Payment for Pharmacist Services

White Paper
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California pharmacists are at a pinnacle moment in advancing the profession and becoming key contributors in healthcare reform. Pharmacists are moving towards a more direct patient care service model, in which pharmacists provide services such as immunizations, medication therapy management (MTM), smoking cessation consultation, and other clinical services to patients. California has been looked upon as the state leader and innovator in pharmacy practice due to recent state legislation that passed in October 2013, SB 493 (Hernandez).

SB 493 came at a time when healthcare reform was at its peak. Covered California experienced its first open enrollment beginning October 2013. Since then, Medi-Cal, California’s state Medicaid program, enrolled 2.7 million more beneficiaries. There are now over 11 million people, or 30% of the state’s population, enrolled in the state Medi-Cal system. Due to this expansion, the shortage of primary care physicians and clinics has become an issue for patients, particularly those accessing healthcare for the first time. The ratio of primary care physicians is between 35 to 49 per every 100,000 Medi-Cal enrollees, which is far below the requirements placed by the Health Resources and Services Administration (HRSA), which states that the ratio should be between 60 to 80 providers for every 100,000 patients. Therefore, it has been extremely difficult for patients to make timely appointments with their primary care physicians to obtain the treatment or care they need.

SB 493 expanded the value of pharmacist-delivered services, which had previously only been provided in a limited number of collaborative practice settings, by expanding the availability of these services to other practice sites such as community, hospital, clinic, and other pharmacist practice settings. As highly accessible health care professionals, pharmacists are well trained and positioned to collaborate with physicians and other providers to improve patient outcomes.

SB 493 gave California pharmacists in all practice settings the authority to provide the following services:

- Provide consultation on drug therapy, disease management and disease prevention
- Furnish self-administered hormonal contraceptives (birth control pill, patch, and ring)
- Furnish travel medications
- Furnish prescription nicotine replacement products and devices for smoking cessation
- Administer all immunizations to patients three years of age or older
- Order and interpret diagnostic tests while managing a patient’s drug therapy.

The bill also established Advanced Practice Pharmacist (APP), which further expanded the scope of practice for pharmacists. Pharmacists who receive APP recognition will be authorized to perform the duties indicated above as well as perform patient assessments; order and interpret drug therapy-related tests in coordination with the patient’s primary care provider or diagnosing prescriber; and refer patients to other healthcare providers. In addition, APP pharmacists will be able to initiate, adjust, and discontinue drug therapy pursuant to an order by a patient’s treating prescriber and in accordance with established protocols as well as participate in the evaluation and management of...
diseases and health conditions in collaboration with other healthcare providers.3

Although SB 493 recognized pharmacists as health care providers under California state law and expanded their scope of practice, the bill did not mandate payment for pharmacist patient care services. Credentialing and contracting with payers is necessary before pharmacists can be compensated on a broad scale for clinical services outlined in SB 493. The creation of business models that incorporate additional patient care services will require the use of existing medical payment models for these services that traditionally have not applied to pharmacists due to lack of provider status.

Evidence overwhelmingly demonstrates that pharmacists who provide patient care services achieve improved health outcomes, expand patient access to care, and successfully manage or reduce health care costs. Although data shows that pharmacy services such as MTM, smoking cessation, disease management, immunizations, etc., help reduce the costs of treating chronic illnesses, payers largely have not yet added pharmacists as providers.4

At the national level strides are being made with pharmacist payment system reform legislation. H.R. 592 (Guthrie) and S 314 (Grassley) would recognize pharmacists as providers under Medicare Part B. Because Medicaid and private payers often follow precedents set by Medicare, federal payment system reform for pharmacists within the Social Security Act will further enhance the requirement for relevant pharmacist payment models. If H.R. 592 or S 314 is passed, this will build a competitive environment, in which there will be an incentive for commercial payers to start reimbursing pharmacists.5

