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## 2017 House of Delegates

### *Report of the Policy Committee*

- ❖ Patient Access to Pharmacist-Prescribed Medications
- ❖ Pharmacists' Role within Value-Based Payment Models
- ❖ Pharmacy Performance Networks

#### Committee Members

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## 2016–2017 APhA Policy Committee Report

### **Patient Access to Pharmacist-Prescribed Medications**

*The committee recommends that the association adopt the following statements:*

1. APhA asserts that pharmacists' patient care services and related pharmacist prescribing are beneficial to improving patient access to care, patient outcomes, and community health and align with coordinated, team-based care.  
[Refer to Summary of Discussion Items 2, 3.]
2. APhA supports increased patient access to care through pharmacist prescriptive authority models including, but not limited to, collaborative practice agreements and statewide protocols.  
[Refer to Summary of Discussion Items 3, 4, 5, 6, 7, 8.]
3. APhA opposes requirements and restrictions impeding patient access to pharmacist-provided patient care services and related pharmacist prescribing that do not improve quality, safety, and efficiency.  
[Refer to Summary of Discussion Items 9, 10, 11, 12.]
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.  
[Refer to Summary of Discussion Items 3, 13, 14, 15, 16]
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as other prescribers.  
[Refer to Summary of Discussion Items 17, 18.]
6. APhA supports the right of patients to fill pharmacist-prescribed medications at a pharmacy of their choice.  
[Refer to Summary of Discussion Item 19.]

## **Summary of Discussion**

1. The committee discussed the use of the terms *initiate*, *furnish*, and *prescribe* and the way *initiate* and *furnish* may create barriers to payment to pharmacists for prescriptive authority and appropriate reimbursement for the medication (if not prescribed). In some states, the term *initiate* does not have the same legal meaning as *prescribe* and also may be unfamiliar to patients. The committee agreed that using a term other than *prescribe* would not be beneficial to describe a patient care function that is already being performed by other health care professionals.
2. The committee discussed how the focus and intent of statement 1 is access to the pharmacists who are able to prescribe and those associated services as opposed to focusing on only access to medications.
3. The committee agreed that circumstances exist where pharmacist prescribing is not appropriate because pharmacists are not being formally trained as diagnosticians. The committee also discussed specific cases where a diagnosis would not be required, such as preventive care, travel medicine, immunizations, etc.
4. The committee reviewed all existing forms of pharmacist prescriptive authority models. The committee discussed including standing orders in the policy statement itself, but chose not to keep this item in the statement because it does not explicitly belong in the area of prescribing practices.
5. The committee discussed the need for prescriptive authority models that do not limit pharmacists' role in prescribing practices.
6. The committee discussed the education and training related to pharmacist prescribing and did not intend to identify any special training measures beyond the curriculum for the Doctor of Pharmacy degree.

7. The committee referenced the document “Pharmacist Collaborative Practice Agreements: Key Elements for CPA Legislative and Regulatory Authority,”<sup>1</sup> when discussing the current landscape of prescriptive authority models. This document was developed by the Collaborative Practice Workgroup, which was convened by the National Alliance of State Pharmacy Associations.
8. The committee specifically included the term *models* because it is used by the Center for Medicare and Medicaid Innovation and also encompasses existing models while including potential future models.
9. The committee reviewed potential forms of restrictions such as practice setting, additional education requirements, specific prescribers, specific pharmacists, or specific patients and chose the verb *oppose* to highlight the importance of advocating against these types of legislative barriers and administrative restrictions.
10. The committee acknowledged that a legitimate reason for requirements or restrictions on pharmacist prescribing practices may exist. However, the committee agreed that any requirements and restrictions should be evidence based and not be arbitrary and also should not impede patient access. The committee initially chose the term *unsubstantiated* in place of *arbitrary*, but chose not to use *unsubstantiated* because *arbitrary* was clearer.
11. The committee discussed the importance of having statement 3 as guidance for state-level implementation. The committee intends to support the removal of legislative, regulatory, or policy barriers, such as practice restrictions or limitations on which and how many prescribers may collaborate with pharmacists under a CPA, that would limit patient access to medications prescribed by pharmacists.
12. The committee discussed the importance of pharmacists in their respective states working with state boards of pharmacy, state pharmacy associations, and other state-level legislative and regulatory bodies to advance pharmacists’ role as prescribers in a state scope of practice act.

