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APhA

August 15, 2017

Ways and Means
Subcommittee on Health
Chairman Pat Tiberi (R-OH)

RE: Medicare Red Tape Relief Project

Dear Chairman Tiberi:

The American Pharmacists Association (APhA) appreciates the opportunity to provide input to the Ways and Means, Subcommittee on Health (hereinafter, "Subcommittee") on the "Medicare Red Tape Relief Project" aimed at identifying opportunities to reduce legislative and regulatory burdens on health care professionals to improve the efficiency and quality of the Medicare program for seniors and individuals with disabilities.

APhA, founded in 1852 as the American Pharmaceutical Association, represents 64,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and the uniformed services.

As health care remains a major focus of Congress and the Administration, APhA continues to emphasize the importance of legislative changes and regulatory flexibility that support patient access to and coverage of pharmacists' patient care services and safe and affordable medications. We also strongly encourage policies which do not unnecessarily restrict choice, allowing patients to access care from the provider, including pharmacist or pharmacy, of their choice.

I. Pharmacy and Medically Underserved Areas Enhancement Act

As Congress considers new approaches to enhance Medicare pursuant to the Medicare Red Tape Relief Project, APhA highly recommends including the provisions found in the Pharmacy and Medically Underserved Areas Enhancement Act (H.R.592). H.R. 592 would provide access to and coverage of pharmacists' patient care services under Medicare Part B in medically underserved communities consistent with state scope of practice laws. Currently, Medicare Part B beneficiaries are unnecessarily precluded from seeking care and services from pharmacists. In addition, because new programs often use existing Medicare requirements and

definitions, pharmacists are further disincentivized or prohibited from participating in other care models and opportunities.

Given the U.S. spends almost $300 billion annually on medication-related problems and 14% of Medicare fee–for-service beneficiaries have six or more chronic diseases, Medicare Part B recognition of pharmacists and their services is a commonsense solution to help improve and sustain the Medicare program.[1,2] No other health care professional has more medication-related education and training than the pharmacist. Pharmacist-provided care reduces costs and improves patient care and outcomes.[3,4] H.R. 592 allows for care delivery to be better structured to optimize the skills and expertise of practitioners, including pharmacists, thereby increasing access, improving quality and helping lower costs. While this policy is an important antidote to the problem of patient access, it is also an example of bipartisan health care legislation directly benefiting patients and the health care system as a whole. Therefore, APhA urges the Subcommittee's inclusion of the Pharmacy and Medically Underserved Areas Enhancement Act as part of the Medicare Red Tape Relief Project recommendations and corresponding legislative changes to improve the efficiency and quality of the Medicare program.

II. Improved Access to Health Care

When identifying ways to improve the Medicare program, it is important for the Subcommittee to consider the fact that pharmacists are the most accessible health care providers as 91% of all Americans live within five miles of a community pharmacy.[5] Pharmacists often form collaborative practice agreements with physicians and other health care providers to expand access to care. In addition to being medication experts on the patient's health care team, pharmacists also provide a broad array of services beyond dispensing medications, including disease state and medication management, smoking cessation counseling, health and wellness screenings, preventive services, and immunizations. Unfortunately, due to statutory and regulatory barriers, pharmacists are often an underutilized health care resource. Because pharmacists are not directly reimbursed for these services, their impact is minimized despite the growing primary care provider shortage.[6] Accordingly, APhA requests, in addition to the legislative change described previously, the Subcommittee encourage the Department of Health and Human Services (HHS) and its Centers for Medicare and Medicaid Services (CMS) to use their regulatory discretion, similar to efforts CMS applied for chronic care management (CCM) and transitional care management (TCM) services, to remove barriers preventing qualified

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[1] Department of Health and Human Services – Office of the Assistant Secretary. Multiple Chronic Conditions Among Medicare Beneficiaries: State-level Variations in Prevalence, Utilization, and Cost, 2011, Medicare & Medicaid Research Review, 2013, 3(3), available at: https://www.cms.gov/mmrr/Downloads/MMRR2013_003_03_b02.pdf.

[2] IMS Institute for Healthcare Informatics Avoidable costs in US health care. 2013. Available at:http://www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Institute/RUOM-2013/IHII_Responsible_Use_Medicines_2013.pdf.

