September 10, 2018

Ms. Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019 [CMS-1693-P]

On behalf of the College of Psychiatric and Neurologic Pharmacists (CPNP), we appreciate the opportunity to provide feedback on the Centers for Medicare and Medicaid Services’ (CMS) Proposed Rule [CMS-1693-P], Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program.

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.

While approaches to prevention, intervention, and treatment have improved, gaps in the health system continue to persist for the treatment of those with substance use or mental health disorders. CPNP supports the measures proposed by CMS to improve treatment and services for patients suffering from mental health and opioid or substance use disorders. Specifically, we are responding to provide feedback on the solicitation of comments from stakeholders regarding the creation of a bundled episode of care for management and counseling treatment for substance use disorders (SUDs).

**Comments on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders**

CPNP broadly supports CMS’s consideration of a separate payment for a bundled episode of care for components of medication assisted treatment (MAT) and non-MAT associated management and counseling for SUDs and recommends psychiatric pharmacists be included among the types of practitioners eligible for participation and provision of these services.
Pharmacists today graduate with a Doctorate of Pharmacy degree, a required six to eight years of higher education to complete, and have more medication-related training than any other health care professional. Psychiatric pharmacists, a specialty within clinical pharmacy, are board certified and residency-trained mental health care practitioners who have specialized training in providing direct patient care and treatment for the complete range of psychiatric and SUDs. 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 health care team, with patients, families, nurses, social workers, and PCPs or psychiatrists, and to identify medication-related problems, increase the number of patients who can be treated, and optimize care.

Given the challenges we face in addressing the opioid epidemic and other SUDs, it is unfortunate that the expertise of psychiatric pharmacists continues to be severely underutilized and misunderstood by many in the practice of healthcare. There are arguably few in the practice of healthcare who are more uniquely qualified to understand addiction as a mental health disorder and the risk potential for certain prescription drug induced conditions like opioid use disorder (OUD). However, federal limitations on reimbursement and prescriber authority have impeded psychiatric pharmacists’ integration into the healthcare team and their ability to provide care throughout the system. As a result, their scope of practice varies significantly across states and throughout certain health care systems, including the Veterans Affairs Administration (VA).

Role of Psychiatric Pharmacists in the Treatment of SUDs and Benefits of their Involvement

As identified in federal guidelines and by CMS, the episode of care seeks to include physical exam and assessment; psychosocial assessment; treatment planning; counseling; medication management and supportive services; care coordination; management of care transitions; individual and family support services and health promotion. Ideally, when included as an integrated member of the health care team, psychiatric pharmacists are able to (1) provide direct patient care, including treatment assessment and planning, optimization of medication regimens, dosing and prescribing; (2) monitor patients for potential adverse drug reactions and interactions; (3) educate providers, patients, and families on psychiatric and addiction medications as well as psychiatric and substance use disorders and other related conditions; and (4) work to reduce medication costs and demonstrate cost savings to health care systems.

As an example, for each patient that is considered for opioid therapy, pharmacists can help perform the necessary tasks which include evaluating past and current therapies, counseling and initiating a consent for long-term opioid therapy, identifying and recommending non-pharmacological and non-opioids that might be more appropriate for their disorder, ordering and evaluating baseline urine toxicology screens, providing and interpreting validated risk assessment tools for opioid abuse and misuse, assessing percent risk of opioid-induced respiratory depression, prescribing and counseling about naloxone therapy to prevent overdose, ordering and interpreting pharmacogenetic testing that can affect response and toxicity to opioid and other medications, and more. This scenario is similarly applicable to the care of all patients struggling with mental or substance use disorders as well.
Psychiatric pharmacists also have a deep understanding of MAT that extends beyond that of most other health care providers. When included in providing MAT services, psychiatric pharmacists’ involvement has been demonstrated to improve patient adherence and success with buprenorphine treatment for OUD; reduce per patient dosing of buprenorphine through improved medication management, monitoring and titration; and reduce overall costs for treating patients with SUDs by relieving providers from services including medication management, patient counseling, monitoring and follow-ups.

