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Todd A. Tucker Jr.
Ohio Northern University

Sarah Turley
Ohio Northern University

Kaila Bollinger
Ohio Northern University

Lara Long
Ohio Northern University

Jenelle Sobotka
Ohio Northern University

See next page for additional authors

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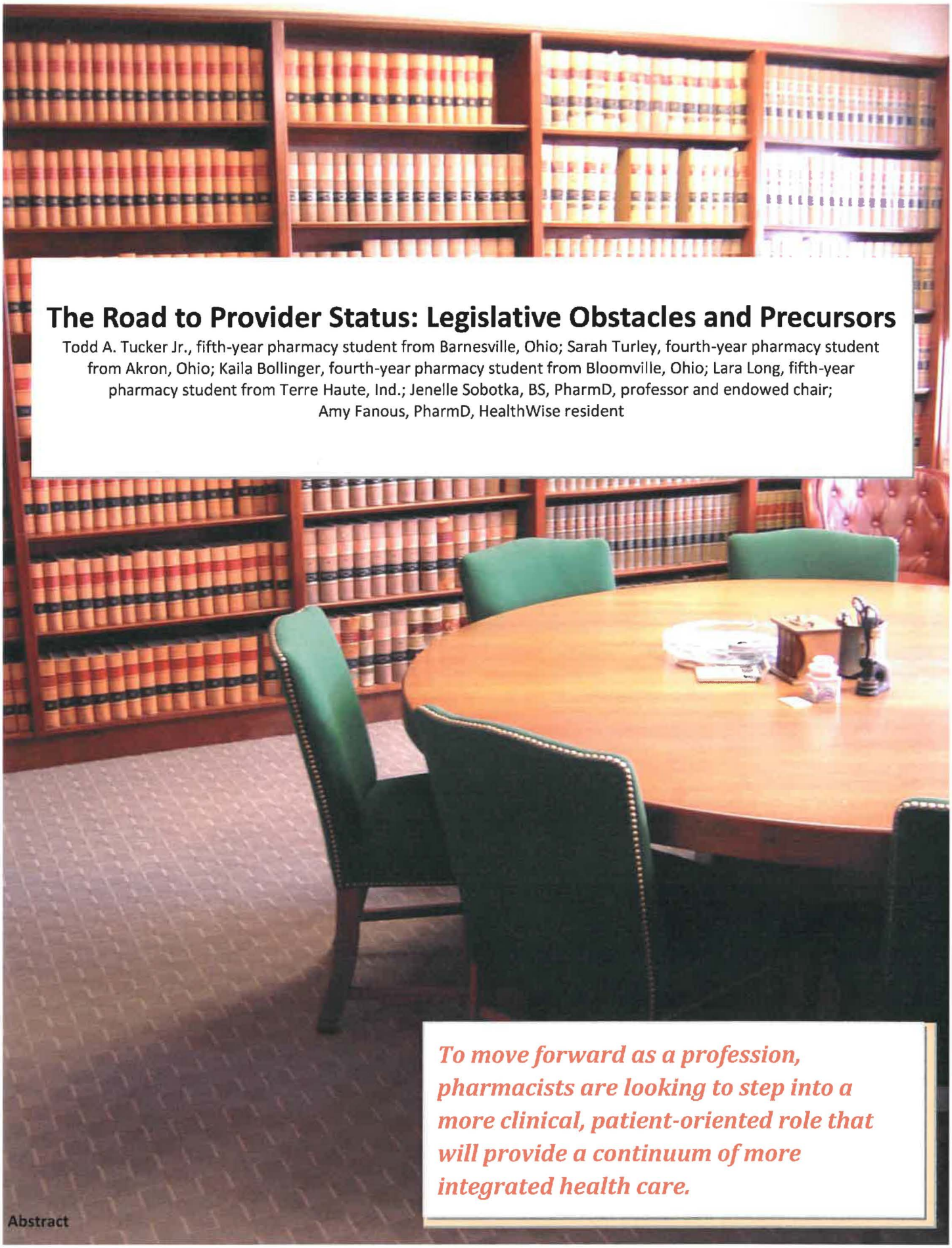

