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On behalf of the American Association of Psychiatric Pharmacists

Statement for the Record for the Subcommittee on Health Care hearing
Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs

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Submitted via email to Statementsfortherecord@finance.senate.gov

On behalf of the American Association of Psychiatric Pharmacists (AAPP), we appreciate the opportunity to submit a statement for the record for the Subcommittee on Health hearing *Closing Gaps in the Care Continuum: Opportunities to Improve Substance Use Disorder Care in the Federal Health Programs* and applaud the Senate Finance Committee for their ongoing efforts to address the mental health and substance use disorder crisis.

AAPP 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 disorders (SUD), receive safe, appropriate, and effective treatment. Members are clinical pharmacists who specialize in psychiatry, including the treatment of substance use disorders (SUD), and psychopharmacology.

The need for substance use services, including for opioid use disorders (OUD), is greater than ever and services are not keeping up with demand. In 2020, 41.1 million people needed treatment for a SUD, but only 4 million (9.7%) received any treatment.[1] For adults with co-occurring mental illness and SUD, 49.5% received neither substance use treatment nor mental health services and only 5.7% received treatment for both.[1] There are fewer than 1,816 programs providing methadone to approximately 409,000 Americans.[2] Only 11% of opioid treatment programs provide medications for opioid use disorder (MOUD) using methadone

[1] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Available at: https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report

[2] Pew Charitable Trusts Issue Brief. (2021). Opioid Treatment Programs: A Key Treatment System Component. Available at: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/07/opioid-treatment-programs-a-key-treatment-system-component

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and/or buprenorphine.[3] There are several reasons adults do not receive substance use treatment including the fact that 19.1% have no health care coverage or can't afford coverage, 14.4% can't find the type of program they want, and 11.9% are concerned about stigma.[1] Even after removal of some regulatory prescribing restrictions for buprenorphine, significant barriers to this highly effective and safe treatment remain such as stigma, insufficient training, poor care coordination, and inadequate reimbursement.[4,5]

AAPP supports the Committee's and Congress' expansion of the list of qualified health providers under Medicare to provide mental health and SUD services. The Consolidated Appropriations Act, 2023 established a new statutory Medicare benefit category for services furnished by marriage and family therapists (MFTs) and mental health counselors (MHCs). Unfortunately, an important provider of mental health and substance use services has been excluded from these workforce expansions and incentives – the psychiatric pharmacist. **We urge the Committee to remedy this exclusion by adding psychiatric pharmacists as Qualified Health Providers (QHPs) under Medicare for the following reasons.**

1. **Psychiatric pharmacists are clinical pharmacists that serve on care teams with other clinicians to provide direct patient care services. Psychiatric pharmacists treat patients under a collaborative practice agreement with a physician.**

2. **Psychiatric pharmacists are residency-trained medication experts that increase the capacity of mental health and SUD teams to care for more patients and add much needed psychiatric expertise in a primary care setting.**

3. **Psychiatric pharmacists use an evidence-based process of care known as comprehensive medication management (CMM), the standard of care which reviews all the medications a patient is taking including prescription and non-prescription. CMM is essential when 80% of patient treatment plans involve medication.**

4. **Designating psychiatric pharmacists as QHPs under Medicare will allow reimbursement for CMM, thereby making it financially feasible for practices to utilize the much needed services of psychiatric pharmacists.**

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[3] Andrilla CHA, Moore TE, Patterson DG, Larson EH. Geographic Distribution of Providers With a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update. J Rural Health. 2019;35(1):108-112. DOI: 10.1111/jrh.12307. PubMed PMID: 29923637.

