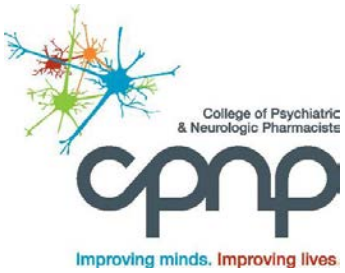

November 29, 2019

The Honorable Richard E. Neal
Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Ranking Member
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

RE: Rural and Underserved Communities Health Task Force Request for Information

Dear Chairman Neal and Ranking Member Brady:

On behalf of the College of Psychiatric and Neurologic Pharmacists (CPNP), we appreciate the opportunity to respond to the Rural and Underserved Communities Health Task Force's Request for Information (RFI), as outlined on the Ways and Means Committee website.

CPNP is a professional association of more than 2,300 members who envision a world where all individuals living with mental illness, including those with substance use and neurologic disorders, receive safe, appropriate, and effective treatment. Most members are specialty pharmacists and Board Certified Psychiatric Pharmacists (BCPPs) who specialize in psychiatry, substance use disorder, psychopharmacology, and neurology. When included as members of a healthcare team, psychiatric pharmacists can expand access to treatment, improve quality of care and reduce overall costs by putting their extensive expertise to use.

Pharmacists today graduate with a Doctorate of Pharmacy degree, a required six to eight years of higher education to complete, and have more training specific to medication use than any other healthcare professional. Psychiatric pharmacists, a specialty within clinical pharmacy, are primarily board certified and residency-trained mental healthcare practitioners who have specialized training in providing direct patient care and pharmacotherapy for the complete range of psychiatric and substance use disorders. Because of their specialized training in pharmacology, pharmacokinetics, and drug-drug and drug-disease interactions, psychiatric pharmacists are well positioned to partner, as a member of the healthcare team, with primary care providers (PCPs), psychiatrists, and other healthcare professionals to make recommendations on initial prescribing and dosing, to identify medication-related problems, and to increase the number of patients who can be treated by providing medication management and counseling, monitoring, and routine follow-up visits for individuals receiving medication assisted treatment (MAT) and other similar treatments for SUDs and mental health disorders.

Despite these overwhelming benefits, sufficient reimbursement continues to stand in the way of many practices seeking to include a psychiatric pharmacist on the care team and as part of their provision of telehealth services. Medicare does not recognize clinical psychiatric pharmacists as providers and as such will not reimburse healthcare systems or providers who employ them for their services. In many states, this means that they also are not recognized by private insurers or Medicaid, and many health systems and providers are reluctant to adopt these practices without the ability to be reimbursed for the services provided by psychiatric pharmacists. This is

to the detriment of those health systems successfully employing psychiatric pharmacists to reach rural patients in particular.

The following comments seek to highlight the benefits and unique role of psychiatric pharmacists when utilized on the interdisciplinary care team to help address shortages, particularly for the treatment of mental health and substance use disorders, and to help expand access to care in rural and underserved areas.

CPNP Comments on Ways and Means RFI

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Psychiatric pharmacists have made a positive impact through the use of telehealth. In Colorado, for example, Dr. Jeffrey Gold is a psychiatric pharmacist who has improved healthcare services for rural veterans by combining telemedicine, specifically face-to-face interactions with patients via computer, with patient visits to VA community-based outpatient clinics. This kind of hub-and-spoke model, with a central psychiatric pharmacist working with outpatient clinics across the state, successfully leverages psychiatric pharmacist expertise and improves patient care. Patients have to travel less and receive the best possible care and medication management. Through this approach, Dr. Gold visits 118 veterans per month, with 85% of those visits taking place via telehealth. He has also been able to make over 1,900 medication interventions to maximize the effectiveness of his patients' regimens.[1]

In order to expand the use of psychiatric pharmacists and to ensure they are included as part of the care team, the Committee should consider legislation that would reform reimbursement through Medicare, Medicaid, and other federal programs to better account for the cost of providing care in rural areas. Due to the reliance of rural providers on federal payments, it is all the more critical that psychiatric pharmacists be eligible for Medicare reimbursement through Part B; otherwise, healthcare systems and providers who want to employ psychiatric pharmacists will have little incentive to bring them on-board. Rural providers do not have the financial capacity to bring on psychiatric pharmacists without recognition from Medicare.