The Road to Provider Status: Legislative Obstacles and Precursors

Todd A. Tucker Jr., fifth-year pharmacy student from Barnesville, Ohio; Sarah Turley, fourth-year pharmacy student from Akron, Ohio; Kaila Bollinger, fourth-year pharmacy student from Bloomville, Ohio; Lara Long, fifth-year pharmacy student from Terre Haute, Ind.; Jenelle Sobotka, BS, PharmD, professor and endowed chair; Amy Fanous, PharmD, HealthWise resident

To move forward as a profession, pharmacists are looking to step into a more clinical, patient-oriented role that will provide a continuum of more integrated health care.

Abstract

Pharmacy and health care in general are undergoing a massive restructuring toward team-based care, which offers many professions the opportunity to expand their current roles. Pharmacists have joined in the movement toward quality-driven, patient-centered care and are embarking on a journey to gain provider status. Becoming legally recognized health care providers on a national level will not be an easy feat, but through state legislation, three states have demonstrated the expanded role pharmacists can have in patient care.

Introduction

The roles of the pharmacist have changed drastically over the years and with the current focus being on chronic disease state management, preventative care and coordination of care, many pharmacists are looking to become more involved in direct patient care.[1] Pharmacists want to be recognized for their role on the patient-care team and improvements in medication-use outcomes.[2] To move forward as a profession, pharmacists are looking to step into a more clinical, patient-oriented role that will provide a continuum of more integrated health care. The road for pharmacists to achieve health care provider status will present with many, seemingly insurmountable obstacles including the push for national legislation.

The Social Security Act and Other Federal Legislation

The Social Security Act (SSA) of 1965 was the beginning of the federal government's Medicare program. The original program consisted of two parts: Part A, known as hospital insurance, and Part B, known as supplementary medical insurance. Part B covers medical services such as physician visits, x-rays and diagnostic tests, certain outpatient services at hospitals, rehabilitation facilities, home dialysis equipment, ambulance services, physical and speech therapy, mammography screening and pap smears, outpatient mental health services, routine physical examinations, blood screening tests and diabetes screening tests and services.[3] Some examples of existing providers under the current Part B rules include nurse practitioners, dieticians, psychologists, social workers, optometrists, nurse-midwives and dentists along with primary care physicians.[2] Pharmacists and pharmacists' patient-care services are currently left out of Medicare Part B benefits, but effort is being put forward to fight the status quo.

Medication coverage and pharmacist services were left out of Medicare entirely until the adoption of the Medicare Modernization Act of 2003. This piece of legislation was one of the most drastic changes to the current system of Medicare since its inception.[3] This bill not only provided Medicare beneficiaries with prescription drug coverage, but also provided coverage for medication therapy management (MTM) for select beneficiaries. The MTM services were aimed at optimizing therapeutic outcomes by improving medication adherence and decreasing adverse drug reactions.[4] Upon introducing the bill to the Senate, Sen. Tim Johnson of South Dakota said, "The pharmacist's specialized training in medication therapy management has been demonstrated repeatedly to improve the quality of care patients receive and to control health care costs associated with medication complications." This statement demonstrates the firm belief in the roles of pharmacists as health care providers that is spreading across America and gaining the attention of federal legislators.[5]

Patient eligibility for these MTM services has continued to change. Many patients qualify automatically and actually have to opt out of services. According to the Centers for Medicare and Medicaid Services (CMS), beginning in 2013, in order to be eligible for MTM, Part D plans should target Medicare beneficiaries who meet the following criteria:[6]

- Have multiple chronic disease states with three being the maximum number of disease states plan sponsors can require for enrollment,
- Take multiple Part D medications with eight being the maximum number that can be required for enrollment,
- Accumulate predicted annual Part D drug costs exceeding $3,144.[6]

These eligibility criteria vary among plan sponsors, but as noted these sponsors have certain restrictions as to the maximum quantity of disease states and medications required. With the baby boomer generation continuing to age, the number of Medicare beneficiaries eligible for MTM services will continue to increase. In fact, approximately 10,000 baby boomers will turn 65 each day for the next 16 years.[7] The aging population as well as the expanded eligibility criteria will present pharmacists with additional opportunities to move into a more impactful role in team-based care.

