# House Industry, Business, and Labor Committee

# HB 1095

# January 11, 2023

Chairman Louser and members of the House Industry, Business, and Labor Committee, for the record, my name is Jesse Rue, and I am a pharmacist who works at both a hospital and drugstore in Rugby, ND. I am submitting my testimony in support of HB 1095, which would include comprehensive medication optimization services into health benefit plan designs.

This committee may hear testimony to the effect that the provisions in this bill are not necessary, or perhaps the tasks described are already being undertaken across North Dakota. Experience has taught me the opposite, and that implementing such a program would benefit citizens in Rugby and across the state.

In my experience, this bill describes work that has great value, addresses critical health needs for the state, and—critically—this bill describes work which is not being done at grand scale across North Dakota.

**I wish to highlight three key benefits of this bill:**

- **Optimized Care:** creates framework to deploy a high quality, high value care model throughout the state.
- **Coordinated Care**: activates pharmacists into coordinated care teams regardless of practice site.
- **Efficient and Scalable**: harnesses processes already in place such as medical billing and provider credentialing, which enable reliable and scalable deployments so that all can enjoy the benefits across the state.

**DISTINCT INNOVATIONS IN THIS BILL**

**This bill describes a model that is distinct from current standard pharmacy dispensing practices. It describes an intensive, coordinated model to improve care for chronic diseases, improve quality of care, and reduce costs.**

I was pleased to see language about developing standards of care guidance as a central tenet of this bill. While each patient is unique, chronic conditions often have treatment guidelines which improve the care quality and health of the great majority of people. To take a broad, statewide approach to this in partnership with insurance plans is quite innovative.

Built correctly, we believe these standards will improve care quality while ensuring that providers retain the ability to personalize care to the needs of each patient.

**Good care coordination means cost avoidance.** Care coordination is a critical tool to impact Emergency Room (ER) visits as well as hospital admissions. Ongoing monitoring and optimization of therapy at the community level is essential for any comprehensive efforts at reducing ER and hospital utilization. Care Management activities are the best tool we have to improve quality and reduce avoidable expenses, thereby increasing value for patients, plans, and sponsors. **It is my belief that good care coordination for chronic disease cannot be done without pharmacy medication expertise being deployed to the problem.**

It may well be true that all politics is local—the same can be said for healthcare. One key to success with this bill is that it must activate the patient's community providers (such as community pharmacists) into the patient care team.

This care cannot be delivered by a computer algorithm, and it cannot be outsourced to a faceless call center in Arizona. It is care which must be delivered in the patient's own community by the patient's own provider team, and I hope that this bill will reflect that should it gain your support.

Individually, many pieces of this bill have successful precedent in other states. Putting the pieces together as described in HB 1095? **That would be truly innovative.**

**CARE IS SHIFTING INTO THE COMMUNITY**

Care increasingly is shifting to outpatient and community settings. As such, a robust strategy to engage community-based caregivers like pharmacists is essential to realize benefits.

Coordinating care in the community, monitoring medication therapy for populations, and utilizing health information in modern ways can all be understood as key aspects of true medication optimization work. With proper information, pharmacists are able to provide this today, particularly in rural areas where access challenges are most acute.

**COMMUNITY BASED PROVIDERS AND COORDINATING CARE**

Care Coordination is a concept that is foundational to this bill, and it is vital to creating the healthcare infrastructure that will serve us into the future.

It is unlikely that value-based care can be successful at scale without recognizing the need for ongoing, community-based care in these populations. In this sense, the accessibility, ease of access, and frequency of engagement with pharmacists is a resource that this bill can tap. Activating caregivers in the community, clinic, and hospital settings is essential.

This is work that is not being done at scale across North Dakota and which this bill can help remedy.

**LACK OF CAPACITY**

In this bill's text, I appreciate the annual notice to notify the patient and primary care provider of eligibility. **I respectfully offer the suggestion that language be inserted to also notify the patient's primary community pharmacy.** If we are to innovate care in North Dakota, we must begin with the proper notifications to the key players or else we will fail at creating coordinated models. This attribution process of patients to specific providers, clinics, and pharmacies is a procedure well known to payers today.

There are care coordination programs in place nationally which do have many things in common with the provisions of this bill. The best example may be Chronic Care Management, known as CCM. Similar to this bill, CCM strives to provide intensive care to patients with chronic diseases through care coordination efforts. Medicare has a great affinity for CCM because their studies have repeatedly demonstrated CCM to be effective in improving care as well as saving money.

The biggest problem that Medicare experiences with CCM? Lack of uptake by providers.

> "Almost 9 in 10 PCPs (86%) say they have felt unable to address the needs of their chronic care patients adequately—with 28% saying this happens frequently. For most physicians—85%, lack of time was cited as the key culprit."
>
> The Whole Patient and Nothing but the Patient (ajmc.com)

> Since inception in 2016, less than 10% of the over 30 million Medicare beneficiaries with multiple chronic conditions are receiving CCM service. This concerns CMS considerably, given their belief that the program's effectiveness is legitimate, proven, and quantifiable.
>
> Chronic Care Management Services Improve Health Outcomes and Reduce Costs for America's Seniors | Bipartisan Policy Center

It is remarkable that Medicare has created a framework program that improves health and reduces expenses but they do not have adequate caregiver uptake in delivering the program. And so, Medicare cannot reap the benefits.

Neither can the patients across the country. I am very confident that CCM-style services are underutilized in North Dakota the same as they are across the country.

This presents a clear opportunity for patients, caregivers, payers and sponsors across North Dakota—through this bill, there is a mechanism to install similar themes to the CCM program and tap into underutilized pharmacist providers to scale this rapidly.

Increasing the availability of qualified healthcare providers to deliver these services is a rational step forward and directly addresses roadblocks that medical practices have in delivering that care. (In fact, there may be areas to improve the current bill's plan design by incorporating some of the eligibility criteria and frequency of care visits from CCM).

**CHRONIC CARE DELIVERY IS BECOMING CONTINUOUS**

Nationwide, we have been witnessing a clear shift in care from an episodic model (where less follow-up occurs between clinic visits) to a model which monitors one's health for the entire time between clinic visits. This ongoing approach is a true innovation and allows care teams to intervene before patients deteriorate to the point of requiring a visit to the ER or hospital. The optimization foundation of this bill helps to harmonize North Dakota with that future.

Patients with chronic diseases represent the highest expenditures in our health system today and will continue to do so for the foreseeable future. **For most chronic diseases, medication therapy remains a foundational part of their therapy, so it is rational to include medication specialists such as part of the core benefit design.**

This is another key benefit of this bill.

**CONCLUSION**

The future of high quality, affordable care depends heavily upon improving health outside clinic and hospital locations. Community providers will increase in importance.

Rural health is community-focused and deeply tied to relationships. This is a reality which community caregivers (such as pharmacies) understand intuitively and operate in daily.

This bill creates a roadmap to activate these caregivers into the larger care team, as it is only by thoughtful collaboration that we can meet the needs of the people we serve. **This is a bill that I believe has several real and long-term benefits for my rural community as well as other communities across the state, whether they be rural, suburban, or urban.**

I ask for your support of HB 1095. Thank you for your time and consideration.

Respectfully Submitted,

Jesse Rue, PharmD, BCPS

Rugby, ND