[4] Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

[5] Jones CM, Olsen Y, Ali MM, et al. Characteristics and Prescribing Patterns of Clinicians Waivered to Prescribe Buprenorphine for Opioid Use Disorder Before and After Release of New Practice Guidelines. *JAMA Health Forum.* 2023;4(7):e231982. doi:10.1001/jamahealthforum.2023.1982

5. **Expand access to methadone outside of Opioid Treatment Programs.**

6. **Maintain access to buprenorphine treatment via telehealth.**

The Role of a Psychiatric Pharmacists

Psychiatric pharmacists are important members 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. They are distinct from dispensing pharmacists. They have extensive additional education beyond the Doctor of Pharmacy degree, typically including one year of general pharmacy residency, one year of psychiatric pharmacy residency, and certification through the Board Certified Psychiatric Pharmacist (BCPP) examination. Psychiatric pharmacists also serve in decision-making and leadership roles in health care organizations, state and federal organizations, academia, and industry.

Psychiatric pharmacists have a deep understanding of Medications for Opioid Use Disorder (MOUD) that extends beyond that of most other health care providers. When included in the provision of MOUD services through a collaborative practice arrangement, psychiatric pharmacists' involvement has been demonstrated to improve patient adherence and success with buprenorphine treatment for opioid use disorders; reduce per patient dosage of buprenorphine through improved medication management, monitoring and titration; and reduce overall costs. Furthermore, given the insufficient number and continued attrition of providers in addiction medicine, psychiatric pharmacists can be utilized to increase access to SUD treatment by providing medication management, education, monitoring, and follow-up care.

Psychiatric pharmacists add unique value to the care team as they can:

- Recommend or prescribe appropriate medications;
- Evaluate responses and modify treatment;
- Manage adverse reactions to medication;
- Resolve drug interactions;
- Support medication adherence;
- Manage complex medication regimens for individuals living with multiple chronic conditions including mental illness, including substance use disorders; and
- Provide medication education.

One of the most important services psychiatric pharmacists provide is expert, evidence-based CMM services for the most complex patients with mental health and substance use disorders. Psychiatric pharmacists increase capacity of the health care team to deliver care, provide psychopharmacology expertise, as well as improve patient outcomes and reduce overall health

care costs. In fact, the Veterans Health Administration[6] has embraced CMM provided by clinical pharmacist practitioners as its standard of care throughout the system.

Although the CMM model is well accepted in some government funded health systems such as the VA and federally qualified health centers, it has not gained widespread acceptance. The primary cause for this lag is the lack of recognition of psychiatric pharmacists as QHPs and the failure of Medicare to reimburse practices for CMM as a covered service.

Psychiatric Pharmacists Fill Gaps in the Mental Health and Substance Use Workforce and Expand Capacity of Care Teams

As we know, the behavioral health workforce has reached a tipping point. In fact, more than 150 million people live in Mental Health Professional Shortage Areas (HPSAs) as defined by the Health Resources and Services Administration (HRSA).[7] Alarmingly, more than 60% of counties in the United States have an unmet need for mental health services.[8] Given the workforce shortages due to burnout, reimbursement issues, and provider capacity, it is more important than ever to allow providers to practice at the top of their license and allow more types of providers to step in and assume more general duties. For example, as is the case with primary care physicians (PCP) and physician's assistants (PA); the PA is able to measure vitals, administer vaccines etc., freeing up the PCP to address more pressing issues.

Similarly, we strongly urge you to consider the benefits of adding psychiatric pharmacists to the mental health and substance use workforce as an integral part of the care team. Given that psychiatric pharmacists can prescribe, evaluate, manage, triage, and educate patients with mental health and SUD, not leveraging their expertise during this critical time is a missed opportunity.

Psychiatric Pharmacists Provide an Essential Patient Care Service – Comprehensive Medication Management – That Should be Reimbursed by Medicare

Medications are involved in 80% of all treatment plans and affect almost every aspect of a patient's life.[9]

CMM is of the greatest benefit to:

- Patients who have not reached or are not maintaining treatment goals;
- Patients who are experiencing adverse effects from their medications;
- Patients who have difficulty understanding and following their medication regimen;

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[6] VA's Clinical Pharmacy Practice Office, https://www.pbm.va.gov/PBM/CPPO/Clinical_Pharmacy_Practice_Office_Home.asp..

