American Pharmacists Association
House of Delegates – San Antonio
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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: **Randy McDonough (on behalf of APhA-APPM) and Michael Rupp (Delegate for Arizona)**
(Name)

March 27, 2009 ____________
(Date) **(Organization)**

Subject: Standard Reimbursement Model

Standard reimbursement model for prescription drugs dispensed by community pharmacies (Independent Drug Stores, Traditional Chain Drug Stores, Supermarkets and Mass Merchandisers) under public and private third party prescription benefit programs.

Motion:

Whereas, the mission of pharmacy is to serve society as the profession responsible for the appropriate use of medications, medical devices and professional services to achieve optimal therapeutic outcomes,

and;

Whereas, accomplishing the mission of pharmacy requires that consumers have convenient access to high quality sources of community-based pharmacist care,

and;

Whereas, the continued financial viability of community pharmacy requires equitable and sustainable reimbursement for prescription drugs and related services that are delivered to patients under public and private third party insurance plans,

Therefore be it resolved, that the APhA recommends adoption of a standard reimbursement model for prescription drugs dispensed by community pharmacies (Independent Drug Stores,

Traditional Chain Drug Stores, Supermarkets and Mass Merchandisers) under public and private third party prescription benefit programs. The standard reimbursement model should consist of the following four components:

1. an ingredient component that is based on the actual cost incurred by participating pharmacies to acquire the drug product (i.e., actual acquisition cost), and;

2. a dispensing fee component that is based on annual measurement of the actual operating costs incurred by participating pharmacies to legally dispense prescription drugs, and;

3. a mutually acceptable margin of profit for components 1 and 2, and;

4. additional performance-based incentives tied to the delivery of dispensing-related services intended to achieve selected patient and plan outcomes.

Background:

(extracted from the 1994 APhA white paper, *Achieving Value from Pharmacists' Services*)

The goal of an outpatient pharmacy services benefit must be to improve the quality of patients' drug therapy and ultimately their health while controlling overall health care costs. To accomplish this, the benefit must guarantee that patients have access to high-quality drugs and the related pharmacist professional services needed to ensure that patients use the medications properly.

Pharmacists wish to achieve this goal, but the current system discourages the best possible drug therapy for patients and controlling health care costs for payers. The present methods of compensating pharmacists cast them in the role of drug distributors rather than as informed health care professionals who add value over and above the distributive role. The dispensing fee – the foundation of virtually every current pharmacy benefit – is paid to pharmacists only for filling ever larger volumes of prescriptions, not for optimizing the use of drug products.

By defining the pharmacy benefit as mere product distribution, payers have neglected the importance of the pharmacist's management of the drug product to achieve its potential value. In and of itself, a drug does not have benefits. Rather, it is the *optimal use* of the drug that produces therapeutic benefits to patients and economic benefits to payers. Medications taken properly can harm, or at the very least, do nothing to help a patient. Either alternative is wasteful. Health plan design must encourage the professional activities of pharmacists that are essential for the optimal use of drug products.

The new outpatient pharmacy services benefit and the methods of paying for pharmacists' professional services can change the way that policymakers and health plan administrators view prescription drugs. The benefit – and compensation for it – separates the drug product from the pharmacist's professional services that help ensure that the patient takes the drug properly. Nothing less will accomplish third-party payers' goals: To improve the quality of patients drug therapy while controlling overall health care costs.

Current APhA Policy & Bylaws:

2004 Manufacturers' Pricing Policies

1968 APhA supports pharmaceutical industry adoption of a "transparent pricing" system which would eliminate hidden discounts, free goods, and other subtle economic devices.

(JAPhA NS8:362 July 1968) (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)

1994 Product Licensing Agreements and Restricted Distribution

APhA opposes any manufacturer-provider relationship which involves product licensing agreements and/or restricted distribution arrangements which infringe on pharmacists' rights to provide pharmaceuticals and pharmaceutical care to their patients.