In 2015, Washington state passed SB 5557 and Oregon signed into law HB 2028, which authorizes pharmacists to be in provider networks and be paid for the clinical services they provide.6 Because of these recent pharmacist payment model reform bills, California pharmacists are ready to move away from a singular function of medication dispensing model, and become change agents of healthcare reform. Pharmacists have already begun changing their business model to incorporate pharmacist-delivered care services in their pharmacy, but are now waiting to become credentialed by payers and integrated into care models developed in response to the Affordable Care Act.
The purpose of this white paper is to provide payers, legislators, consumer advocates, and professionals of the healthcare community information where pharmacists can be incorporated into the healthcare delivery system within the different financing models that exist today (Fee-for-Service, Integrated Care, and Direct Contracting). This paper will also educate readers on the barriers that exist for pharmacists being incorporated into the healthcare team, identify the key influencers among the payer community, and highlight the value characteristics that payers will require for coverage of pharmacist services. Exploration into these innovative relationships will enable pharmacists to engage with health plans and other third-party payers.

Section 2: Purpose
Background

In a fee-for-service (FFS) payment model, healthcare providers are reimbursed for the number and array of clinical services they provide. Pharmacists are reimbursed by third-party payers, who are private, public, or commercial insurers. In a FFS model, reimbursement for dispensing medication is based on the dispensing fee and the prescription drug cost. Pharmacy Benefit Managers (PBMs) are contracted directly by payers to oversee the administrative adjudication of prescription drug reimbursement; therefore, pharmacies receive product-based reimbursement from PBMs as opposed to the actual payer.7

Because PBM models are not designed to pay for patient care services, alternative models need to be developed, such as the payment models that have been established for Medication Therapy Management (MTM) services, which are not billed through the patient’s PBM.

Pharmacist Services in FFS Payment Model: Coverage Through Which Benefit?

Prescription drugs are covered under the pharmacy benefit division of a health plan or payer and are managed by the PBM, whereas all other health care services fall under the medical benefit and are managed by health plans.8 Payment for pharmacist-delivered services outlined in SB 493 that incorporate more direct patient care is rapidly evolving and may be covered under a diverse benefit structure.9 Figure 1 shows examples of diverse models to date.

Key Influencers Among the Payer Community

Third-Party payers, which include commercial, private insurance agencies, Medicare and Medi-Cal, and PBMs and managed care organizations, are the main stakeholders among the payer community that determine payments for health services. Pharmacists and consumer advocates will have to build relationships with third-party payers in order to explain the need for pharmacists to become credentialed within the medical benefits division of the health plan. Pharmacists will have to partner with health plans in a FFS model in order to demonstrate improved patient health outcomes and lower costs. In order to do so, payers may require pharmacists who wish to provide patient-centered services to have some credentials in addition to a professional license in order to document that pharmacists are able to provide specialty or clinical care.10 Guidelines and recommendations developed by stakeholders such as the Council on Credentialing in Pharmacy (CCCP) and Outcomes MTM can be referenced to leverage the value of pharmacists in order for payers to include them as paid healthcare providers under contract.

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Therapy Management</td>
<td>Medical Benefit and Alternative Billing Models such as Outcomes and Mirixa</td>
</tr>
<tr>
<td>Disease Management</td>
<td>Medical Benefit</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Pharmacy or Medical Benefit</td>
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<tr>
<td>Travel Medications and Consultation</td>
<td>Pharmacy of Medical Benefit</td>
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<td>Hormonal Contraceptives</td>
<td>Pharmacy or Medical Benefit</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Pharmacy or Medical Benefit</td>
</tr>
</tbody>
</table>

Figure 1.
Possible Credentials Necessary by Payers

Some patient-centered services will require the need for advanced training, yet today, credentialing of these trainings does not exist. Payers currently credential other healthcare providers by requiring them to provide background information such as education, training, and experience working in a clinical setting. The requirement for credentialing with training documentation and quality assurance among Advanced Practice Pharmacists is not prevalent today. Documentation that highlights the pharmacist’s work as a healthcare provider beyond furnishing and dispensing medication should suffice in order to become credentialed. Regardless of the specific service offered, the major components needed for credentialing to receive payment for pharmacist services include obtaining a provider number, acquiring a statement of medical need and proper claim forms, writing a cover letter, and preparing to submit claims to third-party payers. Each insurance company may have specific requirements for each type of health care professional for the credentialing process, such as advanced certification or training.\(^\text{11}\)

Barriers for Receiving Payment

The ultimate barrier for pharmacists receiving payment is lack of awareness from the health plan or insurance company for non-dispensing patient services. SB 493 clearly establishes pharmacist competency to provide direct patient care services that would otherwise be covered under the medical benefit. Some health plans may know that pharmacists are providing these services, but they do not yet have a clear mechanism for pharmacists to be compensated for the services. Figure 2 shows examples of common barriers preventing pharmacists from receiving payments for each listed patient service.

