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The Honorable Sheldon Whitehouse
U.S. Senate
503 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy
U.S. Senate
455 Dirksen Senate Office Building
Washington, DC 20510

Submitted electronically via: physician_payment@cassidy.senate.gov

Dear Senators Whitehouse and Cassidy,

On behalf of the American College of Clinical Pharmacy (ACCP), I am writing to thank you for your leadership in introducing S. 4338, the Pay PCPs Act, and for providing this opportunity to respond to your request for information.

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 16,000 clinical pharmacists, residents, fellows, students, scientists, educators and others who are committed to excellence in clinical pharmacy practice and evidence-based pharmacotherapy.

ACCP's members practice in a variety of team-based settings, including ambulatory care environments, hospitals, colleges of pharmacy and medicine, the pharmaceutical industry, government and long-term care facilities, and managed care organizations. Our focus is the optimization of medication regimens to achieve patient-centered therapeutic goals. This is done through a scientific, evidence-based, and cost-effective patient-care process which we refer to as

comprehensive medication management (CMM).[1]

It is estimated that $528 billion dollars a year, equivalent to 16 percent of total health care spending[2], is consumed due to inappropriate or otherwise ineffective medication use. Given the central role that medications play in the care and treatment of chronic conditions, combined with the continuing growth in the range, complexity and cost of medications -- and greater understanding of the genetic and physiologic differences in how people respond to their medications -- the nation's health care system consistently fails to deliver the full promise medications can offer.

Your draft legislation would allow the Secretary to include four types of service in hybrid payments: (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management visits, regardless of modality, for new and established patients.

We recommend that CMM, implemented based on a standard, evidence-based process[3], should be included as an additional service eligible for hybrid payments as part of your legislative effort. CMM is a holistic, consistent patient care process that ensures each patient's medications are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.[4]

As part of the CMM service, the clinical pharmacist develops an individualized medication therapy care plan in collaboration with the patient and the health care team that achieves the intended goals of therapy with appropriate follow-up to ensure optimal medication use[5] and outcomes.[6] CMM has

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[1] GTMRx Institute Toolkit: 10 Steps to Achieve Comprehensive Medication Management (CMM). Published February 2021. Accessed 7/10/24. Available here.
[2] Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug–Related Morbidity and Mortality. Annals of Pharmacotherapy. 2018;52(9):829-837. doi:10.1177/1060028018765159. Accessed 7/11/24. Available here.
[3] GTMRx Institute Definition: What is the Comprehensive Medication Management Process? Accessed 7/10/24. Available here.
[4] McInnis, Terry, et al., editors. The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. 2nd ed., Patient-Centered Primary Care Collaborative, The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. PCPCC Medication Management Task Force collaborative document. Published: June 2012. Accessed 7/10/24. Available here.
[5] Zillich AJ, Jaynes HA, Bex SD, Boldt AS, Walston CM, Ramsey DC, Sutherland JM, Bravata DM. Evaluation of pharmacist care for hypertension in the Veterans Affairs patient-centered medical home: a retrospective case-control study. Am J Med. 2015 May;128(5):539.e1-6. doi: 10.1016/j.amjmed.2014.11.027. Epub 2014 Dec 20. PMID: 25534422. Accessed: 7/10/24. Available here.
[6] Pham K. Alternative payment approaches for advancing comprehensive medication management in primary care. Pharm Pract (Granada). 2020 Oct-

been shown to improve health outcomes, reduce hospitalizations and readmissions, and improve access to care.[7] Through these improvements, CMM can enhance performance-based incentives in value-based payment models. CMM also shows value on total cost of care with a decrease in total health expenditures[8] and cost avoidance.[9]

Approximately 84% of all office visits to primary care physicians involve medication therapy,[10] yet 275,000 people die each year due to non-optimized medications.[11] We believe that clinical pharmacists providing CMM services as part of interprofessional teams in collaboration with primary care clinicians can significantly contribute to advances in quality, equity, and access through individualized and population-based approaches to care.

Integrating CMM services can help achieve cost savings through medication optimization in evolving payment models and demonstration projects focused mostly on primary care settings. Evidence indicates that CMM has a return-on-investment of at least 3:1 and as high as 12:1 when applied to patients with chronic conditions.[12]

Evidence to Prove CMM is Vital for Primary Care

1. Comprehensive Primary Care Plus (CPC+)[13] was a unique public-private partnership, in which practices are supported by 52 aligned payers in 18 regions program that worked to improve quality, access, and efficiency of primary care. Most notably, Track 2 practices were required to provide CMM to patients receiving care management and those in transitions of care who are likely to benefit. Track 2 practices increased the

Dec;18(4):2238. doi: 10.18549/PharmPract.2020.4.2238. Epub 2020 Dec 8. PMID: 33343776; PMCID: PMC7739512. Accessed: 7/10/24. Available here.

