College of Psychiatric & Neurologic Pharmacists

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November 1, 2021

The Honorable Ron Wyden
Chairman, Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Wyden and Senator Crapo:

On behalf of the College of Psychiatric and Neurologic Pharmacists (CPNP), we write in response to your request for policy recommendations to improve access to health care services for Americans with mental health and substance use disorders. We laud your leadership in embarking on a bipartisan effort to examine behavioral health care needs and to understanding the underlying factors that contribute to the gaps in this important patient care.

CPNP is a professional association of nearly 3,000 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. Members are specialty pharmacists, and most are Board Certified Psychiatric Pharmacists (BCPPs) who specialize in psychiatry, substance use disorder, psychopharmacology, and neurology. Pharmacists graduate with a Doctor of Pharmacy degree, a required six to eight years of higher education and have more training specific to medication use than any other healthcare professional. With a significant mental health care professional shortage, psychiatric pharmacists offer to be another resource to improve outcomes for patients with psychiatric and substance use disorders.

Psychiatric pharmacists are an underutilized resource on the frontlines providing direct patient care, optimizing medication outcomes, and supporting fellow health care colleagues in primary care and mental health. In response to your request for evidence-based solutions and ideas to enhance behavioral health care in America, CPNP offers the following recommendations –

1. Strengthening the Mental Health and Substance Use Workforce

Increase access to mental health and substance use providers by requiring Medicare to pay for patient care services provided by psychiatric pharmacists

Pharmacists today graduate with a Doctor of Pharmacy degree, which requires six to eight years of higher education, and have more training specific to medication use than any other health care professional. Psychiatric pharmacy practice specializes in treating patients living with psychiatric, neurologic, and substance use disorders. Psychiatric pharmacists have extensive training and expertise in medication treatment and the psychosocial factors inherent within these illnesses. Psychiatric pharmacists work as treatment team members but also in decision-making and leadership roles in state and federal organizations, academia, and industry. They can extend their reach by partnering with and educating patients, families, and providers and advocating for the appropriate use of medications.

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Despite their central role in the health care system, psychiatric pharmacists are not currently eligible to enroll in or bill Medicare. This lack of payment for psychiatric pharmacist services limits access to their services and their ability to increase the capacity of the care team, including psychiatrists, to see more patients. Many psychiatric pharmacists, working as team members often through collaborative practice agreements, provide all levels of care including prescribing medications and managing all medications to optimize outcomes, addressing drug interactions, and promoting adherence to therapies. Psychiatric pharmacists are trained to perform mental status exams and identify symptoms of mental illnesses that respond to, or are poorly responsive to, psychiatric medications.

As to substance use disorders, psychiatric pharmacists have a deep understanding of Medication Assisted Therapy (MAT) that extends beyond that of most other health care providers. When included in the provision of MAT services, psychiatric pharmacists' involvement has been demonstrated to improve patient adherence and success with buprenorphine treatment for opioid use disorders; reduce per patient dosing of buprenorphine through improved medication management, monitoring, and titration; and reduce overall costs for treating patients with substance use disorders by relieving providers from delivering services including medication management, counseling, monitoring and follow-ups.

Because the Centers for Medicare & Medicaid Services (CMS) does not directly oversee pharmacists under Medicare, the agency often inadvertently excludes pharmacists during rulemaking. As such CMS will not reimburse health care 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 and is also an opportunity to reach rural patients.

Increase access to comprehensive medication management (CMM) for persons with mental health and substance use disorders; CMM is not a covered service under Medicare

As stated above, psychiatric pharmacists are an important member of the health care team working in collaboration with the patient and other health care providers including psychiatrists, other physicians, therapists, social workers, and nurses. Psychiatric pharmacists provide expert, evidence based Comprehensive Medication Management (CMM) services for the most complex patients with mental health and substance use disorders. This can only happen if these services are covered and psychiatric pharmacists are reimbursed. CMM is a specific set of services that include assessing all a patient's medications– prescription, nonprescription, vitamins, and supplements; assessing each medication to ensure that it is appropriate, effective, safe, and can be taken as intended; identifying and addressing medication-related problems; developing individualized care plans with therapy goals and personalized interventions; prescribing medications and ordering laboratory or other diagnostic tests (varies by state); following up with appointments at regular intervals (e.g., weekly, biweekly or monthly) to evaluate response, adverse effects, progress toward treatment goals, and to adjust medications as needed; educating patient and family about medications and lifestyle modifications; and referring to other providers and specialists for services such as diagnostic clarification, psychotherapy, and dietary counseling.