Next Steps for Pharmacists

Although pharmacists will soon start to incorporate changes in their business model to provide more patient-centered services, adding a higher level of service without being reimbursed or compensated is a challenge that pharmacies face. Without payment, it is not possible for pharmacists to operate and sustain these new models of health care services. Nonetheless, pharmacists are changing their care model to incorporate patient care services instead of relying on the traditional volume-based model of dispensing medications.\(^\text{12}\)

### Strengths, Weaknesses, Opportunities, and Threats for Pharmacists Receiving Payment in a FFS Model by Third-Party Payers:

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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</thead>
<tbody>
<tr>
<td>FFS is an established model with which pharmacists are most familiar. Improves access to care. Drives more collaboration and communication with other providers. Allows pharmacist providers to prepare simple budget plans to ensure ROI.</td>
<td>Health insurance companies are moving away from traditional FFS plans. No formalized credentialing process. Inconsistent benefit designs. Not included in the network of providers for patient care services.</td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
<tr>
<td>Providing more patient services beyond dispensing drugs. Advanced Practice Pharmacist allows for expanding services that can be offered.</td>
<td>Third-party payers will likely contend that FFS reimbursement to pharmacists will inflate health care costs. Not enough pharmacists are currently changing their patient care models. Other health care providers may see additional patient care services provided by pharmacists as competition.</td>
</tr>
</tbody>
</table>
Background

Integrated care is the delivery of quality, affordable, and coordinated care to patients by providers encompassing all facets of health care. This care model under the ACA provides for grants or contracts to primary care providers that work with interdisciplinary teams and provide continuity of care to patients. Pharmacists are recognized as crucial members of the integrated healthcare team.\(^\text{13}\)

The ACA specifically created two integrated care models: Accountable Care Organizations (ACOs) and Patient Centered Medical Homes. Under authority of the Centers for Medicare and Medicaid Services (CMS), ACOs came to fruition as pilot projects in which health care providers and institutions were given the opportunity to participate as partners to form innovative solutions to meet the aims of the ACA: quality, affordability, and coordination. In the original pilot ACOs, the shared savings program was part of a shared cost payment system in which providers within the ACO had a contractual agreement with CMS to be accountable for the quality and cost of care to the Medicare beneficiaries that they served.\(^\text{14}\)

Today, ACOs are medical organizations made up of physicians, hospitals, and other healthcare providers that provide coordinated and cost-effective health care specifically to Medicare beneficiaries under a shared savings program. However, ACO models continue to evolve in order to provide care for all patient populations with chronic diseases regardless of coverage.

Similar to ACOs, a Patient Centered Medical Home (PCMH) also provides coordinated and quality care. PCMHs run on a FFS payment model plus shared cost incentives. The major difference between a PCMH and an ACO is that PCMHs are smaller care delivery models, whereas ACOs are made up of many medical homes and manage the care of a larger population.\(^\text{15}\)

The National Committee for Quality Assurance (NCQA) establishes standards that determine which practices are deemed to serve and be recognized as a PCMH.\(^\text{16}\)

The ACA created this payment model to reward provider performance. With better quality care and clinical outcomes, such new integrated care models like ACOs and PCMHs will likely become a sustainable innovation in health care delivery.

Pharmacists have more opportunities to be part of the care team in ACOs and PCMHs because effective medication management is a critical factor for improving the outcomes of patients who have chronic conditions.\(^\text{17}\)

Therefore, the unique skills of pharmacists to provide medication management beyond the dispensing setting are paramount to success in this area.

Pharmacist Services in an Integrated Care Model: Coverage Through Medical or Pharmacy Benefit?

Pharmacists who provide non-dispensing services in an integrated care model will have to establish agreements directly with medical groups, health plans, or primary care physicians/physician groups who are contracted to care for the patients. Therefore, coverage for non-dispensing pharmacy services such as MTM or disease management would be reimbursed through the medical benefit. In an integrated care payment system, providers can be paid...
on a FFS basis, but also have the opportunity to receive a portion of the shared savings incurred if the collaborative team has displayed successful health outcomes for their patients. There are a few differences between ACOs and PCMH payer and payment models.

