Payment for Clinical Pharmacy Services Revisited

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Key Words: clinical pharmacy services, payment, Patient Protection and Affordable Care Act.

(Pharmacotherapy 2011;31(1):1–8)

It has been over 30 years since the first articles describing payment models for clinical pharmacy services were published. The purpose of this editorial is not to simply revisit the problem that most pharmacists already understand all too well, but to provide a fresh perspective on the pharmacy profession’s continued challenges, to highlight the opportunities (or threats) presented in the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), and to offer a simple checklist for addressing the elements that must be in place to ensure payment for clinical pharmacy services.

Our progress has been steady but slow. In 1977, the first, to our knowledge, documented instance of payment for clinical pharmacy services was published in the American Journal of Hospital Pharmacy.1 The authors described payment from Blue Cross Blue Shield of Central Ohio for a home therapy education program for antihemophilic factor. In the same issue of the journal, another article outlined a stepwise approach for obtaining third-party reimbursement for clinical pharmacy services separate from dispensing fees.2 Since the early reports, payment models for clinical pharmacy services have progressed slowly, despite evidence that such services provide a solid return on investment and improve patient outcomes.3–5 Still, there remains a public perception that these services are “free.” A recent article in the Chicago Tribune touted pharmacists as a “vital, if underused part of health care” and went on to say that pharmacists can help people understand how their drug therapy works—for free.6 Payment for clinical pharmacy services may continue to expand slowly as we train new generations of pharmacists who perform clinical rather than distributive services, and as the public perception of clinical pharmacy services continues to improve.7 However, a more rapid impetus to change may come with the passage of the Affordable Care Act in which pharmacists’ medication management services are included as a key element in health care reform.8

Lack of Widespread Payment for Clinical Pharmacy Services

To date, only a limited number of pharmacists have been successful at securing payment for clinical pharmacy services (Figure 1). This is partly because pharmacists are not designated as providers under Medicare Part B, which would help to ensure recognition as “providers of health care” and payment for services by payers such as the government and private insurance companies. The professions that are designated as providers under Medicare Part B are physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of
podiatric medicine, doctor of optometry, doctor of chiropractic medicine), physician assistants, certified clinical nurse specialists, nurse practitioners, clinical psychologists, certified nurse midwives, and clinical social workers. Pharmacists face several barriers to becoming recognized as providers and securing payment. Some believe that clinical pharmacy services do not always lead to a savings in pharmacy or other spending and therefore are not cost neutral, that services similar to what clinical pharmacy offers can be provided by other less costly providers such as nurses or physician assistants, or in the worst case, clinical pharmacy services are not needed or do not add value. These objections are being overcome with pharmacoeconomic data and support provided by pharmacists and our professional organizations. One of the more challenging objections is that since services of most pharmacists are associated with a product (prescriptions), some assume their clinical services are paid through the margins on the dispensing of prescriptions.

Hospital pharmacy services (both inpatient and outpatient) at the University of Illinois Medical Center at Chicago are cojoined both organizationally and fiscally with the University of Illinois at Chicago College of Pharmacy, with a single Director of Pharmacy. Inpatient pharmacy services are managed jointly by the Medical Center and College of Pharmacy; ambulatory pharmacy services act as a self-supporting unit of the College of Pharmacy. Clinical pharmacists practicing in the inpatient setting are economically justified based on the perceived value of their contributions and costs saved (since inpatient pharmacy is viewed as a cost center, as payment for care is capped). Ambulatory pharmacy services consist of seven independently operated “own-use” outpatient pharmacies and an array of clinical pharmacist–managed clinics, including antithrombosis, medication therapy management (MTM), amiodarone, and smoking cessation. Prescriptions are filled for students, employees, and University of Illinois Medical Center outpatients and discharged inpatients in various specialties such as end-stage renal disease, transplantation, and oncology. Revenue generated from prescriptions provides funding for the majority of personnel in the Ambulatory Care Pharmacy Department, including clinical pharmacists, which, in turn, provide both didactic