13. The committee further reviewed situations where a diagnosis may already exist (diabetes, etc.) and commented that the medications associated with conditions already being treated can be appropriately managed by pharmacists, but that such management should be performed in coordination with patients' other health care providers.
14. The committee reviewed the full spectrum of coordinated care and discussed the importance of monitoring and follow-up after the actions of prescribing.
15. The committee recognized that a pharmacist may be the health care system entry point for many patients, and pharmacists should be aware of potential situations that necessitate referral. The committee also discussed the importance for a patient to visit not only with a pharmacist but also with other members of the health care team when appropriate.
16. The committee discussed that coordination of care applies not only to prospective communication but also to retrospective communication with other members of the health care team.
17. The committee discussed that when a pharmacist issues a prescription, the pharmacist is then recognized as the prescriber on record and also recognized for coverage and compensation in the same way as other prescribers.
18. The committee reviewed existing billing codes used by prescribers and asserted that pharmacists should be able to use those same billing codes for pharmacist-prescribed medication and service.
19. The committee reviewed the APhA **2011 Potential Conflicts of Interest in Pharmacy Practice** policy statement when discussing issues related to conflicts of interest. The committee decided to further emphasize patients' autonomy to choose where they may fill their prescriptions in addition to existing policy on the subject.

20. The committee reviewed existing Washington State Administrative Code, specifically the definition of pharmacy practice (item 28 under the **RCW 18.64.011: Definitions** section) and **WAC 246-863-100, Pharmacist prescriptive authority—Prior board notification of written guideline or protocol required.**
21. The committee reviewed Oregon legislation (Oregon Revised Statutes, Chapter 689, Pharmacists; Drug Outlets; Drug Sales—Miscellaneous, 689.683 Prescription and dispensation of certain contraceptives; rules; insurance coverage) regarding hormonal contraceptive assessment, prescribing, dispensing, and referral by a pharmacist.
22. The committee discussed the importance of education and training but believes that pharmacists' current education prepares them for the authority to prescribe. The committee also reviewed the APhA **1975 Pharmacist's Responsibility for Continuing Competence** policy statement, which highlights the importance of pharmacists retaining their level of competence throughout their career.
23. The committee discussed that pharmacists should inherently understand that they have the professional responsibility to practice within their level of education and training as mentioned in the pharmacists' code of ethics.
24. The committee discussed the importance of sharing these practices with consumers and the public, but it assumed that information sharing would occur on the practice, state, and national level once approval of authority was obtained.

## **Reference**

1. Collaborative Practice Workgroup, National Alliance of State Pharmacy Associations. *Pharmacist Collaborative Practice Agreements: Key Elements for Legislative and Regulatory Authority*. 2015. Available at: <http://naspa.us/wp-content/uploads/2015/07/CPA-Workgroup-Report-FINAL.pdf>. Accessed August 8, 2016.

## 2016–2017 APhA Policy Committee Report

### **Pharmacists' Role within Value-Based Payment Models**

*The committee recommends that the association adopt the following statements:*

1. APhA supports value-based payment models that include pharmacists as vital health care team members and that promote coordinated care, improve health outcomes, and lower total costs of health care.  
[Refer to Summary of Discussion Items 3, 4.]
2. APhA advocates for the development and implementation of meaningful quality measures within value-based payment models that achieve optimal health and medication outcomes that pharmacists can impact.  
[Refer to Summary of Discussion Items 5, 6.]
3. APhA advocates for mechanisms to recognize and compensate pharmacists for their contributions toward meeting quality measures and reducing total costs of care in value-based payment models.  
[Refer to Summary of Discussion Items 5, 6, 7, 8, 9, 10.]
4. APhA advocates that pharmacists must have the ability to access and exchange electronic health record data within value-based payment models in order to achieve optimal health and medication outcomes.  
[Refer to Summary of Discussion Item 11.]
5. APhA supports education, training, and resources that help pharmacists transform and integrate their practices with value-based payment models and programs.  
[Refer to Summary of Discussion Items 12, 13.]

