



Comments of the American College of Clinical Pharmacy

Statement in Response to the Request for Information Regarding Maternal and Infant Health Care in Rural Communities

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**Submitted electronically to
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The American College of Clinical Pharmacy (ACCP) appreciates the opportunity to provide the following statement to the Centers for Medicare and Medicaid Services (CMS) related to the Request for Information (RFI) regarding maternal and infant health care in rural communities

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 more than 15,000 clinical pharmacists, residents, fellows, students, scientists, educators and others who are committed to excellence in clinical pharmacy practice and evidence-based pharmacotherapy. The College's Practice and Research Networks include clinical pharmacists who practice, teach, and conduct research in a wide range of specialties, including several focused on the care of patients at the focus of this CMS initiative: Women's Health, Pediatrics, Adult Medicine, Ambulatory Care, Emergency Medicine, Psychiatry and Neurology, and Pain and Palliative Care. ACCP members typically practice in team-based acute and ambulatory care settings. Our focus is the optimization of medication regimens to achieve patient-centered therapeutic goals

Across our entire health care delivery system it is estimated that \$528 billion dollars a year, equivalent to 16 percent of total health care spending, is consumed due to inappropriate or otherwise ineffective medication use.¹ Given the central role that medications play in care and treatment of women and children, including the prenatal and antenatal periods, combined with continuing growth in the number of available medications, their complexity, cost, and our greater understanding of the impact of pharmacogenomics in patient response, the nation's health care systems often fails to deliver the full promise medications can offer.

With the growing complexity of medication therapies, the impact of medication use on maternal and fetal health is of concern to public and health experts. Studies indicate that 70% of women in the United States took at least one medication during the first trimester of pregnancy.² Pregnant women are not typically included in premarketing medication studies due to unknown teratogenic risks and, as a result, knowledge of drug safety in pregnancy is often limited. This lack of data is just one of the barriers to providing optimal care and heightens the value that clinical pharmacists bring to the health care team as trusted sources of medication information for women before, during, and after pregnancy.³ ACCP members who have a clinical practice in women's health or pediatrics, as well as those who care for women and children in acute care or other settings, provide these services on a daily basis throughout the country. They work to overcome the barriers imposed by limited data and to extend patient access to information and to the healthcare team. Dr. Kimberly Thrasher, an ACCP member working with clinics in Cape Fear, NC, noted that pharmacists can interact with patients at multiple levels to improve patient outcomes, including complex monitoring the safe use of medication regimens for comorbidities such as asthma, hypertension, or diabetes. Taking into account the unique challenges that Medicaid-enrolled pregnant, child or maternal patients already face, ensuring optimal medication use is an even higher priority.

The ability of pharmacists to extend patient care services is especially important in rural areas. Pharmacists working in rural maternal, pediatric, and family medicine clinics have increased patient access by turning to innovative methods for providing care, including telehealth services. At this time, telehealth is a reimbursable service in Medicaid programs in all but two states (Connecticut and Rhode Island). Requirements for Medicaid payment depend on the state and

site of service, the technology used, and the distance between the patient's home and the clinic or provider's location. More than half of the states allow providers of telehealth services to bill and receive reimbursement by private insurers similar to that for patients seen in-person in the hospital or clinic setting, according to telehealth parity laws. Furthermore, 36 states allow telehealth delivered primarily through interactive video to be billed and reimbursed by Medicaid. However, even if a state allows pharmacists to be reimbursed for CMM services, the pharmacist must consult with the patient's insurance company to confirm coverage. The prevalence of clinical pharmacists providing telehealth has increased, but challenges remain with compensation for clinical pharmacy services.⁴

A recent assessment of pharmacists delivering public health services in rural and urban areas of Iowa and North Dakota documented the efficacy of the pharmacists in successfully increasing opportunities for patients to access a pharmacist in underserved communities.⁵ Rural pharmacists were providing medication optimization services, immunizations, tobacco cessation counseling, medication take-back programs, and partnering with community leaders to identify and solve health risks in the community. These findings reflect what our ACCP members have described and highlight the need for expanding and supporting the rural pharmacy workforce.⁶

ACCP believes that in order to achieve the overarching goal of transforming health care delivery in America, it is necessary to transform payment structures to improve quality and patient outcomes and advance a forward-looking, coordinated framework for health care providers that rewards value and outcomes. We can achieve this goal by adopting team-based patient-centered health care that delivers better clinical quality, smarter spending, and healthier people and communities. Comprehensive medication management (CMM) is a direct patient care service, provided by a pharmacist working as a member of the patient's health care team, that has been demonstrated to significantly improve clinical outcomes and enhance the safety of medication use.