CMM services benefit patients needing complex care coordination among multiple providers; with multiple chronic conditions; on complex medication regimens; who are not meeting treatment goals; who have serious medication adverse effects; transitioning between health care settings; taking specialty medications like clozapine or long-acting injectable antipsychotic medications; who would benefit from genetic testing to optimize their medication regimen; with tobacco, alcohol, opioid, or

other substance use disorders (SUDs) who may benefit from medication treatment; and who have conditions that complicate psychiatric medication treatment such as pregnancy, advanced age, concomitant medical illness; and those receiving antipsychotic medications as children.

To enable patients access to these critical services, Congress can enact legislation requiring the coverage of Comprehensive Medication Management under Medicare Part B. As you are aware, once Medicare provides coverage many private payers and Medicaid programs will follow suit.

Address payment deficiencies that contribute to a lack of access to care and medication coordination
Medicare limits physicians to billing only the lowest-level evaluation and management (E/M) code for pharmacist-provided incident-to services, regardless of the duration and complexity of the E/M services provided. This policy undermines health system care models that leverage care team members, including psychiatric pharmacists to support physicians, thereby threatening patient access to critical services, including comprehensive medication management. The CMS E/M policy is fundamentally at odds with efforts to implement care models that include clinical pharmacists. Many commercial payers as well as states consider pharmacists to be qualified health professionals whose services can be billed incident-to a physician using the higher-level E/M codes.

In addition, CPNP supports the *Pharmacy and Medically Underserved Areas Enhancement Act* (H.R. 2759/ S. 1362) to add pharmacists to the list of providers whose patient care services, when delivered to patients in medically underserved communities, are covered by Medicare Part B. Psychiatric pharmacists will continue to be an underutilized provider of mental health and substance use services until the services they provide are paid for sufficiently. This legislation seeks to expand access to patient care services in medically underserved areas where need is most acute due to the lack of providers.

Test models of care utilizing pharmacist-provided patient care services
With the shift to value-based care, CPNP urges Congress to support the development and testing of payment models through the Center for Medicare and Medicaid innovation in which psychiatric pharmacists manage medications through the process of CMM. CPNP recommends CMS test a model that incentivizes psychiatric pharmacist involvement across relevant Medicare service lines, including in value-based models such as the Comprehensive Primary Care Plus (CPC+) primary care model. This advanced primary care model integrates clinical pharmacists as part of the care team to provide medication management services, that includes evaluating medication regimens, providing medication self-management support for patients to help them adhere to their prescribed therapies, and promoting clinically-sound, cost-effective medication therapies.

Remove barriers to Mediation Assisted Therapy
To expand access to medication assisted treatment, CPNP supports the *Mainstreaming Addiction and Treatment Act* (S. 445/H.R. 1384) to eliminate the DATA waiver (or X waiver) requirement to allow buprenorphine to be utilized like other Schedule III drugs. CPNP believes more needs to be done to increase access to substance use treatment and removal of the DATA waiver requirement is an important step. In the absence of the elimination of the X waiver, CPNP urges the "qualifying other practitioner" requirements be revised to include psychiatric pharmacists as eligible for the DATA waiver. At present, the exclusion of psychiatric pharmacists from X-waiver eligibility has deprived patients of access to MAT at a time when demand for care far outstrips capacity.

Provide loan repayment for serving in Health Professional Shortage Areas
Currently, pharmacists are not eligible to participate in most of the NHSC student loan repayment programs, which are open to primary care clinicians in a Health Resources and Services (HRSA)-approved service site in a Health Professionals Shortage Area. An exception is the Substance Use Disorder Workforce Loan Repayment Program. To increase greater participation in behavior health, we recommend that pharmacists be eligible for additional NHSC loan repayment programs. CPNP also supports robust funding for Behavioral Health Workforce Education and Training program, the Loan Repayment Program for Substance Use Disorder Treatment Workforce, and the Mental and Substance Use Disorder Workforce Training Demonstration Program.