**ACOs**: An ACO is a legal entity that applies to be part of the Medicare Shared Savings Program and enters into a three-year agreement with CMS agreeing to be held accountable for the quality and cost of care for Medicare beneficiaries assigned to the ACO. Pharmacies in an ACO setting will have to be contracted by the medical group as an organization. The only way for individual pharmacists to be contracted into an ACO is if the pharmacy within the ACO model hires pharmacist employees. ACOs are required to serve at least 5,000 patients or beneficiaries and have to create a governing body that performs assessments and evaluations and reviews care provided to patients. ACO providers are paid through traditional FFS under Medicare, while also incurring the overall shared savings obtained from providing care to patients. The providers within the ACO have to prove that they met all the quality requirements and met the minimum savings threshold in order to obtain the shared savings payment.  

**PCMHs**: Individual pharmacists including those working in hospitals or a community pharmacy, or as long-term care consultants, are eligible to enter into a PCMH agreement. Pharmacists are generally employed or contracted into a PCMH under a medical group, although partnerships can also exist with pharmacy schools and hospitals. Pharmacists may also be contracted by primary care providers who have been qualified by the National Committee for Quality Assurance (NCQA) as a PCMH. Regional pharmacists who work in a health plan may also provide services to several PCMHs in a particular geographic area. FFS reimbursement from third-party payers is still present in a PCMH, along with additional incentive payments for patients with positive health outcomes. These incentive payments can be paid in numerous ways and is up to the medical group as to how they want to distribute the shared value savings. Such payment types include:

**Adjustments**: Includes payment for non-traditional reimbursed services or higher rates for qualified practices in a PCMH.

**FFS Plus**: Consists of a FFS payment with either lump sum payments, per member per month (PMPM) payments, or a PMPM and a pay-for-performance (P4P).

**Shared savings**: Occurs when practices that meet payer-specified quality metrics can qualify for 50/50 shared savings using a formula that roughly adjusts for case mix and compares expected expenditures against total practice cost.

**Comprehensive payment**: Includes enhanced payment to support medical home systems and is similar to a capitation model.

**Grant-based**: Intends to cover all payments for medical home transformation costs and is based on an approved budget.

**Key Influencers of Quality Measures Among the Payer Community**

Nationally, it is advisable to keep current with the Pharmacy Quality Alliance (PQA) and specifically with the workgroups and their development of new quality measures. The work of this organization will create quality measures that will define the role of the pharmacist in quality-based payment models.

From a community pharmacy organization perspective, being a member of the PQA is critical to remain current with quality activity across the nation. Being an influencer within the quality measure arena will help position the organization to succeed in new payment models: participating in leadership forums, providing comments on proposed new measures, and contributing to the pharmacy profession.

The National Committee for Quality Assurance (NCQA), the organization responsible for Healthcare Effectiveness Data and Information Set (HEDIS) measures, develops standards for recognizing a physician practice as a PCMH. NCQA was the first organization to establish a formal recognition process. Those standards specify that practices must implement evidence-based care-management plans, use non-physicians to manage patient care, coordinate care transitions, support patient self-management, and track test results and patient referrals.

Other groups such as Joint Commission, Accreditation Association for Ambulatory Health Care, Center for Pharmacy Practice Accreditation (CPPA), and Utilization Review Accreditation Commission (URAC) are developing accreditation programs.

Health plans are key influencers in the PCMH payer community since they reimburse medical groups at a higher rate if they are PCMH recognized or accredited. However, medical groups and provider networks that are recognized as a PCMH should be seen as the most influential stakeholder since primary care organizations will likely seek MTM or other clinical services provided by pharmacists. It is imperative that pharmacists build relationships...
and market their services with PCPs and medical groups so that they become included in the medical home care team.