## Summary of Discussion

1. The committee considered the terminology *value-based care models* but used instead the terminology *value-based payment models* because it more accurately reflects current and familiar terminology without limiting the scope of policy statements to existing models.
2. The committee reviewed current definitions and explanations for value-based payment models from the Centers for Medicare and Medicaid Services (CMS) and specifically reviewed the concepts described in CMS's Quality Payment Program. The committee also reviewed a white paper developed by Optum, titled "Can Value-Based Reimbursement Models Transform Health Care?"<sup>1</sup> and released in August 2013, to gain additional guidance when discussing value-based payment models.
3. The committee discussed the importance of concepts behind value-based payment models (coordinated care, improved health outcomes, and lower costs) and wanted to support the direction in which value-based payment models are leading patient care. The committee also wanted to ensure that pharmacists are recognized as a part of the health care team in value-based payment models.
4. The committee reviewed existing APhA policy on the topic of team-based care and believed a policy statement should support a pharmacist's role on the health care team within existing and future value-based payment models, regardless of setting.
5. The committee does not intend for this statement to require the creation of additional pharmacist-only measures, but rather to assist in identifying measures where a pharmacist can assist other providers within a value-based payment model.
6. The committee discussed specifically including only *patient care quality measures*, but it did not want to limit the statement to only patient care measures because pharmacists may have a broader effect on organizational quality or other measures.



7. The committee recognized the need for a pharmacist to be recognized as a provider and reviewed the APhA **2013 Pharmacists Providing Primary Care Services** and **2013 Ensuring Access to Pharmacy Services** policy statements. The committee discussed how recognition as a provider supports the economic standing of a value-based payment model.
8. The committee recognized that value-based payment models are measured through multiple metrics and that identification of the specific measures in which pharmacists have an effect on patient care is important.
9. The committee recognized that as outcomes become broader, attributing a pharmacist's role in meeting a measure will be increasingly difficult. The committee believed, regardless of the type of measure, that determining how pharmacists assist in meeting measures is imperative.
10. The committee discussed including the terminology *team-based care* within statement 4, but determined it was not necessary because a pharmacist will be practicing as part of the team within a value-based payment model.
11. The committee recognized the importance of health information technology (HIT) and reviewed the APhA **2009 Health Information Technology** and **2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care** policy statements. Because patient data are essential to the success of a value-based payment model, the committee developed an additional policy statement regarding HIT to reiterate the importance of HIT not being a barrier.
12. The committee discussed the importance of continuing education providers and colleges and schools of pharmacy providing education related to value-based payment models.
13. The committee discussed that education, training, and resources should cover all aspects of specific payment models used within value-based payment models. Specifically, the committee recognized that risk-based contracting is an important strategy within value-based payment models that pharmacists need to understand.

14. The committee discussed the existing role of fee-for-service payments as part of existing models in the health care landscape. However, the committee did not address fee-for-service models because it wanted policy statements under this topic to focus on future value-based payment models.
15. The committee recognized the incentive measurements used in the Merit-based Incentive Payment System (MIPS) developed by CMS, Advancing Care Information, which outlines objectives and measures related to HIT services within value-based payment models. The committee discussed the importance of pharmacists' inclusion in the implementation of the following objectives: access to protected health information, electronic prescribing, patient electronic access, coordination of care through patient engagement, health information exchange, and public health and clinical data registry reporting. These objectives and measures are outlined in a Notice of Proposed Rule Making titled "Merit-based Incentive Payment System: Advancing Care Information," a document published by CMS.<sup>2</sup>
16. The committee discussed the concept of pharmacy group practices as a strategy for participation in value-based payment models, but it did not believe this strategy needed a specific policy statement because this concept is still in the early stages of development.

## References

1. Optum. *Can Value-Based Reimbursement Models Transform Health Care?* 2013. Available at: <https://www.optum.com/content/dam/optum/resources/whitePapers/can-value-base-reimburesment-models-transform.pdf>.
2. Centers for Medicare and Medicaid Services. Merit-based Incentive Payment System—Advancing Care Information. Notice of Proposed Rule Making. Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Fact-Sheet.pdf>.

## 2016–2017 APhA Policy Committee Report

### Pharmacy Performance Networks

*The committee recommends that the association adopt the following statements:*

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.  
[Refer to Summary of Discussion Items 2, 3, 4, 5, 6.]
2. APhA urges public and private payers to develop transparent and fair reimbursement strategies for medication products separate and apart from performance measurements associated with the provision of pharmacists' patient care services.  
[Refer to Summary of Discussion Items 7, 8, 9, 10, 11, 12.]
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Further, updates on provider and practice performance against these measures should be provided in a timely and regular manner.  
[Refer to Summary of Discussion Items 12, 13, 14.]
4. APhA supports pharmacists' professional autonomy to appropriately identify and select the interventions that improve evidence-based quality measures within performance networks.  
[Refer to Summary of Discussion Items 15, 16, 17.]