We recommend allowing Medicare to reimburse pharmacists for providing Part B services, which would otherwise be provided by a physician, nurse practitioner or physician assistant.

5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

[1] https://cpnp.org/psychpharm/profile?view=link-5-1566850513&.pdf

The example of Dr. Jeffrey Gold, as described previously, is an excellent example of leveraging telehealth. By working remotely with a number of VA outpatient clinics throughout Colorado, Dr. Gold can help patients in remote areas that otherwise would not be able to see him. Telehealth enables Dr. Gold to share his expertise throughout the state and vastly increases the number of patients seen. With additional psychiatric pharmacists properly reimbursed through Medicare, this system could expand.

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The VA Tennessee Valley Healthcare System demonstrates how psychiatric pharmacists can lessen the blow of workforce shortages. The System lost multiple psychiatric prescribers recently, but with psychiatric pharmacists as part of the team, the System was able to sustain mental health care services to veterans, due in part to a VA scope of care that allows psychiatric pharmacists to prescribe medications.

Psychiatric pharmacists can fill in gaps in areas with provider shortages and improve patient outcomes. In the Tennessee VA example, psychiatric pharmacists have been able to increase the use of MAT for opioid use disorder by 10% and increase outpatient clinical pharmacy specialist encounters 80 times over in a 5-year period. In short, psychiatric pharmacists ensured more patients received access to care.[2]

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

The VA Tennessee Valley Healthcare System also demonstrates how to expand access to substance use treatment. In broader terms, however, we would note that clinical pharmacists have extensive training in medication and medication management, expertise that rural and underserved communities need to address substance use. Clinical pharmacists are a vital resource to educate providers in their day-to-day practice of prescribing and monitoring patients' medications and are also a key contributor to continuing education programs for providers. In terms of the Committee's work to meet behavioral and substance use treatment needs, we encourage increased reliance on clinical and psychiatric pharmacists with unique expertise in the areas of mental health and addiction treatments.[3]

We would also cite the example of California Medi-Cal. California's Medicaid program, Medi-Cal has a Short Doyle Program for mental health services that recognizes clinical pharmacists as providers in the clinic setting, and they are able to bill for medication support services. This allows reimbursement for psychiatric pharmacy for prescribing medications, assessing medication regimens and providing recommendations, patient education, and direct patient care. Adoption of a similar approach in other states would immediately expand the number of available providers.

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[2] https://cpnp.org/psychpharm/profile?view=link-1-1566841506&.pdf
[3] *Id.*

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

Psychiatric pharmacists strengthen patient safety and improve care quality through their extensive training in medication and medication management. We urge two policy efforts: 1) Recognize psychiatric pharmacists' role as a critical member of MAT teams, and 2) work to ensure Medicare and Medicaid, especially through their reimbursement policies, incentivize providers to incorporate psychiatric pharmacists into MAT teams.

It bears repeating that as of now, Medicare does not recognize clinical psychiatric pharmacists as providers and as such will not reimburse healthcare systems or providers who employ them for their services. In many states, this means that they also are not recognized by private insurers or Medicaid. As noted above, there are many examples of practices where psychiatric pharmacists have been successfully integrated into healthcare teams and have improved patient outcomes and reduced overall healthcare costs. We recommend allowing Medicare to reimburse pharmacists for providing Part B services.

Conclusion

CPNP appreciates the opportunity to provide comments to the Committee and the Task Force. CPNP hopes our comments demonstrate the important role of psychiatric pharmacists and the potential for them, when fully integrated into the interprofessional healthcare team, to increase access and improve quality and costs of care for rural and underserved populations. Psychiatric pharmacists are a vital resource that should be recognized and utilized in the multidisciplinary approach to addressing the need for an affordable, accessible healthcare system. If you have any questions or require any additional information, please do not hesitate to contact me or our Health Policy Consultant, Laura Hanen at laura.hanen@dbr.com .

Sincerely,

Brenda Schimenti

Brenda Schimenti
Executive Director, CPNP

cc: The Honorable Danny Davis
The Honorable Terri Sewell
The Honorable Brad Wenstrup
The Honorable Jodey Arrington