(Am Pharm NS34(6):55 June 1994) (Reviewed 2004) (Reviewed 2006)

1985 Pharmaceutical Pricing

APhA supports a system of equal opportunity with the same terms, conditions, and prices available for all pharmacies.

(Am Pharm NS25(5):52 May 1985) (Reviewed 2004) (Reviewed 2006)

1993 Payment System Reform Curriculum

APhA encourages the colleges and schools of pharmacy to incorporate the concept of payment system reform throughout the curricula for all professional programs, and should work with pharmacy organizations to ensure the integration of these concepts into practitioners' continuing development.

(Am Pharm NS33(7):54 July 1993) (Reviewed 2003) (Reviewed 2006)

2005 Empowerment of Pharmacists as Drug Therapy Managers

2003 1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through:

1996 (a) advocacy,

(b) contracting with other health care professionals, or

(c) pharmacists administering vaccines to vulnerable patients.

2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

JAPhA NS36(6):395 June 1996) (JAPhA NS43(5):Suppl. 1:S57 September/October 2003) (JAPhA NS45(5):556 September/October 2005) (Reviewed 2007)

2005 Reimbursement for Unapproved (Off-label) Uses of FDA-Approved Drug Products

1990 APhA supports coverage of FDA-approved drugs and pharmacist services connected with the delivery of such drugs by government and other third-party payers when used rationally for indications other than those specified in the product labeling.

(Am Pharm NS30(6):45 June 1990) (JAPhA NS45(5):557 September/October 2005)

2005 Catastrophic Illness: Coverage for Pharmacist Services Included

1987 1. APhA supports comprehensive, catastrophic illness insurance coverage that

recognizes the essential need for pharmaceutical products and pharmacist services in all patient care environments, including the home.

2. APhA encourages inclusion of pharmacist services and the most efficient and readily accessible system of drug delivery in any insurance coverage for catastrophic illness that may be enacted.

(Am Pharm NS27(6):422 June 1987) (JAPhA NS45(5):557 September/October 2005)

2005 ***Drug Regimen Review (DRR)***

1987 APhA endorses appropriate compensation to pharmacists for performing drug regimen review.

(Am Pharm NS27(6):422 June 1987) (JAPhA NS45(5):557 September/October 2005)

2005 ***Pharmacists and Home Health Care***

1985

1. APhA supports establishment of pharmacist consulting services for home care.
2. Medicaid and other third-party programs should recognize the consulting role of the pharmacist in reducing the misuse of drugs and maximizing their therapeutic effectiveness through fair and equitable reimbursement for consulting functions which is not tied to the provision of medications.
3. Medicaid and other third-party programs also should reimburse pharmacists for innovative packaging and services that will maximize adherence, increase the opportunity for drug utilization review, and better meet the informational needs of the patient and the care giver.

(Am Pharm NS25(5):51 May 1985) (JAPhA NS45(5):557 September/October 2005)

1993 ***Pharmacists' Services***

1. APhA supports development of pharmacy payment systems that include reimbursement of the cost of any medication or device provided; the cost of preparing the medication or device; the costs of administrative services; return on capital investment; and payment for both the dispensing-related and non-dispensing-related cognitive services.
2. APhA believes that appropriate incentives for the pharmacist providing care should be part of any payment system.

(Am Pharm NS33(7):53 July 1993) (Reviewed 2005) (Reviewed 2007)

2005 ***Medicare Prescription Drug Benefits***

1978

1. APhA endorses extension of Medicare coverage to include a Medicare prescription drug benefit.
2. A Medicare prescription drug benefit should:
   (a) Place drug product cost reimbursement on an actual acquisition cost basis;
   (b) Ensure a dispensing fee comparable to that charged the self-paying public;
   (c) Allow for professional discretion in identification of drug products in the labeling of dispensed prescriptions;
   (d) Prevent dispensing by physicians under this program; and
   (e) Remove the price-posting requirement as a condition of participation in the program.