Figure 1. Timeline of payment initiatives for clinical pharmacy services. *Groups organized to promote payment for clinical pharmacy services. **Legislation was introduced but not passed; all bills included a provision for payment for clinical pharmacy services.
and experiential education to the students of the University of Illinois at Chicago College of Pharmacy. In essence, revenue from pharmacy services helps support the College’s academic mission in addition to providing care. Until recently, the majority of prescriptions were reimbursed using the average wholesale price (AWP) as the pricing benchmark. However, over the past few years, pharmacy reimbursement has undergone several changes due to the observation by payers and the government that AWP is often an artificially inflated price. In 2005, reimbursement for drugs under Medicare Part B (e.g., immunosuppressant drugs) changed from an AWP-based formula to one based on a calculated average sales price (ASP) plus a small percentage markup. In 2005, the reimbursement formula was ASP + 6%, and in 2010, the formula is ASP + 4%.

Additional changes in reimbursement are on the horizon for the Medicaid program. Starting in 2011, the reimbursement benchmark for generic drugs in the Medicaid program will be changed from AWP to average manufacturer price (AMP), or the average price paid to manufacturers by wholesalers. Major payers such as Medicare and Medicaid set the precedent for all payment methodologies, and it can be expected that reduced reimbursement by private payers will follow the lead. Due to changes in the reimbursement structure by most major payers such as Medicaid, Medicare, and other private third-party payers, the margins gained from prescription dispensing are shrinking. By any measure, these margins will not be able to pay for the broad scope of professional and clinical services rendered by pharmacists. The small margin on drugs and so-called dispensing fees should be viewed as a “technical fee” akin to a patient visiting a hospital-based clinic. Technical fees reimburse the facility for costs related to patient-care space and equipment whereas “professional fees” reimburse the provider for professional services. At this time and unlike other health care providers, pharmacists do not have a professional fee component to their payment scheme.

**Unbundling and Lessons from the Optometry Model**

It is time to divorce payment for clinical pharmacy services from prescription dispensing (Figure 2). Unbundling the payment is necessary because clinical pharmacy services are not always directly associated with dispensing, nor are they currently paid for by the dispensing process. Indeed, clinical pharmacy services may result in a reduction in the number and types of drugs dispensed. The unbundling of clinical pharmacy services and prescription dispensing is necessary to avoid any perceived conflict of interest between the two. This is being addressed by the Affordable Care Act, which mandates a study of potential conflict of interest in pharmacist-provided medication management services.

**Figure 2.** Past, present, and future payment sources for clinical pharmacy services. Yesterday, clinical pharmacy services were paid by the margin from dispensing; there was no direct payment of clinical pharmacy services. Today, there is some direct payment for clinical pharmacy services; however, the majority of payment is still from the margin from dispensing. Tomorrow, clinical pharmacy services will be paid by the government or private payers, and clinical pharmacists will not have to rely on the margin from dispensing to pay for their services.
Precedent exists for the successful unbundling of product and service reimbursement in another health profession—optometry. Through the historical existence of optometry, most of the work done by optometrists was vision testing and dispensing of eyeglasses, and payment for optometric services independent of the product (eyeglasses) was not widely accepted. In the 20th century, an increase in the frequency of treatments other than eyeglasses occurred along with an increasing complexity and broadening of the scope of practice. In 1971, Rhode Island was the first state to allow optometrists to use diagnostic agents, and in 1976, West Virginia was the first state to allow optometrists to prescribe therapeutic agents. In a landmark article in 1974, an expanded role for optometrists was argued for that would be reimbursed by Medicare and private insurance. Today, optometric services are defined as primary care by the federal government, and services provided by ophthalmologists are considered secondary or tertiary care. Optometrists provide diagnostic and therapeutic services related to the eye and receive payment for these services by Medicare and other payers. Opticians dispense eyeglasses and may or may not be employed by an optometrist. In fact, eye examinations and other services provided by an optometrist are unbundled and billed separately from eyeglass-dispensing services. Optometry has been defined as the gatekeeper of eye-care delivery due to its link between opticians and ophthalmologists, and its role in primary care. It is an efficient model and one that appropriately uses the expertise of all the providers—optometrists, opticians, and ophthalmologists.

