patient's condition. Prescribers can make mistakes, and the diagnosis field in the new standard will help pharmacists fix them. The scientific literature is clear: this improves patient safety.[1] In addition, a pharmacy that knows the diagnosis a medication was prescribed for can print patient-friendly medication labels and patient education materials that are directly relevant to the use of that medication for that diagnosis. These improved materials can lead to better patient understanding and adherence to their medication regimen.

Thank you for the opportunity to comment.

Sincerely,

Mary T. Bassett, MD, MPH
Commissioner

[1] Warholak-Juarez T, Rupp MT, Salazar TA, Foster S. Effect of patient information on the quality of pharmacists' drug use review decisions. J Am Pharm Assoc (Wash). 2000;40(4):500-08.