[7] Health Workforce Shortage Areas, HRSA, November 9, 2022, *available at* https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[8] Id.

[9] Comprehensive Medication Management in Team-Based Care, American College of Clinical Pharmacy, p. 3, https://www.pcpcc.org/sites/default/files/event-attachments/CMM%20Brief.pdf.

- Patients in need of preventive therapy; and
- Patients who are often readmitted to the hospital.

CMM has the proven effect of keeping individuals on track to reach their treatment goals and keeping individuals out of the hospital, both of which can ultimately save the Medicare program critical dollars.[10]

The benefits of CMM can be quantified through a calculation of return on investment (ROI), or how much value the service adds compared with the cost of delivering the service. The ROI of medication management services has been studied in numerous patient populations. The data from the delivery of this service are positive, with a demonstrated ROI as high as 12:1 with an average of 3:1–5:1. The ROI reflects a decrease in hospital and emergency department admissions and readmission, and a reduction in the use of adverse outcomes from unnecessary and inappropriate medications. This estimate is conservative; the ROI is likely to be much greater because practitioners routinely underestimate the impact of clinical pharmacists' services on a patient's quality of life. In addition, it is difficult to place a number on high patient satisfaction and physician acceptance.[11] **Data suggest that providing CMM will help the Medicare program avoid almost 6 million physician office visits and 670,000 emergency department visits annually, saving more than $1 billion and more than $500 million, respectively, per year.[12]**

Because They are Not a QHP Under Medicare, Psychiatric Pharmacists Cannot be Paid Using E&M Codes Commensurate with the Services Provided and Documented Like All Other Providers

When billing "incident to" for psychiatric pharmacists' services, even when documentation meets the criteria for higher-level visits, their services are not reimbursed above a level one Evaluation and Management (E&M) visit because they are not a QHP. Being designated a QHP, allows higher levels of incident to billing under the supervision of a physician and would make collaboration with a psychiatric pharmacist more financially feasible for physician practices. Billing and reimbursement must be addressed in order to allow health care systems and providers to employ psychiatric pharmacists.

Further, the lack of sufficient reimbursement from Medicare has a cascading effect. Since Medicare does not recognize psychiatric pharmacists as providers, neither does Medicaid or

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[10] Chung, TH et al. The evaluation of comprehensive medication management for chronic disease in primary care clinics, a Texas delivery system reform incentive payment program, NIH PubMed, July 20, 2020, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7372764/.

[11] Patient-Centered Primary Care Collaborative (PCPCC). The patient-centered medical home: integrating comprehensive medication management to optimize patient outcomes resource guide, 2nd ed. Washington, DC: PCPCC, 2012, *available at* www.pcpcc.org/sites/default/files/media/medmanagement.pdf..

[12] Comprehensive Medication Management in Team-Based Care, American College of Clinical Pharmacy, p. 6, *available at* https://www.pcpcc.org/sites/default/files/event-attachments/CMM%20Brief.pdf.

other health plans in most states. Many health systems and providers are unable to add psychiatric pharmacists to their teams without the ability to be reimbursed for their services.

Expand Access to Methadone Outside of Opioid Treatment Programs

Methadone, a synthetic, long-lasting opioid agonist, is a gold standard medical treatment for OUD. Methadone is the most well-studied pharmacotherapy for OUD,[13] with the longest track record. Methadone is safe and effective for patients when indicated, dispensed, and consumed properly.[14] However, there are fewer than 1,816 programs providing methadone to approximately 409,000 Americans.[2]

Psychiatric pharmacists support expanding access to methadone outside of the Opioid Treatment Program (OTP) setting and therefore supports the *Modernizing Opioid Treatment Access Act* (S. 644) for doing so. The legislation that has passed out of the Senate Health, Education, Labor, and Pensions Committee seeks to address the antiquated, forty-year-old methadone regulations to save lives. The bill would also fix the contradictory policy that pharmacies can dispense methadone for pain but not to treat OUD. The bill also allows for the use of telehealth support for counseling and other ancillary services. Furthermore, expanding access to methadone outside of OTPs will help decrease stigma people experience in seeking treatment by integrating it into the health care system.