The relevance of the optometry model to pharmacy is clear. As pharmacy technicians assume a greater dispensing role, as dispensing technology is more widely utilized, as the training and credentialing of pharmacists becomes more complex, and as the scope of pharmacy practice is broadened, pharmacists can be defined as the “medication gatekeepers.” Patients could visit their pharmacist for medication management services, the same way they visit their optometrist for eye-care services. The relevance of the optometry model to pharmacy was noted by one author, who observed that if the unbundled model is appropriate for dispensing eyeglasses, it should also work for dispensing pharmaceuticals, “with all of the potential risks, not to mention wasted resources that an ill-fitted prescription can have on a patient.” As with optometry, pharmacy provider status will require legislative change. Clinical pharmacists should be recognized as freestanding providers of medication management services, ideally by being designated as providers under Medicare Part B.

Incremental Gains and the Promise of Health Care Reform

Pharmacists are making incremental gains in securing payment for clinical services. Currently, Medicare Part B pays pharmacists for administering immunizations and training patients in outpatient diabetes mellitus self-management (only certified diabetes educators who are part of a multidisciplinary team), for durable medical equipment and supplies, and for Clinical Laboratory Improvement Amendments (CLIA)-waived laboratory tests. Medicare Part D pays plan sponsors for MTM services; however, plan sponsors are not required to use pharmacists to deliver those services. Pharmacists have made progress in leveraging their accessibility to the public by providing a growing number of immunizations every year. In addition, there are examples throughout the country of health insurance companies, pharmacy benefit management companies, medical groups, employers, city or county governments, or state Medicaid agencies paying for clinical services by pharmacists, such as MTM, smoking cessation, asthma management, lipid control, diabetes management, and many others. The disadvantage of this incremental approach is that each one is narrow in its application, regional in scope, and fragmented, and the pharmacist or organization must successfully negotiate with the payer in order to receive payment for a specific set of services. There have been attempts to establish a more widespread payment structure, specifically with pharmacists designated as providers under Medicare Part B. A bill calling for Part B payment for clinical pharmacy services (HR 5780) was introduced in Congress in 2008, but it died in committee. It was reintroduced as HR 5389, the Medicare Clinical Pharmacist Practitioner Services Coverage Act of 2010. It has been referred to the Subcommittee on Health of the House Ways and Means Committee. More recently, United States Senator Kay Hagan (Democrat, North Carolina) introduced the Medication Therapy Management Expanded Benefits Act of 2010. It will allow pharmacists to identify individuals for MTM who are not otherwise targeted by Part D sponsors and
requires a sponsor to offer any willing pharmacy in its network of MTM providers. This legislation is currently assigned to the Senate Finance Committee.

A major advancement was achieved with the recent passage of the Affordable Care Act, which is groundbreaking in its recognition of pharmacists as providers of MTM services. Five driving concepts form the foundation of the Act: a focus on high-risk patients, strengthening of the role of primary care physicians, funding for pilot projects and programs to reform the payment structure, a focus on outcomes, and an emphasis on the delivery of health care with team-based care as a driving force. Within the Act, there are 157 mentions of pharmacy, pharmacists, pharmaceuticals, or medications. It establishes community health teams, which include pharmacists, to support the patient-centered medical home model. The health team will provide access to pharmacist-delivered MTM services and medication reconciliation. A new Center for Medicare and Medicaid Innovation will be established to test payment and service delivery models, including MTM models. There will be a pilot program to test a payment bundle for an episode of care that includes care coordination, medication reconciliation, discharge planning, and transitional care services. A new Medication Management Grant Program will be established for MTM programs provided by pharmacists working as part of a collaborative interdisciplinary approach to manage chronic disease. These are just a few of the significant provisions for clinical pharmacy services in the Affordable Care Act. In a recent article in Health Affairs, the authors argue for including pharmacists in the patient-centered medical home. They state that "pharmacists can play important roles in optimizing therapeutic outcomes and promoting safe, cost-effective medication use for patients in medical homes. They are well-trained health professionals, yet they are often underused." Some may argue that the collaborative framework of the Affordable Care Act precludes the opportunity for pharmacists to secure Part B provider status. In other words, the timing is not right for Part B provider status to be granted since it allows for fee-for-service payment to pharmacists and is not perceived as being cost neutral. We believe that both collaborative provisions under the Affordable Care Act and Part B provider status can and should coexist and that Part B provider status is still necessary in order for clinical pharmacists to be recognized and positioned for securing payment for providing clinical services. This would grant the much-needed recognition that pharmacists have been seeking for decades and will cement pharmacy's role as medication therapy managers. Without provider recognition, the concern always exists that other providers may be substituted to deliver clinical pharmacy services and medication management.