**Required Credentials in Order to Be Approved into an ACO or PCMH**

Pharmacists who acquire an Advanced Practice Pharmacist (APP) credential and operational capabilities have a competitive advantage to be hired or contracted into a medical group or provider network operating in an ACO or PCMH and show measurable value of their services for direct care of patients. Additional continuing education training for clinical services such as MTM, immunizations, etc., will also help a pharmacist who is seeking employment or a contract agreement with a medical provider group. Pharmacies or pharmacist networks particularly looking to be part of an ACO will also need to show proof of their articles of incorporation, an employee identification number, or a National Provider Identification (NPI) number, and a copy of liability insurance. Pharmacists will be expected to demonstrate their value and qualifications and be credentialed by the medical group, ACO, or PCMH to provide direct patient care. Experience with using health information technology (HIT), working in a team-based care environment, providing direct patient care, and having excellent communication skills will be desirable qualifications.

**Barriers for Participating in an ACO or PCMH**

One of the major barriers for pharmacists becoming members of an integrated care team is taking the responsibility and risk for payments and outcomes, which pharmacies and pharmacists have not traditionally done. Another potential barrier for pharmacists is not having an electronic health record (EHR) system that integrates with a shared database among other providers in the ACO or PCMH. This is a significant issue, especially for community pharmacists. Although there has been discussion and movement towards obtaining interoperable systems for all healthcare providers to use, such health IT ecosystems are not yet in use.

**Next Steps for Pharmacists**

First, pharmacists must identify a need in the community or within a provider network where they can improve a patient population’s medication regimens and outcomes. Access to community data will be necessary to assess whether comprehensive medication management or other possible pharmacy services are needed. Pharmacists need to develop a business plan or proposal in order to market their practice or pharmacy network. The business proposal will need to address strategies that improve quality care and reduce overall health costs. In addition, pharmacists who are looking to be hired within a care team must have strong credentials.

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**Strengths, Weaknesses, Opportunities, and Threats for Pharmacists in an Integrated Care Model**

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>Medical homes can lead to higher quality and lower costs, and can improve patients’ and providers’ experience of care. Payment reform through the ACA has set the stage that integrated care models are the future model for providing care.</td>
<td>Integrated Care models may make more sense for chronically ill, elderly persons and less sense for young, healthy persons for whom it may not be cost-effective. ACOs and PCMHs are still very new models. Many original ACO pilot projects did not succeed; therefore, the structure is still developing. Responsibility for patients without them being obligated to get all their care from the ACO.</td>
</tr>
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<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
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<tbody>
<tr>
<td>Reduces individual risk to pharmacists. Shared financial risk for pharmacists. FFS plus shared savings payment.</td>
<td>Shared savings distribution is up to the Medical Group, not necessarily all the providers.</td>
</tr>
</tbody>
</table>
Background

Direct contracting has become a growing concept throughout the country and is gaining more popularity with companies and organizations who want to foster health and wellness within the culture of their workforce. Also referred to as direct reimbursement, direct contracting is an innovative approach in which the employer directly contracts with providers to offer patient care, health, and wellness services as a direct benefit for their employees. Employers can contract with a pharmacy, service entity, or pharmacist(s) directly. Under a direct contracting plan, an employee (patient) can schedule an appointment with a pharmacist to jointly develop a unique health and wellness plan for the patient or the pharmacist may offer a wellness class to a group of employees. The services may be prepaid by the company or the employee might self-pay with reimbursement from the employer at predetermined rates specified by the contract. Patient care and wellness services may also be rendered without the need for brick-and-mortar location. A home visit, a conference room, or an office may suffice for a pharmacist providing services such as smoking cessation, disease management, or preventative healthcare services in a convenient and comfortable setting without the need for a pharmacy location.

Traditionally, direct contracting plans have only been available to physicians and dentists. With the passage of SB 493, pharmacists are now able to offer their health and wellness services beyond drug dispensing and have the opportunity to market these services in a direct contract with any organization or entity willing to offer such services for their employees. Although health and wellness programs are becoming increasingly popular, only a few California companies have successfully implemented a direct contract benefits model with pharmacists.

Pharmacist Services in Direct Contracting: Coverage Through Pharmacy or Medical Benefit?