Multifaceted Approach to Securing Payment for Pharmacists

While the inclusion of MTM in Medicare Part D has provided reimbursement of some services, this program is restrictive and includes only a small portion of the services pharmacists are capable of providing.[8] There is now a recognized need for establishment of pharmacists as health care providers in Medicare Part B.

In December 2012, a We the People petition was created calling for the profession of pharmacy to be awarded health care provider status under Medicare Part B.[9] The petition reads, "By changing the compensation structure allowed under Medicare, we can ensure that patients have access to the medication expertise of pharmacists. Studies have shown that when a pharmacist is directly involved in patient care, patients have fewer adverse drug reactions, experience improved outcomes, and health care costs are

reduced."[10] The petition quickly surpassed its requirement of 25,000 signatures, and an official review and response is now required by the White House. As the evidence continues to suggest that pharmacists provide positive health outcomes for patients, "A logical next step is making the services pharmacists provide eligible for recognition and payment by Medicare, Medicaid, and other third-party payers, including states and private health plans," says American Society of Health-System Pharmacists (ASHP) CEO Paul Abramowitz.[2, 9] Minnesota recently completed a 10-year evaluation of MTM services which provided evidence that pharmacists' MTM interventions provided a return on investment of $1.29 per $1.00 in estimated cost savings for avoided physician office visits, urgent care and emergency room visits.[11] This is just one example of the kind of palpable impact pharmacist intervention can have on health outcomes and cost savings for patients. Recognition of pharmacists as health care professionals would create incentive for these programs to be commonplace.

Consensus Between Organizations

In order for legislation to be passed to grant pharmacists provider status, national pharmacy organizations will have to unite in a profession-wide push for provider status. Dr. Paul Abramowitz made the statement, "Achieving provider status will also require a strong and cohesive national coalition of pharmacy organizations, consumer groups and other health care organizations that understand the value pharmacists bring to the care of the American people."[2, 12] The ASHP has made the attainment of provider status a top-priority strategic issue for the coming year. Likewise, the American Pharmacists Association (APhA) is also taking on the issue as a top priority for 2013.

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A statement by APhA executive Vice President and CEO, Thomas E. Menighan says, "We believe a strategic coalition of pharmacy, consumer and other health care organizations is the right approach."[8] In a press release on Jan. 29, 2013, APhA appropriated $1.5 million in a commitment to a long-range effort by the organization to gain recognition for pharmacist's role as health care provider. Steven T. Simenson, APhA president-elect and chair of the Provider Status Task Force stated, "The ultimate goal is a consensus-based approach for advocacy and legislative efforts, which increases our chances of increasing patient access to the clinical care services we can provide."[13] As a part of the APhA Annual Meeting and Convention in March 2013, a meeting concerning Provider Status for Pharmacists: Creating a National Action Plan, was included in the agenda for discussion. The meeting joined almost 200 pharmacy leaders from national organizations, state associations and academia. The pharmacy leaders considered various draft principles for seeking recognition for pharmacists' role as health care providers under one common voice and message. R. Pete Vanderveen, Ph.D., R.Ph., dean, University of Southern California School of Pharmacy spoke and said, "The forces have never before been so perfectly aligned for pharmacists to be a recognized provider on the health care team. Our government is trying to take control of health care costs and pharmacists have hard data that show our value—both in improving patient outcomes and saving health care dollars."[14] However, for this legislation to come to fruition, it will take more than a national push by leading pharmacy organizations.