A Simple Checklist for Payment for Clinical Pharmacy Services

A structure for widespread payment for clinical pharmacy services, with or without Part B provider status, should become more of a reality under the Affordable Care Act. Now is the time to capitalize on the opportunities offered by the Act and to associate a price with our value. There are six fundamental elements that must be in place to ensure payment. These elements, summarized as a checklist below, can help pharmacists define their role and seek recognition and payment for clinical pharmacy services. The checklist can be applied to any proposal for services in the Affordable Care Act, including participation in medical homes, community health teams, accountable care organizations, and applying for MTM grants, or designing programs for medication reconciliation or discharge planning.

1. Focus on Pharmacy's Role as a “Medication Gatekeeper”

Pharmacists should accept responsibility and accountability for the medication use process and focus on pharmacists' distinctive competencies in medication management. Pharmacists are drug therapy experts with unique responsibilities in patient safety and medication safety, prevention and wellness through appropriate medication use, and transitions of care and medication reconciliation, to name a few. The Affordable Care Act allows pharmacists to look for new opportunities to deliver clinical pharmacy services. Unlike physician assistants or nurse practitioners, pharmacists are not "physician extenders." There is ample opportunity and need for medication management in health care. Pharmacists should not allow themselves to be replaced by the Internet, machines, printed medication information, or physician extenders who lack adequate training in medication use.
2. Unbundle Payment for Clinical Pharmacy Services from Dispensing

Clinical pharmacists should break the ties with payment for the dispensing of outpatient drugs so that payers do not perceive a conflict of interest in performing both services. This is not to say that an organization cannot both dispense drugs and provide clinical pharmacy services, but payment for these functions should be organizationally separate. Consider optometrists who provide both eye-care services and dispense eyeglasses. They are distinct functions that are billed separately, albeit under the same umbrella of care.

3. Link Specialty Credentialing to Payment for Clinical Services When Appropriate

The requirement for certification should match the complexity of the clinical pharmacy service to be delivered and paid for. The Council on Credentialing in Pharmacy embraced a broad framework for credentialing in pharmacy. The majority of pharmacists are generalists whose practices address the widest variety of patients and diseases. For pharmacists with a more narrow focus on specific diseases, patient settings, or health care issues, there are various types of postlicensure certifications. These include Board Certified Pharmacotherapy Specialist (BCPS), Certified Disease Manager (CDM), Certified Diabetes Educator (CDE), Certified Geriatric Pharmacist (CGP), and Board Certified with Added Qualifications (Advanced Diabetes Management, Nuclear Pharmacist, Nutrition Support Pharmacist, Oncology Pharmacist, or Psychiatric Pharmacist). We believe this specialty-credentialing framework can be the foundation for various payment mechanisms. At this point, a professionwide strategy for credentialing does not exist, and it is not tied in a logical fashion to post-Pharm.D. training. We believe such a coherent strategy, if it were present, could facilitate the achievement of payment for patient care services rendered by pharmacists.

4. Document Policies, Procedures, and Outcomes for Clinical Pharmacy Services

The Affordable Care Act signifies a shift to team-based care and payment based on outcomes and performance. The pharmacist’s role in the health care team will depend on their ability to carefully document policies, procedures, and outcomes that are a direct result of the clinical pharmacy services provided. Pharmacists will be called on to analyze and report outcomes through ongoing case reports, medical record reviews, and assessment studies. This will require a comprehensive, systematic approach to documentation of services and assessment of outcomes. Documentation procedures, systems, and software are available through the literature, professional associations, and commercially. Pharmacists should be careful to include a clinical assessment component for services provided. Like physicians, pharmacists may receive payment based on performance, so pharmacists should be prepared to demonstrate outcomes of care rendered. For MTM, a comprehensive tool kit is available that includes procedures and documentation forms for program development, implementation, and assessment.