Direct contracting is a unique opportunity for pharmacists to be paid for the clinical services they provide from an entity other than a commercial or public third-party payer; therefore, payment for patient care or wellness services can be set by an agreeable contract with a company or by direct payment from the patient. The specific payment mechanism might depend on the scale of the patient population to be served. This scale may be a large corporation of thousands to a local population of singular patients. With a large enterprise, a contract most often will be a requirement, and with a singular patient a direct one-on-one payment for services would be most efficient. Pharmacists need to carefully design their services to meet the enterprise or local needs and market such services to the population, workforce, or community accordingly. Some patient care or wellness services might require the design of an interdisciplinary care team with nurse, podiatrist, physician, nutritionist, etc., to effectively provide services similar to a well-designed Medical Home.

One example of a direct contract is the Asheville project, which is a collaboration between the North Carolina Center for Pharmaceutical Care and the City of Asheville that
self-funds its health insurance plan for municipal employees, their families, and retirees. In this project, trained pharmacists are paired with patients who have chronic health problems such as diabetes, asthma, hypertension, and high cholesterol. Patients visit their assigned pharmacist regularly, and the pharmacists provide the appropriate care followed with communication and coordination with the patient’s physician. Pharmacists record or document every interaction they make for their patients and submit their claim forms to the insurance plan.

The Asheville project still exists today. Uniquely, the project was conducted in a closed system where the addition of the pharmacist service resulted in greater savings than the added cost of payment for the pharmacists. The City of Asheville adopted this approach as an additional health care benefit to empower their employees to control their own chronic diseases, reduce their health risks, and ultimately lower their health care costs.

Pharmacists can also help extend an organization’s current wellness benefit program. Organizations that offer a wellness program as a company benefit to their employees often foster a culture of health and nutrition in one’s daily life. Wellness programs are becoming increasingly popular because employers understand that in order to have a successful and productive team, it is important for their employees to live and maintain a healthy lifestyle to enhance company productivity and presence. The types and extent of Wellness programs vary from organization to organization as well as the benefits that employees receive. Nonetheless, pharmacists have the capability to market their services to employers who want to promote wellness and reduce disease burden for their employees. A company with or without an established wellness program for their employees may contract a pharmacist to come to the office or workplace to provide services such as flu shot immunizations, smoking cessation consulting services, MTM, or disease management. A pharmacist who provides such services in an office or workplace setting will have to obtain a contract agreement with the organization or work as an employee of a pharmacy service entity that has obtained a contract agreement, and has appropriate licenses and liability insurance to perform clinical services.

Key Influencers Among the Payer Community

Employer groups will be the primary payers for pharmacists who want to provide health and wellness services using direct contracting agreements. Hence, pharmacists will need to establish relationships with employers’ human resources and benefit management personnel in order to market their services. Pharmacists will need to make the case that the provision of health and wellness services by direct contract is aligned with current trends and offers a beneficial enhancement to existing wellness programs. Pharmacists will also need to reiterate that patient care and wellness services will provide superior health outcomes by providing preventive care directly to the employees, thus reducing absenteeism, turnover, and other costly employment expenses.

Arguments in support of adopting a wellness model by a company include enhancing the return on investment (ROI) from recapturing opportunity cost and increasing “presentee-ism” and productivity. Implementing informatics strategies may provide important data for outcomes analysis and effective benefit design with potential for the company to negotiate for lowered healthcare premiums for their company health insurance benefits utilizing this data.

Pharmacists will also need to foster relationships with benefit managers or benefit design consultants. A benefit design consultant reviews health or wellness benefit options for the company and looks at the best options to meet the quality and organizational goals of the employer.

Benefit design consultants can become major influencers for pharmacists interested in setting up direct contract agreements. Pharmacist-provided services offer additional options to meet the organizational goals of an enterprise. This happens because benefit design consultants are not restricted to working solely for insurance companies. They have the capability to provide all benefit options to a company including those that are not provided by third-party payers. Nonetheless, pharmacists will have to educate benefit consultants on the patient care and wellness services that they are capable of providing and the benefits to the employer.

Other groups that remain as key stakeholders for pharmacists interested in providing direct contracting services include entities such as the National Business Group on Health, McKesson RelayHealth, and Outcomes MTM. These organizations foster innovation and advancement of healthcare services that provide quality care in a cost-effective way by improving patient outcomes. Direct contracting models for patient care and wellness services can be supported by such organizations and are a good starting point for pharmacists and patient advocates to begin relationships.

