The Honorable Sheldon Whitehouse
U.S. Senate
503 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy
U.S. Senate
455 Dirksen Senate Office Building
Washington, DC 20510

July 11, 2024

Submitted electronically via: physician_payment@cassidy.senate.gov

Re: Request for Information on S. 4338, the Pay PCPs Act

Dear Senators Whitehouse and Cassidy,

Thank you for your leadership in introducing S. 4338, the Pay PCPs Act, and for providing this opportunity to respond to the above-referenced request for information.

The GTMRx Institute (Get the Medications Right www.gtmr.org) is a non-profit coalition of 1,700 members focused on ensuring optimal use of medication and gene therapies through interprofessional and team-based care. This is done through a scientific, evidence-based, and cost-effective decision-making processes which we refer to as comprehensive medication management (CMM).[1]

Your draft legislation would allow the Secretary to include four types of service in hybrid payments: (1) Care management services, (2) Communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) Behavioral health integration services, and (4) Office-based evaluation and management visits, regardless of modality, for new and established patients.

We recommend that CMM, implemented based on a standard, evidence-based process[2], should be included as an additional service eligible for hybrid payments as part of your legislative effort. Primary care physicians are tasked with the coordination and implementation of specialist physician(s) care continuity plans, including all medication therapy prescribed and/or discontinued. Comprehensive medication management (CMM) is a holistic, consistent patient care process that ensures each patient's medications are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.[3] As part of the CMM service, the clinical pharmacist develops an individualized medication therapy care plan in collaboration with the patient, the health care team and the prescribing physician that achieves the intended goals of therapy with appropriate follow-

[1] GTMRx Institute Toolkit: 10 Steps to Achieve Comprehensive Medication Management (CMM). Published February 2021. Accessed 7/10/24. Available here.
[2] GTMRx Institute Definition: What is the Comprehensive Medication Management Process? Accessed 7/10/24. Available here.
[3] McInnis, Terry, et al., editors. The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. 2nd ed., Patient-Centered Primary Care Collaborative, The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. PCPCC Medication Management Task Force collaborative document. Published: June 2012. Accessed 7/10/24. Available here.

up to ensure optimal medication use[4] and outcomes[5] CMM has been shown to improve health outcomes, reduce hospitalizations and readmissions, and improve access to care.[6] Through these improvements, CMM moves beyond adherence programs to enhance performance-based incentives in value-based payment models by addressing medication misuse, overuse and underuse. CMM also shows value on total cost of care with a decrease in total health expenditures[7] and cost avoidance.[8] There is a growing body of literature demonstrating the value of CMM in achieving the quintuple aim of health care: better care, reduced health care costs, an improved patient experience, provider well-being, and health equity [9].

We believe that clinical pharmacists providing CMM services as part of interprofessional teams in collaboration with primary care clinicians can significantly contribute to advances in quality, equity, and access through individualized and population-based approaches to care. Integrating CMM services can help achieve medication optimization in evolving CMMI payment models and demonstration projects focused mostly on primary care settings.

Approximately 84% of all office visits to primary care physicians involve medication therapy,[10,11] 275,000 people die each year due to non-optimized medications contributing to $528B in annual costs (16% health care spending).[12] and evidence shows that CMM has a ROI of at least 3:1 and as high as 12:1 when applied to patients with chronic conditions.[13]

**Evidence to Prove CMM is Vital for Primary Care**

[4] Zillich AJ, Jaynes HA, Bex SD, Boldt AS, Walston CM, Ramsey DC, Sutherland JM, Bravata DM. Evaluation of pharmacist care for hypertension in the Veterans Affairs patient-centered medical home: a retrospective case-control study. Am J Med. 2015 May;128(5):539.e1-6. doi: 10.1016/j.amjmed.2014.11.027. Epub 2014 Dec 20. PMID: 25534422. Accessed: 7/10/24. Available here.
[5] Pham K. Alternative payment approaches for advancing comprehensive medication management in primary care. Pharm Pract (Granada). 2020 Oct-Dec;18(4):2238. doi: 10.18549/PharmPract.2020.4.2238. Epub 2020 Dec 8. PMID: 33343776; PMCID: PMC7739512. Accessed: 7/10/24. Available here.
[6] Fabel PH, Wagner T, Ziegler B, Fleming PA, Davis RE. A sustainable business model for comprehensive medication management in a patient-centered medical home. J Am Pharm Assoc (2003). 2019 Mar-Apr;59(2):285-290. doi: 10.1016/j.japh.2018.11.001. Epub 2019 Jan 2. PMID: 30611660. Accessed 7/10/24/ Available here.
[7] Ni W, Colayco D, Hashimoto J, Komoto K, Gowda C, Wearda B, McCombs J. Budget Impact Analysis of a Pharmacist-Provided Transition of Care Program. J Manag Care Spec Pharm. 2018 Feb;24(2):90-96. doi: 10.18553/jmcp.2018.24.2.90. PMID: 29384028; PMCID: PMC10398153. Accessed 7/10/24.Available here.
[8] Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. J Manag Care Pharm. 2010 Apr;16(3):185-95. doi: 10.18553/jmcp.2010.16.3.185. PMID: 20331323; PMCID: PMC10437567. Accessed 7/10/24. Available here.
[9] Assessing the Impact of Comprehensive Medication Management on Achievement of the Quadruple Aim. M. Shawn McFarland, PharmD, Marcia L. Buck, PharmD, Erica Crannage, PharmD, Shannon W. Finks, PharmD, Mary Roth McClurg, PharmD, writing on behalf of the Get the Medications Right Institute. Published: January 17, 2021. Accessed: 7/10/24. Available here.
[10] CDC National Ambulatory Medical Care Survey: 2016 National Summary Tables. Accessed 7/10/24, Available here.
[11] Assessing the Impact of Comprehensive Medication Management on Achievement of the Quadruple Aim. M. Shawn McFarland, PharmD, Marcia L. Buck, PharmD, Erica Crannage, PharmD, Shannon W. Finks, PharmD, Mary Roth McClurg, PharmD, writing on behalf of the Get the Medications Right Institute. Published: January 17, 2021. Accessed: 7/10/24. Available here.
[12] Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. Ann Pharmacother. 2018 Sep;52(9):829-837. doi: 10.1177/1060028018765159. Epub 2018 Mar 26. PMID: 29577766. Accessed 7/10/24. Available here.
[13] Amanda Brummel, Adam Lustig, Kimberly Westrich, Michael A. Evans, Gary S. Plank, Jerry Penso, and Robert W. Dubois Journal of Managed Care Pharmacy 2014 20:12, 1152-1158. Accessed 7/10/24. Available here.