(Am Pharm NS18(8):30 July 1978) (JAPhA NS45(5):558 September/October 2005)

2005 Government-Financed Reimbursement

1977 1.APhA supports only those government-operated or -financed, third-party prescription programs which ensure that participating pharmacists receive individualized, equitable compensation for professional services and reimbursement for products provided under the program.

2. APhA regards equitable compensation under any government-operated or -financed, third party prescription programs as requiring payments equivalent to a participating pharmacist's prevailing charges to the self-paying public for comparable services and products, plus additional, documented, direct and indirect costs which are generated by participation in the program.

3.APhA supports those government-operated or -financed, third-party prescription programs which base compensation for professional services on professional fees and reimbursement for products provided on actual cost, with the provision of a specific exception to this policy in those instances when equity in professional compensation cannot otherwise be attained.

(JAPhA NS17:452 July 1977) (JAPhA NS45(5):558 September/October 2005)

2005 Medicare, Medicaid, and Other Third-party Payment Program

1970 1. APhA advocates a professional fee system of reimbursement in Medicare and Medicaid and other third-party payment programs which would recognize variations in services provided and costs incurred by individual pharmacies.

2. APhA supports maintaining close liaison with proponents of national health insurance programs to ensure that pharmacy will have an opportunity to make its views known in the development of such proposals.

(JAPhA NS10:346 June 1970) (JAPhA NS45(5):558 September/October 2005)

1 977 National Health Insurance: Pharmaceutical Service Benefit

1. A National Health Insurance pharmaceutical service benefit must include acceptable methods for ensuring equitable reimbursement to pharmacists for products and services which are to be provided under the program.
2. Reimbursement to pharmacists for dispensed medication and devices under a NHI plan should be based on professional fees for professional services, plus reimbursement for the actual cost of any drug product or device provided.
3. A NHI, pharmaceutical service benefit must optimize administrative efficiency and minimize administrative costs.

(JAPhA NS17:451 July 1977) (Reviewed 2005)

1994APhA's Role in the Development and Support of New Payment Systems

1. APhA should continue its work with pharmacy benefits' managers and other private and public payers to develop innovative pharmacy benefit designs and compensation strategies for pharmacists' services.
2. APhA may endorse benefit design concepts that recognize and compensate pharmacists for their caregiving services to maximize therapeutic outcomes.

(Am Pharm NS34(6):58 June 1994) (Reviewed 2005)

1994 Responsiveness to Emerging Product and Payment Systems

1. APhA shall work with public and private sectors in developing timely educational

processes which assist pharmacists to implement patient care, understand new payment systems, and apply emerging therapeutic advances to achieve desired patient outcomes.
2. APhA supports payment systems that distinguish between compensation for the provision of pharmaceutical care and reimbursement for product distribution.
3. APhA shall participate in the identification, development, and implementation of models for procurement and handling of therapeutic and diagnostic pharmaceutical products and devices which assure the continuous provision of pharmaceutical care by pharmacists.

(Am Pharm NS34(6):56 June 1994) (Reviewed 2005)

1993 Payment System Reform

1. APhA must advocate reform of pharmacy payment systems to enhance the delivery of comprehensive medication-use management services.
2. APhA must assume a leadership role, in cooperation with other pharmacy organizations, patients, other providers of health services, and third-party payers, in developing a payment system reform plan.
3. APhA should encourage universal acceptance of all components of pharmaceutical care and their integration into pharmacy practice to support payment for services.

(Am Pharm NS33(7):53 July 1993) (Reviewed 2005)

1987 Compensation for Cognitive Services

1. APhA recognizes that pharmacists provide to patients cognitive services (i.e., services requiring professional judgment) which may or may not be related to the dispensing or sale of a product.
2. APhA supports compensation of pharmacists for providing cognitive services (i.e., services requiring professional judgment) which may or may not be related to the dispensing or sale of a product.

(Am Pharm NS27(6):422 June 1987) (Reviewed 2005)

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