The incorporation of CMM into team-based patient care is supported by the Primary Care Collaborative (PCC), in which ACCP, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetrics and Gynecologists, the American Association of Nurse Practitioners and several other primary care medical organizations are actively involved. As part of the effort to reinvest in our nation's primary care infrastructure, these groups recognize that CMM helps ensure the right medication for the patient is taken as intended as part of an overall effort to improve the quality and affordability of the services provided to Medicare beneficiaries. By optimizing medication use, CMM contributes to enhanced productivity for the entire health care team, allowing all team members to maintain focus on their respective professional responsibilities as defined by scope of practice that reflect their particular area of expertise. The availability of pharmacists embedded into primary care practices to provide CMM has been shown to improve physician work life and reduce stress.⁷ Pharmacist-provided CMM may become an increasingly important benefit in rural areas, where shortages of primary care physicians and closures of rural health care facilities continue to occur.^{8,9}

In April 2019, ACCP partnered with a diverse range of stakeholders including Johnson & Johnson and Quest Diagnostics to launch the Get the Medications Right (GTMRx) Institute, a group dedicated to advancing practice transformation, payment and policy solutions to optimize medication use through team-based, patient-centered care delivery and advanced diagnostics.

ACCP would also like to bring to your attention an important study currently underway examining the feasibility and scalability of implementing CMM in contemporary primary care medical practices. The study is being conducted by the University of North Carolina's Eshelman School of Pharmacy through a grant of more than \$2.4 million from ACCP and the ACCP Foundation. Research supported by the grant is measuring the impact of CMM on clinical quality measures, health care costs, and the return on investment that can be realized. In addition, ongoing studies are assessing provider perception of the value and influence of CMM on medical provider well-being in primary care settings as well as patient engagement and satisfaction with CMM services.

As CMS continues to tackle the serious issues laid out in the Rethinking Rural Health Initiative, we urge you to consider how these structures can integrate with evolving team-based, quality-focused payment and care delivery models that shift health care payment policy for providers toward value of care and away from volume of services. We would welcome the opportunity to provide further information, data, and connections with successful practices that provide CMM services as part of this effort to optimize the use of medications in our country.

In summary, we thank you for the opportunity to provide feedback as part of this important effort to ensure that women and children who live in rural areas have access to high-quality, affordable health care. ACCP is dedicated to advancing quality-focused, patient-centered, team-based improvement in health care delivery that (1) helps assure medication optimization, (2) enhances patient safety, (3) promotes value-based rather than volume-based care to patients and (4) contributes to greater affordability and sustainability for the Medicare program, including our vulnerable populations in underserved areas.

¹Watanabe JH, et al. *Ann Pharmacother* 2018;52(9):829-37. doi: 10.1177/1060028018765159

²Mitchell AA, et al. *Am J Obstet Gynecol* 2011;205(1):51.e51-51e.58.
doi:10.1016/j.ajog.2011.02.029.

³Lynch MM, et al. *Qual Health Res* 2018;27(13):2071-80. doi:10.1177/1049732317732027

⁴Badowski ME, et al. *Pharmacotherapy* 2018;38(2):e7-e16. doi: 10.1002/phar.2071.

⁵Scott DM, et al. *Pharm Pract* 2016;14(4):836. doi:10.18549/PharmPract.2016.04.836.

⁶Scott MA, et al. *Am J Health-Syst Pharm* 2017;74:20005-12. doi:10.2146/ajhp160727.

⁷Funk KA, et al. *J Am Board Fam Med.* 2019;32(4):462-73.
doi:10.3122/jabfm.2019.04.180376.

⁸Projecting the supply and demand for primary care practitioners through 2020. Rockville, MD: Department of Health and Human Services; 2013.

⁹National Rural Health Association. What's different about rural health care?
<https://www.ruralhealthweb.org/about-nrha/about-rural-health-care> (accessed 03/19/2020).