Required Credentials in Order to Be Approved by a Payer

At minimum, a pharmacist will need to show proof of a current or valid state license, and any required certifications documenting competencies to perform a specific service. Pharmacists who enter into a direct contract
agreement with an organization will be required to have adequate training to provide the patient care or wellness services established by current community standards of care. The quality and extent of this training may vary by pharmacists individually. An Advanced Practice Pharmacist credential may be required if a pharmacist is contracted to provide disease management services or other advanced practice activities, so that they have the ability and confidence to initiate drug therapy testing and other clinical activities that require advanced protocols. A pharmacy or pharmacy service entity who enters into a direct contract agreement with an organization will need to assemble a team of pharmacists who have complementary skills to provide the required contracted services.

Business management and marketing skills will be critical to convince employers that the direct contracting model will offer distinct advantages to improve employee health and quality of care utilizing proactive preventive care. Pharmacists will need to demonstrate that they can reduce employees’ sick days and increase productivity in the workplace. Data validation of the health and wellness outcomes would solidify the case for an enterprise to seriously consider adopting a direct contracting strategy for their employees.

**Next Steps for Pharmacists**

In order for pharmacists to begin a direct contract, the profession needs to develop innovative and marketable business models with emphasis on wellness, prevention, and medication management that meets the specific business needs of an enterprise. Marketing tools, strategies, and resources are particularly necessary for a pharmacist or pharmacy to pursue a direct contract with organizations. In addition, pharmacists will need to tailor specific specialty services or disease management programs for an enterprise that has a workforce with a high prevalence of chronic diseases or a high-costing healthcare demographic. Pharmacists will also need to have adequate skills to negotiate with employer groups on payment and contract rates and service types to be provided by a pharmacist.

**Barriers for Receiving Payment**

Direct contracting of pharmacist clinical and wellness services is not a brand new concept. In a simple payment structure, the employer group can pay the pharmacist or pharmacy on a regular basis (e.g., monthly, quarterly) based on contracted population interventions (e.g., class, group counseling, etc.) or fixed number and type of individual interventions (e.g., personalized medication therapy). However, a universal platform for payment transactions has not been fully developed yet. Therefore, organizations who wish to use direct contracting provider services have to develop innovative practice models or have the financial ability to contract with benefit plan designers. Direct contracting requires significant time and resources to fully develop. Once direct contracting becomes broader among employer groups, regulatory or credentialing organizations may become increasingly involved to monitor appropriate training requirements and quality of services for a pharmacist providing these services. If this oversight occurs, then legislative and regulatory support might be increasingly needed as direct contracting evolves.

Patient care and wellness services provided by pharmacists are a new concept for the public. Many organizations, patients, and consumers only visualize pharmacists behind the pharmacy counter dispensing medications and are unaware of the additional services from which they can benefit, despite the passage of SB 493. Therefore, evidence-based practice models and successful marketing of pharmacist consultation services remain important as we justify payment from employer groups.
## Strengths, Weaknesses, Opportunities, and Threats for Pharmacists in Direct Contracting