7 Fabel PH, Wagner T, Ziegler B, Fleming PA, Davis RE. A sustainable business model for comprehensive medication management in a patient-centered medical home. J Am Pharm Assoc (2003). 2019 Mar-Apr;59(2):285-290. doi: 10.1016/j.japh.2018.11.001. Epub 2019 Jan 2. PMID: 30611660. Accessed 7/10/24/ Available here

8 Ni W, Colayco D, Hashimoto J, Komoto K, Gowda C, Wearda B, McCombs J. Budget Impact Analysis of a Pharmacist-Provided Transition of Care Program. J Manag Care Spec Pharm. 2018 Feb;24(2):90-96. doi: 10.18553/jmcp.2018.24.2.90. PMID: 29384028; PMCID: PMC10398153. Accessed 7/10/24.Available here.

9 Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. J Manag Care Pharm. 2010 Apr;16(3):185-95. doi: 10.18553/jmcp.2010.16.3.185. PMID: 20331323; PMCID: PMC10437567. Accessed 7/10/24. Available here.

10 CDC National Ambulatory Medical Care Survey: 2016 National Summary Tables. Accessed 7/10/24, Available here.

11 Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. Ann Pharmacother. 2018 Sep;52(9):829-837. doi: 10.1177/1060028018765159. Epub 2018 Mar 26. PMID: 29577766. Accessed 7/10/24. Available here.

12 Amanda Brummel, Adam Lustig, Kimberly Westrich, Michael A. Evans, Gary S. Plank, Jerry Penso, and Robert W. Dubois Journal of Managed Care Pharmacy 2014 20:12, 1152-1158. Accessed 7/10/24. Available here.

13 CMS Comprehensive Primary Care Plus Model Summary. Accessed 7/10/24. Available here.

comprehensiveness of care delivered, and they were compensated by the Comprehensive Primary Care Payments that increased the amounts they would have received from FFS payments. This incentive aligns well with CMM, which is inherently comprehensive in its process of care, and may support advancement from medication reconciliation or episodic medication management to continual medication management.

2. Maryland Primary Care Program[14] was established by state of Maryland and CMMI under the Maryland Total Cost of Care Model that set the target for total costs of care reductions for Medicare and through broad, innovative care redesign between hospital and non-hospital partners across the state. The model set out to achieve this through its three programs: Hospital Payment Program, Care Redesign Program, and Maryland Primary Care Program (MDPCP). The MDPCP is a multi-payer program designed to transform primary care practice with the goals of lowering costs and improving outcomes. Its specific objectives were to reduce avoidable hospitalization and ED visits and build a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to lower Maryland's Medicare Part A and B expenditures by an annual saving target of USD 300 million by 2023. Practices were required to provide comprehensive primary care services and expand patients' access to care; empanel patients to providers; implement data-driven, risk-stratified care management; provide transitional care management; coordinate care with specialists; enhance patient engagement; integrate behavioral health; screen for social needs; and use health information technology tools to continuously improve quality. Participating practices received prospective payments for these services known as care management fees. Similar to CPC+, MDPCP also included two practice tracks. Track 2 practices were required to provide access to CMM services for patients receiving longitudinal care.

The transition from fee-for service (FFS) to value-based payments provides further opportunities to integrate pharmacists into team-based care. The rewards for efficient, high-quality patient care

[14] Millbank Memorial Fund Issue Brief. Maryland's Innovative Primary Care Program: Building a Foundation for Health and Well-Being. Published: June 2020. Accessed 7/10/24. Available here.

provided by the value-based payment approaches incentivize pharmacists to leverage their training and expertise in collaborative care teams to enhance performance-based incentive payments, increase patient satisfaction, and achieve other practice or system goals.

As part of this effort, we urge you to utilize the unique contributions of clinical pharmacists in the area of medication optimization. We welcome the growing understanding in Congress of the unique value that qualified clinical pharmacists provide in the therapeutic management of complex conditions.

ACCP is dedicated to advancing a 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 and (4) contributes to greater affordability and sustainability for the Medicare program. We look forward to working with you to help achieve these goals.

We appreciate your leadership and the opportunity to comment on these important issues as we work to build the health care infrastructure necessary for primary care to thrive.

Sincerely,

John McGlew
Senior Director, Government Affairs

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