Increase Clinical Pharmacy Residencies
The nation's need for quality health care services includes the services provided by pharmacy residency programs, which prepare pharmacists to work effectively as an integral part of a multidisciplinary health care team. Residency-trained pharmacists participate directly in clinical decisions regarding the use of medications and are leaders in improving patient outcomes. Due to scientific advancements and the evolution of care delivery models, pharmacy residencies are now essential to performing certain patient care services. There continues to be a need for more pharmacy residency programs, and it is in the public's best interest that such programs be adequately funded.

Increase Payment Rates Under Medicaid
CPNP recommends increasing the federal reimbursement rate for mental health and substance use disorder care under Medicaid through passage of the *Medicaid Bump Act* (S. 1727/H.R. 3450). As you are aware, Medicaid is the nation's largest insurer of mental health and substance use treatment for both adults and children. However, many beneficiaries remain on long waitlists for mental and behavioral health services or languish for long periods of time in emergency rooms awaiting treatment. The *Medicaid Bump Act* would incentivize states to expand their Medicaid coverage of mental health and substance use treatment services by providing a corresponding raise in the Federal Assistance Percentage (FMAP) matching rate to 90 percent for behavioral health services. Significantly, increasing Medicaid reimbursement rates also would flow to the mental health and substance use treatment workforce, enhancing the behavioral health system's ability to recruit and retain needed providers.

2. Increasing Integration, Coordination, and Access to Care
To better promote care integration, coordination, and access, we reiterate our recommendations above regarding the need to remove barriers to psychiatric pharmacists to increase their numbers in serving on primary care and mental health care teams. Clinicians want to use psychiatric pharmacists to enable to provide care in the primary care setting and increase access to mental health and substance use services. Until these services are sufficiently reimbursed by Medicare, primary clinicians cannot afford to bring psychiatric pharmacist on board.

In addition, CPNP supports nationwide expansion of the pilot Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration program through the bipartisan *Excellence in Mental Health and Addiction Treatment Act of 2021 (S. 2069/H.R. 4323).* We also recommend providing individuals who are involved with the criminal justice system the opportunity to enroll in Medicaid prior to their release and transition back to their communities through passage of the bipartisan *Medicaid Reentry Act of 2021 (S. 285/H.R. 955).* We further recommend addressing crisis response in a comprehensive manner through the bipartisan *Behavioral Health Crisis Services Expansion Act (S. 1902),* which would provide comprehensive and critical support to develop and sustain crisis services across the country.

3. Ensuring Parity

CPNP recommends extending mental health and substance use treatment parity – required for most of the commercial market and Medicaid plans under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 -- to Medicare, Medicaid, and TRICARE. More than 60 million older adults and individuals with disabilities enrolled in Medicare have limited coverage for mental health and substance use disorder services, as do 20 million enrollees in traditional Medicaid and 10 million enrollees in TRICARE. Congress has not yet extended parity protections for Americans in health coverage administered directly by states and the federal government. Accordingly, we recommend extending the full rights and benefits of the federal Parity Act to Medicare, Medicaid, and TRICARE.

CPNP also recommends adoption of the *Parity Implementation Assistance Act (S. 1962/H.R. 3753).* Under the *Consolidated Appropriations Act of 2020 (CAA)*, health insurers are required to perform comparative analyses demonstrating that they are complying with the federal Parity Act. Recognizing that these analyses can be time consuming and labor intensive for state regulators, the *Parity Implementation Assistance Act* authorizes $25 million in annual grant funding to states for five years.