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>Creates a unique option of revenue.</td>
<td>Will require significant time and resources to fully develop.</td>
</tr>
<tr>
<td>Eliminates the need for third-party payers and creates direct revenue source.</td>
<td>Some pharmacists may not be ready to transition from distribution to direct patient care.</td>
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<tr>
<td>Scalable from a contract with a single individual to a contract with a large corporation.</td>
<td>Legislative and regulatory support is at its infancy and not yet mature.</td>
</tr>
<tr>
<td>Creates opportunities to develop more innovative practice models.</td>
<td>Development covers very broad areas and might be difficult to focus.</td>
</tr>
<tr>
<td>Potential to develop parallel outcomes studies and produce quality measures to prove clinical effectiveness.</td>
<td>Lacks a sophisticated platform or organization to discover, seek, and develop innovative practice models; i.e., technology utilizes business development folks to develop new models and possibilities.</td>
</tr>
<tr>
<td>Might expedite development of new and innovative practice models.</td>
<td>Might require a Pharmacy Services Administration Organization (PSAO) or Independent Practice Association (IPA) to develop, procure, and administer contracts.</td>
</tr>
<tr>
<td>Increases visibility of pharmacists practicing in direct patient care alternatively to drug distribution.</td>
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<tr>
<td>Existing billing codes (ICD9/10, CPT, HCPCS codes) may be deployed.</td>
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<tr>
<td>Might be implemented as a “carve-out” program to existing health benefits.</td>
<td></td>
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<tr>
<td>Wellness and Health already a recognized component in many corporate environments; i.e., paid health club memberships, onsite yoga and exercise programs, etc.</td>
<td></td>
</tr>
<tr>
<td>Development of alternative data sources that can be leveraged as additional revenue to third-party payers and/or existing medical groups to meet demands of existing quality organizations.</td>
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<tr>
<td>Revolutionize the public perception of a pharmacist as a core healthcare provider and standard corporate services</td>
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<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
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</thead>
<tbody>
<tr>
<td>Primary Payers, Corporate Partners, Employer Groups, Benefits Design Groups, Human Resource Departments.</td>
<td>Could limit the opportunity to co-manage patients with primary care providers.</td>
</tr>
<tr>
<td>Potential to develop and test new assumptions and practice models.</td>
<td>“Time to Market” – Can we create and implement in time?</td>
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<tr>
<td>Creation of new practice sites in non-traditional settings.</td>
<td>Development areas are extremely broad – Will we maintain tight focus?</td>
</tr>
<tr>
<td>Further validate the value of pharmacists’ direct clinical and wellness services in a corporate environment.</td>
<td>Internal Opposition – Pharmacists who cannot re-engineer their ability to practice.</td>
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<tr>
<td>Potential to better patient health and increase corporate productivity.</td>
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<tr>
<td>Increase corporate ROI by reduction of “Lost Opportunity Cost.”</td>
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<tr>
<td>Potential to create avenues of innovative practice models via “Disruptive Innovation” by breaking existing paradigms.</td>
<td></td>
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<tr>
<td>Potential to expand job availability within the healthcare sector, including but not limited to pharmacists; and meet the increased demand of new graduates from pharmacy school.</td>
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<tr>
<td>Opportunity for a pharmacist consultant under direct contract to provide services to medical groups who do not have enough resources to hire their own pharmacist to manage risk.</td>
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</table>
Expanded scope of practice for pharmacists in the state of California has changed the landscape for the profession in which they are now quickly being looked upon as integral members of the healthcare team. Pharmacists are growing beyond a dispensing practice model and evolving into the direct patient care and wellness practice model. The provision of patient care and wellness services by California pharmacists brings the expectation of positive patient outcomes and reduction of medication issues. Correspondingly, a pharmacist’s ability to reduce costs associated with patients’ medication therapy has been well documented by Medicare Part D plans and recognized by third-party payers and lawmakers monitoring fiscal spending. Pharmacists are also well positioned to fulfill the goals of the “Triple Aim” as outlined by the Affordable Care Act (ACA): Affordability, Accessibility, and Accountability.

Pharmacists are ready to be fully integrated into the healthcare delivery system, yet the major barrier that still exists is compensation for pharmacist patient care and wellness services.

Pharmacy advocates will begin to work with key influencers within the payer community to initiate contracts that include pharmacists as paid providers to render patient care and wellness activities related to medication management and preventive care. Allowing pharmacists to practice to the full extent of their license would be more cost effective for payers rather than having a primary care physician or nurse initiate and bill for medication treatment.

Although payment for pharmacist services can’t be mandated by legislative action, it is possible that further statutory changes will be necessary in California in order to ensure reimbursement in the Medi-Cal program. Nonetheless, payment for all pharmacy and pharmacist services will be an ongoing effort by multiple stakeholders and will need to be pursued in all payment and care models highlighted throughout this white paper.

Pharmacist-delivered care legislation such as California’s SB 493, or pharmacist payment system reform legislation such as Oregon’s HB 2028 and Washington’s SB 5557 as well as national legislation, H.R. 592/S. 314, are the current paths to affect change in healthcare delivery. These state and federal bills redefine pharmacists’ scope of practice and payment models in step with the emerging role of pharmacists as a member of the healthcare team. Pharmacists should continue to provide the best care for their patients and share the impact they have made in improving health outcomes and reducing costs. As demand for pharmacists’ services increases, there will be increasing pressure on payers to cover these pharmacist services.
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