While legislation to include pharmacists as providers under Medicare Part B would be a huge leap forward for the profession, it may create divisions between all pharmacists and those considered "qualified" pharmacists. The American College of Clinical Pharmacy (ACCP) has a more focused approach than other pharmacy organizations, specifically seeking provider status for clinical pharmacists who would "possess credentials beyond entry level that are commensurate with the scope of services being proposed for coverage and that assure the clinical pharmacist's ability to contribute to team-based, patient-centered care."[12] The ACCP says that in order to be recognized as Medicare providers, pharmacists would need to have a doctor of pharmacy (PharmD) or Bachelor of Science (BS) in pharmacy with evidence of equivalent pharmacotherapeutic knowledge and fulfill multiple other criteria.[9] These may include a valid collaborative drug therapy management (CDTM) agreement with a physician or group and/or clinical privileges granted by a medical staff or credentialing system, completion of a post-graduate accredited residency program or equivalent and board certification as deemed appropriate by the practice in which the pharmacist is participating.[15] The differentiation between which pharmacists can and cannot provide Medicare services may complicate the issue in Congress and the passage of a new bill. Pharmacy organizations will need to come to a consensus on the issue as differing opinions may halt legislator interest in the issue.

Pioneer States

State legislation has enabled many states to adopt CDTM agreements. Such legislation enables pharmacists to work in conjunction with physicians to initiate, modify, continue drug regimens, order laboratory tests and perform patient assessments to varying degrees.[16, 17] At this time, 47 states and the District of Columbia allow for CDTM agreements.[18]

A few states, including New Mexico and North Carolina, have increased the role of the pharmacists at the state level. With New Mexico's passing of the Pharmacist Prescriptive Authority Act (PPAA) in 1993, they became the first state to dramatically increase pharmacist authority. After meeting additional training requirements in diagnosis and patient assessment similar to physician assis-

tants, pharmacists can be designated as pharmacist clinicians who may then register for a personal DEA (Drug Enforcement Agency) number.[16] These requirements include completion of a 60-hour board approved physical assessment course, followed by a 150-hour, 300-patient contact preceptorship supervised by a practitioner with prescriptive authority. Following certification, pharmacist clinicians with a DEA number prescribe under a supervising physician according to a set protocol or CDTM.[16, 19]

North Carolina followed suit in 2000 by passing the Clinical Pharmacist Practitioner (CPP) Act. This act also enables pharmacists to become clinical pharmacist practitioners with the ability to obtain a DEA number and prescriptive authority. Like their New Mexican counterparts, these pharmacists will enter into written CDTM agreements with physicians.[16] In order to become a clinical pharmacist practitioner in accordance with North Carolina law, a pharmacist must meet one of the following requirements as quoted from chapter 46 and page 59 of the North Carolina Administrative Code written by the North Carolina Board of Pharmacy:[20]

- has earned Certification from the Board of Pharmaceutical Specialties, is a Certified Geriatric Pharmacist as certified by the Commission for Certification in Geriatric Pharmacy or has completed an ASHP accredited residency program, which includes two years of clinical experience approved by the Boards; or
- has successfully completed the course of study and holds the academic degree of Doctor of Pharmacy and has three years of clinical experience approved by the Boards and has completed a North Carolina Center for Pharmaceutical Care (NCCPC) or American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice covered by the CPP agreement; or
- has successfully completed the course of study and holds the academic degree of Bachelor of Science in Pharmacy and has five years of clinical experience approved by the Boards and has completed two NCCPC or ACPE approved certificate programs with at least one program in the area of practice covered by the CPP agreement.