[3] *See* Avalere Health, LLC. (2014). Exploring Pharmacists' Role in a Changing Healthcare Environment, available at http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1400680820_05212014-Exploring_Pharmacists_Role_in_a_Changing_Healthcare_Environment.pdf.

[4] *See* United States Public Health Service, Office of the Chief Pharmacist (2011). *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice; A Report to the U.S. Surgeon General 2011, available at: https://dcp.psc.gov/osg/pharmacy/documents/2011AdvancedPharmacyPracticeReporttotheUSSG.pdf.*

[5] NCPDP Pharmacy File, ArcGIS Census Tract File. NACDS Economics Department.

[6] *See* Bodenheimer, T.S. & Smith, M.D. (2013). *Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians*, Health Affairs, 32 (11), 1881-1886, available at: http://content.healthaffairs.org/content/32/11/1881.full.pdf+html.

providers, like pharmacists, from being optimized. Such regulatory action has helped alleviate some of the restrictions preventing pharmacists from providing these services, which also positively impacts their inclusion on care teams and in value-based delivery models.

Sec. 3134 of the Patient Protection and Affordable Care Act (ACA) requires the HHS Secretary to periodically identify potentially misvalued services and to review and make appropriate adjustments to the relative values for those services. In the 2017 Physician Fee Schedule Final Rule,[7] the HHS Secretary exercised this authority to create new billing codes to better facilitate the provision of services in the Psychiatric Collaborative Care Model (CoCM). Therefore, APhA requests the Subcommittee, in addition to encouraging the HHS and CMS to exercise already existing authorities, to continue to include language in legislation to allow the regulatory discretion to better utilize qualified practitioners, such as pharmacists, to enhance the infrastructure essential to effective delivery of health care. Doing so will improve patient access and choice, as well as increase efficiencies in the delivery of services, which is especially important as health care payment and delivery models become more value-based.

III. Network Adequacy

While APhA emphasizes the need for accurate pharmacy network adequacy and access standards, we also recognize the need for patients to be able to seek care from the provider of their choice. As the prevalence of both narrow provider and pharmacy networks has increased, overly restricted choices unjustly decrease patient access and choice. Accordingly, APhA requests Congress clarify that providers willing to meet plans' contractual terms should be allowed to participate in networks. In addition, qualified health care practitioners should be utilized to provide services within their scope of practice to help increase access. Better inclusion of pharmacists will improve care delivery and health outcomes by increasing access, enabling patients to obtain care from the provider(s), including pharmacist(s), of their choice.

IV. Essential Health Benefits

APhA anticipates stakeholders will request additional flexibility pertaining to Essential Health Benefits. APhA requests the Subcommittee maintain prescription drug benefits, preventive and wellness services, and chronic disease management. Any allowed flexibility should maintain patient access to the aforementioned essential health benefits and permit patients to access services and medications from the health care provider of their choice if within the practitioner's scope of practice.

V. Value

APhA has been a strong supporter of recent efforts to insert value into care delivery, payment and coverage. We encourage the Subcommittee, when considering policies, to look beyond isolated components of health care to determine value. Because health insurance coverage is frequently analyzed by the benefit type such as inpatient, outpatient, and drug coverage, a

[7] CMS. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017. Final Rule. November 15, 2016. 81 FR 80170. Available at: https://www.federalregister.gov/documents/2016/11/15/2016-26668/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

patient's overall services, costs and outcomes may never be reviewed comprehensively. HHS and other policymakers cannot continue to consider drug and medical coverage, and their related costs and outcomes, separately if we are to achieve true value in health care. As noted above, the U.S. spends nearly $300 billion dollars annually on medication-related problems, many of which are preventable and better addressed by breaking down the many silos within our health care system. Consequently, health care coverage, payment and delivery policies need to be better integrated to measure and achieve value in our Nation's health care system.

Thank you again for the opportunity to provide comments regarding opportunities to lower costs, improve quality and encourage more innovation in Medicare. As you move forward, please do not hesitate to use APhA as a resource as we share the Subcommittee's interest in providing relief from regulations and mandates that impede innovation, drive up costs and prevent the delivery of better care for Medicare beneficiaries. If you have any questions or require additional information, please contact Alicia Kerry Mica, at amica@aphanet.org or by phone at 202-429-7507.

Sincerely,

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