During the COVID pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) allowed for take-home methadone doses for OUD from opioid treatment programs (OTPs).[15] Research on the methadone COVID flexibilities showed no evidence of increased methadone overdose[16] or diversion.[17] Responsibly expanding access to methadone treatment for OUD in medical settings and areas where it is not available now is critical to saving lives, helping families, and strengthening our communities.[18]

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[13] Substance Abuse and Mental Health Administration. Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families. Treatment Improvement Protocol (TIP) Series, No. 63. Chapter 3B: Methadone; 2018. Accessed March 31, 2022. http://www.ncbi.nlm.nih.gov/books/NBK535269/

[14] Baxter LES, Campbell A, DeShields M, et al. Safe Methadone Induction and Stabilization: Report of an Expert Panel. J Addict Med. 2013;7(6):377-386. doi:10.1097/01.ADM.0000435321.39251.d7

[15] Substance Abuse and Mental Health Services Administration. Medications for the Treatment of Opioid Use Disorder. Proposed Rule; https://www.federalregister.gov/documents/2022/12/16/2022-27193/medications-for-the-treatment-of-opioid-use-disorder; Substance Abuse and Mental Health Services Administration. Methadone Take-Home Flexibilities Extension Guidance, https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance

[16] Sarah Brothers, Adam Viera, Robert Heimer, Changes in methadone program practices and fatal methadone overdose rates in Connecticut during COVID-19, Journal of Substance Abuse Treatment, Volume 131, 2021, 108449, ISSN 0740-5472, https://doi.org/10.1016/j.jsat.2021.108449.

[17] Amram, O., Amiri, S., Panwala, V., Lutz, R., Joudrey, P. J., & Socias, E. (2021). The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 era. *The American Journal of Drug and Alcohol Abuse*, *47*(6), 722–729. https://doi.org/10.1080/00952990.2021.1979991

[18] Joudrey PJ, Chadi N, Roy P, Morford KL, Bach P, Kimmel S, Wang EA, Calcaterra SL. Pharmacy-based methadone dispensing and drive time to methadone treatment in five states within the United States: A cross-sectional study.

Maintain Access to Buprenorphine Treatment Via Telehealth

During the COVID-19 Public Health Emergency, the Drug Enforcement Agency (DEA) and the Department of Health and Human Services temporarily removed the in-person exam requirement for prescribing medication via telemedicine for people with opioid use disorder. Telehealth flexibilities helped a broad range of patients – including veterans, those living in rural areas, people experiencing homelessness, individuals in the criminal justice system, and racial and ethnic minorities – access treatment. The flexibilities are set to expire on December 31, 2024. The Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act (S. 3193) makes the flexibilities permanent, allowing providers to waive the in-person visit requirement of which we support.

In the absence of the passage of legislation, we are concerned that the DEA has yet to release of a revised proposed rule to permit and regulate the prescribing of controlled substances through telehealth. There needs to be sufficient time for comment and finalization of the rule prior to the expiration of the flexibilities at the end of the year.

We thank Chair Cardin and Ranking Member Daines and the Subcommittee for the opportunity to share these comments on the importance of expanding access to an often-overlooked provider of substance use services and removing barriers to care and treatment. For more information, I can be contacted at bschimenti@aapp.org.

Drug Alcohol Depend. 2020 Mar 27;211:107968. doi: 10.1016/j.drugalcdep.2020.107968. Epub ahead of print. PMID: 32268248; PMCID: PMC7529685.