Existing requirements like these may have an impact in any future legislation at either the state or federal level. If legislation were aimed at granting provider status to only "qualified" pharmacists, as opposed to all pharmacists, these state requirements could possibly aid in determining the qualification criteria. Expanded CDTM agreements such as in these states present pharmacists with a great way to become more involved in team-based care. However, despite growing patient and physician acceptance, pharmacist compensation for patient care services remains a large issue. In order to fully realize the clinical impact pharmacists can have, pharmacists will have to come together in a push for national legislation to gain provider status.[16]

Involvement in Legislation

The struggle for pharmacists to be recognized as health care providers under Medicare Part B is similar to the 20-year struggle that nurse practitioners went through to achieve recognition as health care providers.[21] Initial pay for nurse practitioners was through either the hospital, physicians or Medicare. Nurse practitioners were only reimbursed under the physician's provider number rather than being able to receive the reimbursement directly. Despite larger utilization of nurse practitioners, the lack of direct reimbursement remained a significant barrier. Direct reimbursement was the last step needed in the recognition of nurse practitioners as health care providers. To accomplish this, they made direct reimbursement their legislative priority. An aggressive campaign led to incremental legislative and policy victories until finally obtaining health care provider status. The nursing profession utilized contacts on Capitol Hill to achieve their goal. The success in legislation was attributed to personal contacts on the Capitol, respect for the profession and a shared interest on the health care issues. Several nurses worked on health care issues with congressional offices and committees. Many combined clinical training and political activism to aid in achieving provider status. The contacts and participation on the Capitol led to substantial influence of nurses on federal health care policies. Along with making connections, the success in achieving provider status arose from individual nurse practitioners getting involved in politics and from the creation of a uniform group heading toward the same goal. This uniformity finally arrived in 1993 in the form of the National Nurse Practitioner Coalition which became the American College of Nurse Practitioners (ACNP) shortly after. Membership in ACNP was offered to all nurse practitioners and signified strength in the nurse practitioner community and provided the profession the identity it needed to progress in their campaign for provider status. The ACNP encouraged members to contact their legislators and showed them how to properly lobby as well as the importance behind it. Shortly

after, ACNP declared direct reimbursement the top priority at a national meeting in 1996. Later, the Primary Health Practitioner Incentive Act of 1997 was introduced into the House and Senate and was cosponsored by 18 senators and 58 representatives. The bill passed in both the House and the Senate and was later signed by President Clinton as the Balanced Budget Act of 1997. The act finally granted nurse practitioners recognition as health care providers on a federal level. Much like the nurse practitioners, pharmacists need to stand unified and get involved in politics in order for them to be recognized as health care providers.[21]

Future Strategy

There are several ways that pharmacists can become involved in health care legislation. For example, pharmacists may become more involved in legislative advocacy or perhaps even become legislators or legislative aids at either the state or federal level. Staying educated and up-to-date on the legislative issues will allow pharmacists to contact their legislative leaders on important health care issues.

Pharmacists also have the opportunity to be involved in Pharmacy Legislative Day typically hosted by their state pharmacy association. This event allows pharmacists and student pharmacists to travel to the state capitol to talk with legislators about important health care issues related to the profession of pharmacy as well as watch floor debate or committee hearings on bills that pertain to health care.[22]

Another event that has been offered during Pharmacy Legislative Day is for pharmacists to provide legislators and staff with a health care screening. Providing screenings, such as blood pressure and cholesterol, to legislators gives pharmacists a chance to exhibit one of the many ways that pharmacists help to reduce overall health costs. Also, pharmacists are encouraged to meet with individual legislators face-to-face to specifically discuss current legislation and its impact on pharmacists. Such encounters could lead to opportunities to showcase patient care practices first-hand. Meeting with legislators will help to advocate pharmacy as a profession and leave a positive image of pharmacists with legislators and their staff.

Conclusion

The changing environment of the current health care system has increased the emphasis on team-based, quality, patient-centered care. As pharmacists prepare to step into a more clinical role, many are asking to obtain health care provider status. Obtaining this status as pharmacists is within the realm of possibility, but it will take a united effort on the part of all pharmacy organizations. Inclusion as health care providers in Medicare Part B will involve amending the current status of the Social Security Act on a federal level. However, some states are passing legislation to provide pharmacists with a larger role in health care at the state level through different types of CDTM agreements. These states, as well as nurse practitioners, have provided a framework on which pharmacists can work and learn. Changing the role pharmacists have in health care will not be an easy feat, but such a change will only occur with devotion, time, effort and support for our profession.

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