As with MAT, more general studies of non-MAT related programs have shown that when psychiatric or clinical pharmacists are able to provide the services described in collaboration with healthcare providers, including psychiatrists, they increase the rates of medication adherence, reduce the rates of over prescribing, improve patient satisfaction, increase patient knowledge, and reduce costs.1

In many states throughout the U.S. and within the Department of Veterans Affairs (VA) and the Department of Defense (DOD), psychiatric pharmacists are being used more effectively in collaboration with other healthcare professionals to reduce costs and improve patient care. Psychiatric pharmacists through collaborative practice agreements with the VA and DOD are allowed to prescribe and manage patient medications, just like nurse practitioners. Psychiatric pharmacists are particularly important for complex patients and in team based care where they are uniquely qualified in these instances to manage multiple medications and prevent adverse drug reactions or interactions.

The following are examples of programs where psychiatric pharmacists have been successfully employed as part of an integrated care team.

**Practice Models that Employ Psychiatric Pharmacists to Address SUDs or Mental Health Disorders**

1. **Veterans Affairs Administration:** The Veterans Health Administration began a joint initiative between the VA Offices of Mental Health Services and Primary Care Services in 2007. The goal was to integrate evidence-based mental health services into the primary care setting under the Patient Aligned Care Team model. Clinical pharmacists served on care teams, and patients were referred to them for specialty services, including comprehensive medication management. In 2013, approximately 2,640 pharmacists were working in the VA system under advanced scopes of practice, as members of a clinical treatment team and with prescribing privileges. These pharmacists have been working as non-physician providers in nearly 40 subspecialty settings, including pain management and mental health. The value that clinical pharmacists can provide has been recognized, and the role of the clinical pharmacist in the VA system is being standardized. During a 6-month period from April to September, more than 35,000 pharmacy interventions were made and documented by pharmacists across 9 pilot sites. This initiative will

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continue to be deployed across the country as pharmacists, including psychiatric pharmacists, continue to bridge the gap between primary care and specialty care.²

2. **California Medi-Cal**: California’s Medicaid program (Medi-cal) has a Short Doyle Program for mental health services. For Short Doyle Medi-cal, clinical pharmacists are recognized as providers in the clinic setting and 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.

3. **Montana Private Practice Group**: River Stone Health, a psychiatric medication management private practice group, provided comprehensive medication management for patients with psychiatric or neurologic disorders including depression, anxiety, and bipolar disorder. Data demonstrated cost savings of $586 per patient, a 2.8:1 return on investment, and favorable patient outcomes, such as improvement in clinical status and patient satisfaction.³

4. **Montana Medicaid Waiver**: States are struggling with adequate access to care for people with behavioral health disorders. In response, some states, such as Montana, have recently received Medicaid waivers to allow reimbursement for patient care services as part of a team approach to care provided by pharmacists with advanced training clinical pharmacists⁴. Especially in rural or frontier areas these services are often provided in primary care clinics with integrated behavioral health programs. Allowing clinical pharmacists to provide direct patient care services should be assessed to determine the impact on access to care, outcomes, and cost of care.

5. **Connecticut**: In a 1-year pilot project carried out in 2009 and 2010, pharmacists in Connecticut initiated a pharmacist network to contract independently for medication management services. The pharmacists met individually with patients and provided medication management services at 4 health centers in Connecticut. Pharmacist interventions resulted in estimated annual savings of $1,123 per patient in medication claims and $472 per patient in medical, hospital, and emergency department expenses. The estimated total savings were approximately 2.5 times the cost of the fees for the pharmacists and network administration.⁵

We encourage CMS to recognize the significant value psychiatric pharmacists bring to patients and the care team through their involvement and recommend they be included in the development of an episode of care based bundled payment for the treatment of SUDs.

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² Id.
³ Id.
Conclusion

CPNP appreciates the opportunity to provide comments to CMS on the consideration of a new payment for the treatment of SUDs and we look forward to working with CMS on the continued development of these models. CPNP hopes our comments provide new insight on 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 the treatment of SUDs. 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, Sarah Mills at sarah.mills@dbr.com / 202-230-5182.

Sincerely,

Megan Jeffet, PharmD, MS, BCPP
President