1. Comprehensive Primary Care Plus (CPC+)[14] was a unique public-private partnership, in which practices are supported by 52 aligned payers in 18 regions program that worked to improve quality, access, and efficiency of primary care. Most notably, Track 2 practices were required to provide CMM to patients receiving care management and those in transitions of care who are likely to benefit. Track 2 practices increased the comprehensiveness of care delivered, and they were compensated by the Comprehensive Primary Care Payments that increased the amounts they would have received from FFS payments. This incentive aligns well with CMM, which is inherently comprehensive in its process of care, and may support advancement from medication reconciliation or episodic medication management to continual medication management.

2. Maryland Primary Care Program[15] was established by state of Maryland and CMMI under the Maryland Total Cost of Care Model that set the target for total costs of care reductions for Medicare and calls for improved population health outcomes supported by broad, innovative care redesign between hospital and non-hospital partners across the state. The model set out to achieve this through its three programs: Hospital Payment Program, Care Redesign Program, and Maryland Primary Care Program (MDPCP). The MDPCP is a multi-payer program designed to transform primary care practice with the goals of lowering costs and improving outcomes. Its specific objectives were to reduce avoidable hospitalization and ED visits and build a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to lower Maryland's Medicare Part A and B expenditures by an annual saving target of USD 300 million by 2023. Practices were required to provide comprehensive primary care services and expand patients' access to care; empanel patients to providers; implement data-driven, risk-stratified care management; provide transitional care management; coordinate care with specialists; enhance patient engagement; integrate behavioral health; screen for social needs; and use health information technology tools to continuously improve quality. Participating practices received prospective payments for these services known as care management fees. Similar to CPC+, MDPCP also included two practice tracks. Track 2 practices were required to provide access to CMM services for patients receiving longitudinal care.

The transition from fee-for service (FFS) to value-based payments provides further opportunities to integrate pharmacists, working in collaborative practice with physicians, into team-based care. The

[14] CMS Comprehensive Primary Care Plus Model Summary. Accessed 7/10/24. Available here.
[15] Millbank Memorial Fund Issue Brief. Maryland's Innovative Primary Care Program: Building a Foundation for Health and Well-Being. Published: June 2020. Accessed 7/10/24. Available here.

rewards for efficient, high-quality patient care provided by the value-based payment approaches incentivize pharmacists to leverage their training and expertise in collaborative care teams to enhance performance-based incentive payments, increase patient satisfaction, and achieve other practice or system goals.

As you finalize your draft legislation aiming to integrate new models of care that reduces patients' emergency visits, hospitalizations, excess specialist services, and other big cost drivers , GTMRx urges Congress to consider the GTMRx payment and policy recommendations to implement sustainable CMM practices to ensure access to CMM and high-quality care.[16]

In summary, CMM is part of a team-based approach in which all members of the team acknowledge and respect each other's role and unique ability to contribute to the benefits of the people who place their trust in the team. GTMRx believes that clinical pharmacists providing CMM services, in collaboration with primary care clinicians and other team members, can significantly contribute to the current crisis facing primary care.

We appreciate your leadership and the opportunity to comment on these important issues as we work to build the health care infrastructure necessary for primary care to thrive.

Sincerely,

Katherine Herring Capps
GTMRx Institute
Co-Founder & Founding Board Member,
Former Executive Director
Founder & President, Health2 Resources

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[16] GTRMx Payment & Policy Recommendations: Optimizing Medication Use Through Comprehensive Medication Management (CMM) in Practice: Strategic Recommendations for Implementing CMM into the Care Team with Sustainable Payment and Practice Structures. Published May 2022. Accessed 7/10/24. Available here.