4. Expanding Telehealth

Maintain access to mental health and substance use services delivered via telehealth
The *CAA* also removed the geographic restriction for Medicare telehealth services for the diagnosis, evaluation or treatment of a mental health disorder and adds the patient's home as a permissible originating site for these telehealth services. Payment is prohibited unless a physician or practitioner has furnished an item or service in-person within 6 months of the first telehealth visit. CPNP believes that barriers to telehealth for mental health and substance use services should be minimal. Some people with mental health conditions have symptoms that interfere with their ability to attend in-person appointments, such as anxiety or agoraphobia, such that they may prefer telehealth visits for all of their visits. CPNP recommends Congress remove the 6-month in-person visit requirement and leave it to the treating clinician to determine the best interval for their patients to be seen in person if needed. Therefore we recommend passage of the bipartisan *Telemental Health Care Access Act (S. 2061/H.R. 4058)* that would eliminate the 6-month requirement.

CPNP also supports the provision of mental health services to established patients via audio-only telephone calls. In 2019, the Federal Communications Commission reported that between 21.3 and 42 million Americans lack access to broadband. Audio-only visits will ensure that those in areas with limited or no broadband, older adults and younger individuals with disabilities who rely on Medicare for essential behavioral health care won't lose access to critically needed services. In addition, CPNP urges that audio-only services should be available for the treatment of substance use disorders particularly in light of recent CDC research showing that over 40 states saw a rise in opioid-related overdose deaths since the start of the pandemic.

CPNP also recommends that telehealth for mental health and substance use services, including audio-only telehealth services, be reimbursed at the same rate as in-person services, the non-facility rate. For mental and behavioral health providers, whose patients rely heavily on telehealth services, it would be a costly reduction if payment for these services returns to pre-pandemic reimbursement levels. Given the significant investments required of providers to offer and maintain telehealth services, this change could discourage many providers from continuing to offer telehealth services and thereby jeopardize access to mental and behavioral health services for many beneficiaries.

CPNP supports allowing Rural Health Centers and Federally Qualified Health Centers to be paid for mental health visits furnished via real-time, telecommunication technology in the same way they currently do when these services are furnished in-person. This would ensure that Medicare beneficiaries receiving services through these facilities would have the same access to mental and behavioral health services as those treated by providers practicing independently. CPNP also believes outpatient behavioral therapy services offered by Critical Access Hospitals (CAHs) are part of a comprehensive rural behavioral health strategy. Without action to ensure these hospitals can bill behavioral health services via telehealth as they do in-person services, access to these CAH-provided outpatient services will be lost for thousands of Americans in rural areas.

5. Protecting Access to Mental Health Medications

Protect the 340B Drug Pricing Program

The 340B program enables safety net providers to stretch scarce federal resources to provide health care to underserved patients. Covered entities – safety net providers serve low-income patients - generate savings by purchasing 340B outpatient drugs at a discounted rate while receiving the same reimbursement from the insurer. This savings enables covered entities to provide comprehensive health care including free care and discounted or free medication to uninsured, underinsured, or other at-risk patient populations. This includes access to behavioral health medications and services, as well as training for the health care workforce including advanced practice psychiatric pharmacists needed to care for complex patients.

Maintain the Six Protected Classes protections under Medicare Part D

Current Medicare policy requires insurers offering Medicare Part D plans to include on their formularies all or substantially all drugs in six medication classes. The "Six Protected Classes" include antidepressants and antipsychotics. The Six Protected Classes were put in place as acknowledgment that for some conditions individuals respond differently to different medications and formulations, and that individuals need access to a full range of options in achieving wellness. In recent years CMS has proposed creating exceptions to the Six Protected Classes policy to allow insurers to institute new prior authorization or step therapy requirements or exclude medications entirely under some circumstances. CMS, after concerns raised by Congress, ultimately abandoned their proposal. CPNP urges Congress to continue their steadfast support for maintaining the Six Protected Classes' policy as it stands today. By having the Six Protected Classes in place, those with Medicare are more likely to access the medications they need for their mental health conditions at reasonable costs.

CPNP appreciates the opportunity to provide comments about behavioral health access and care delivery. CPNP hopes our comments demonstrate the important role of psychiatric pharmacists and the potential for them, when fully integrated into the interprofessional health care team, to increase access and improve quality and costs of care for patients.

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@faegredrinker.com.

Sincerely,

Brenda Schimenti

Brenda K. Schimenti
Executive Director