5. Establish Quality Standards

Recent publications illustrate that although physicians were paid to deliver quality health care, wide variations existed in the quality, outcomes, utilization, and cost of care being provided. These findings have led to an increasing emphasis on quality in health care and has sparked the beginning of payment for performance initiatives that have occurred within the past decade.

Payment for health care is shifting toward a system based on value. Health care payers require evidence that services are being provided in a consistent manner that achieves the best outcomes. Organizations such as Medicare, the National Committee for Quality Assurance, and the Joint Commission have published standards that are used to evaluate the quality of health care in the United States.

The bar has been raised for pharmacists seeking payment for clinical services. In order to make a business case for payment, clinical pharmacy services must show value through the use of well-defined quality measures, with metrics that include clinical, service, and economic indicators. Services should be standardized, and the perspectives of all stakeholders must be considered when determining value. The benefit gained must clearly exceed the costs associated with providing the services. Whereas the inclusion of pharmacist-delivered services in the Affordable Care Act is promising and may result in some level of compensation for clinical pharmacy services, development of specific
quality metrics will be difficult, as there is wide variability in the models of delivery of MTM and the methods used to ensure improved outcomes. The exact method of payment for clinical pharmacy services will evolve over time, and pharmacists must remain actively engaged in discussions with key decision makers to ensure that fair rates are paid.

6. Embrace Different Payment and Service Models

No one method of payment for clinical pharmacy services currently exists. Pharmacists should become acquainted with all models of payment for clinical pharmacy services, including direct payment (fee-for-service), indirect payment (e.g., payment to the physician, who in turn pays the pharmacist), cost reduction (clinical pharmacy services are justified based on the amount of money saved), payment (i.e., salary) by a health care system for value added and improvement in patient care outcomes, capitation (payment/person/mo), and performance-based payment (payment bonus based on achieving a target).26 Although Part B provider status is the long-term goal, the fee-for-service payment model represented by Part B provider status is not supported by health care reform. The Affordable Care Act favors collaborative care models that may include capitated or performance-based incentive payments. Clinical pharmacy services are best delivered as part of a team, and pharmacists have the flexibility to modify their payment methodology to the financial structure of the team. Since medication use is intimately linked to patient outcomes, pharmacists can participate in team-based methodologies by documenting outcomes and setting up quality indicators for clinical pharmacy services. In the patient-centered medical home model, various payment models have been proposed, including pharmacist subcontracting (at a rate of $2–3/minute of medication management service), financial incentives where the pharmacist helps the medical home achieve quality improvement or performance targets, or capitation payment.18 All of these models can be explored or negotiated when establishing payment for clinical pharmacy services.

Conclusion

For decades, pharmacists have been arguing for payment for clinical pharmacy services. This is not a new concept. With a new generation of pharmacists that is managing more complicated drug therapy to a population that is growing older, we need to ensure these well-trained pharmacists are receiving payment for the services they are trained to perform. Although the Affordable Care Act represents a major achievement toward recognition of the role of the pharmacist in medication management, provider status under Medicare Part B should still be pharmacy’s goal. Like optometry, Medicare Part B provider status will cement pharmacy’s unique role in primary care and offer legislative recognition of this role. Pharmacists can become medication gatekeepers with responsibility for MTM as part of a health care team. Specialty credentialing can provide the framework for payment for clinical pharmacy services. Pharmacists will have ample opportunity to demonstrate their contribution through the patient-centered medical home, MTM grants, and other models and projects proposed in the Affordable Care Act.

Meanwhile, there is much we still need to do to prepare our profession for widespread payment for clinical pharmacy services. We presented a simple checklist for payment that includes reframing the profession and breaking the ties with dispensing so that clinical pharmacy services are unbundled and paid for separately from dispensing. Pharmacists should also document policies, procedures, and outcomes, establish quality standards, and explore different payment models. By embracing the opportunities summarized in this checklist, pharmacists will chart the course to ensure widespread payment for clinical pharmacy services in the near future.

Acknowledgment

The authors wish to thank Glen T. Schumock for his review of this article.

References