

1455 Pennsylvania Avenue
Suite 400
Washington, DC 20004-2514
202.621.1820
202.621.1819 [fax]
www.accp.com



C. Edwin Webb, Pharm.D., M.P.H.
Associate Executive Director
Director, Government and Professional Affairs

June 28, 2013

The Honorable Joe Pitts, Chairman
The Honorable Frank Pallone, Ranking Member
The Honorable Michael Burgess, Vice Chairman

Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts, Ranking Member Pallone and Vice Chairman Burgess,

On behalf of the American College of Clinical Pharmacy (ACCP), I am writing to thank you for holding the June 26, 2013, hearing entitled “A 21st Century Medicare: Bipartisan Proposals to Redesign the Program’s Outdated Benefit Structure.”

ACCP is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in patient care practice and research. ACCP's membership is composed of over 14,000 practitioners, scientists, educators, administrators, students, residents, fellows, and others committed to excellence in clinical pharmacy and patient pharmacotherapy.

As you noted in the hearing memorandum, due to demographic trends over the coming years the number of Americans who depend on the Medicare program for their health care will increase significantly. At the same time, estimates predict that Medicare, in its current form, will become insolvent by as early as 2027. It is clear that in order to protect the integrity of the program for today’s seniors and ensure its sustainability for future generations the structure of Medicare’s current benefit design must be improved and modernized.

Some of the most serious challenges facing Medicare arise from a lack of coordination – both in terms of the delivery of patient care as well as structurally, with coverage for inpatient and outpatient services (and their associated costs) divided between Medicare Part A and Part B, and prescription drugs (together with an important, but limited, medication therapy management (MTM) benefit), are covered under Part D.

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Michael S. Maddux, Pharm.D., FCCP, Executive Director

As a result of this lack of coordination, care is delivered by a variety of providers operating in unconnected professional “silos” and Medicare beneficiaries do not have access to the team-based, patient-centered care that integrated care models are able to deliver.

Structurally, the separation of services under Parts A, B and D means Medicare lacks effective incentives to encourage investment in high value, preventative care that would help avoid more costly future health care expenses such as hospitalizations and emergency room visits.

As the committee explores the process of reforming the “traditional” or Fee-For-Service (FFS) Medicare payment model that inhibits care coordination, incentivizes overutilization and results in increased costs, ACCP urges Congress to enact legislation that would establish a comprehensive medication management (CMM) benefit, delivered by qualified clinical pharmacists.

CMM is a quality-focused, patient-centered, team-based approach to health care delivery that enhances the safety of medication use by patients and ensures help ensure that patients’ medication use is effectively coordinated across all providers and that medication-related outcomes are aligned with patients’ overall care plan and goals of therapy. Clinical pharmacists, working in formal collaboration with physicians and other members of the patient’s health care team, utilize a consistent process of direct patient care that enhances quality of care, improves clinical outcomes and lowers overall health care costs.

The inclusion of a CMM benefit under Medicare Part B would improve the coordination of care among healthcare providers, patients and other caregivers and help prevent avoidable but costly medication errors, adverse drug reactions, and other medication-related patient safety events.

In addition, the establishment of this benefit would help address the structural silos that currently affect the Medicare program. A small investment in clinical pharmacist-delivered patient care under Medicare Part B would almost certainly yield significant savings in avoided hospitalizations and emergency room visits under Medicare Part A.

As Congressman Sarbanes noted during the June 26 hearing, Medicare not only faces problems stemming from the over utilization of care – some of it of questionable value or limited benefit to health - but also those arising from under underutilization of high-value services not currently covered by the program.

CMM is an example of such a service that occurs in progressive health care settings today, including integrated private sector delivery systems, the Veterans Administration, some community health centers and other settings. But it is only rarely available to most Medicare beneficiaries – the people most in need and most likely to benefit from the service.

Data aggregated from 19 distinct medication management service practices suggest that for every dollar invested in providing CMM services to beneficiaries, Medicare could save nine dollars in other, more costly care services such as physician office visits, emergency room visits and hospitalizations.¹

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We have included for your consideration an issue brief summarizing our proposal to establish a Part B comprehensive medication management benefit and a supporting data document providing evidence to show that including these services under Part B would improve outcomes and lower costs. Please feel free to follow up with us at any time if the College and its members can provide additional information.

We thank the Committee for its efforts to improve the Medicare program's outdated benefit structure and we urge you to consider our proposal for the inclusion of comprehensive medication management services within the Part B medical benefit.

Sincerely,

A handwritten signature in black ink, appearing to read "C. E. H. H. H.", written in a cursive style.

**Associate Executive Director
Director, Government and Professional Affairs**

Enclosures (2)

Cc: Michael S. Maddux, Pharm.D. FCCP