## Summary of Discussion

1. The committee first acknowledged APhA's antitrust policies before discussing this topic and developing associated policy statements. The committee inherently did not want to oppose parts of contract negotiations.
2. The committee reviewed the APhA **2011 Pharmacy Practice Accreditation** policy statement on pharmacy practice accreditation and acknowledged that accreditation can be a mechanism for the credentialing process for pharmacy performance networks.
3. The committee discussed that the pharmacy performance network topic should focus on the value of pharmacists and pharmacies in affecting performance in a given network. The committee was not tied to a single definition for *performance network* and determined that coordination of the provider working with the payer to improve outcome measures that affect the Triple Aim (improve outcomes, increase access, decrease cost) was the best focus for these statements.
4. The committee discussed how networks are driven and defined primarily by health plans and/or pharmacy benefit managers, but noted that nothing precludes pharmacies or pharmacists from creating their own performance networks. Pharmacy performance networks could be created by payers, individual practices, or anyone who has a common goal in meeting certain standards.
5. The committee discussed the potential existence of a performance network as part of a larger offering of additional networks for pharmacies as a means to avoid reducing access to patients.
6. The committee discussed that the goal for performance networks related to pharmacy services is to provide adequate patient access to high-quality pharmacists or pharmacies. The committee recognized that performance networks should not be used by a health plan or pharmacy benefit manager to recuperate fees imposed on it by another source.

7. The committee discussed the importance of each practice setting developing and implementing strategies related to performance measures. A pharmacist is the individual who determines what is best for the patient at the setting where services and medications are delivered.
8. The committee discussed the use of compensation versus reimbursement and determined that reimbursement was the most correct choice for this topic.
9. The committee discussed how the quality and performance of a pharmacist or pharmacy is not always related to a medication, and therefore a fee should not be imposed on product reimbursement because of variance in quality and performance. The committee acknowledged that a separate service reimbursement and product reimbursement should exist and that associated fees would be imposed on the respective reimbursement.
10. The committee discussed the current issue surrounding direct and indirect remuneration fees and other fees being imposed on pharmacies. The committee intended to keep the statement broad in order to avoid limiting it to a single type of fee or deduction to a pharmacy when future fees may arise.
11. The committee reviewed the APhA **2004, 1968 Manufacturers Pricing Policies** policy statement as it pertains to the issue of transparency related to pricing.
12. The committee acknowledged that transparency means prospective and retrospective disclosure of information as it applies to the inclusion of specific measures and to the calculation of payment related to performance.
13. The committee discussed that all measures included in performance networks should be evidence based and show improvement in patient outcomes. Although all measures may not always be tied specifically to medication, they should show a pharmacist's effect on total quality and costs of health care.

14. The committee discussed how a standard list of measures should be available for all pharmacy settings and that there would be flexibility in which of these standard measures pharmacies would then be measured and graded upon. The committee reviewed the existing quality measures, including CMS's Accountable Care Organization quality program measures, Pharmacy Quality Alliance–developed measures, measures used within the Comprehensive Primary Care Initiative, and measures to be included in the Medicare Access and CHIP Reauthorization Act of 2015.
15. The committee discussed the inclusion of both services and tools and determined that both are important to call out in the policy statement. Some aspects of patient care are more administrative by nature and are included in the term *tool*, whereas *services* includes activities related to cognitive services provided by a pharmacist.
16. The committee acknowledged that *processes* and *clinical interventions* include the Pharmacists' Patient Care Process by the Joint Commission of Pharmacy Practitioners, clinical interventions, documentation tools, and other tools and resources used by pharmacists.
17. The committee specifically used the term *appropriate* to ensure a measure would be used in the same manner that it was developed. The committee discussed the process of measure development and identified that use of a measure outside of the scope in which it was scientifically developed is inappropriate. The committee also acknowledged that measures should come with some form of guidance in order to ensure adherence to their scope of effective measurement.
18. The committee discussed the need for the use of quality measures to incentivize continuous quality improvement in the practice setting. The committee reviewed the nature of risk-based payment models and determined that if pharmacists participate in one of these models, then pharmacists need to be willing to risk losing dollars owing to a lack of performance.

19. The committee reviewed the need for pharmacist education, development, and training regarding performance networks, but believed that the important part of this policy topic is transparency. Therefore, a transparent process would result in pharmacists understanding how they are being measured and how any reimbursement would be affected by quality.

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