APhA

Recommendations for Health Plans and Pharmacists to Advance Coverage of Pharmacists' Services in the Medical Benefit

The American Pharmacists Association convened a group of thought leaders representing health plans and pharmacist practitioners to provide insights into successes, challenges, and barriers in scaling pharmacists' patient care services covered through the health plan medical benefit.[1] The following recommendations, based upon learnings from these thought leaders at the original convening and subsequent collaborative discussion sessions, are intended to foster collaboration and assist health plan representatives and pharmacist practitioners in advancing coverage for pharmacists' patient care services.

[1] Optimizing patient outcomes: Health plans and pharmacists summit: Meeting proceedings. Murphy, EM, Burns, A. J Am Pharm Assoc. 63(6):1826-1838.e1.

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RECOMMENDATIONS

1. Pharmacists' impact on patients' access to care, health, wellness, outcomes, and health care expenditures must be widely promoted to advance nationwide coverage and reimbursement for pharmacists' patient care services.

2. For equitable patient access to care, the pharmacy profession must advocate to state legislative bodies and regulatory agencies to align pharmacists' practice authorities with their education and training. Pharmacists' scope of practice must be standardized nationwide through state-level legislative and/or regulatory advocacy efforts.

3. To expand and sustain patient access to pharmacists' patient care services nationwide, pharmacists' recognition, coverage, and reimbursement under the medical benefit in the Medicare program must be achieved through federal legislative and regulatory advocacy by pharmacists and health plans. At the state level, pharmacists must be recognized, covered, and reimbursed under the medical benefit in the Medicaid program through state legislative and/or regulatory advocacy by pharmacists and health plans.

4. Commercial health plans and employer groups do not require the same regulatory and legislative mandates seen in Medicare and Medicaid and, therefore, must partner with pharmacists in the provision of covered patient care services under the medical benefit to improve care and lower costs.

5. Pharmacists should be prepared to evaluate and engage in multiple types of payment models and assume responsibility for potential risk across any health plan lines of business when exploring coverage and reimbursement opportunities for patient care services under the medical benefit. Health plans must cover pharmacists' patient care services under the medical benefit regardless of setting and align coverage and reimbursement with that of other provider types.

6. Health plans and pharmacists should collaborate with health plan accreditors (e.g., AAAHC, NCQA, and URAC) to support the integration of pharmacists as a clinician type into their accreditation processes and communications for patient care services delivered under the medical benefit.

7. When coverage and sustainable reimbursement for pharmacists' patient care services are available under the medical benefit, pharmacists and pharmacies should actively partner with health plans to deliver services and drive collective patient care outcomes.

8. Best practices must be shared to facilitate contracting for pharmacists' patient care services between health plans and pharmacists under the medical benefit. Pharmacists, health plans, and other convening parties must collaborate to foster optimization of contracting opportunities for coverage and reimbursement of pharmacists' patient care services under the medical benefit.

9. Processes for pharmacist enrollment, including individualized and delegated credentialing, must be aligned with other provider types within a health plan's medical benefit.

10. Health plans and pharmacists must collaborate to implement successful billing processes under the medical benefit for pharmacists' patient care services.

11. Value-based payment programs for pharmacists' patient care services represent new, evolving opportunities, and pharmacists and health plans must partner to deliver programs that are mutually beneficial for patients, pharmacists, and health plans. Education and resources on value-based programs, such as quality measurement, bi-directional data exchange, attribution, and risk management are needed to foster uptake of these programs in the health care marketplace.

APhA was founded in 1852 as the American Pharmaceutical Association.

RECOMMENDATION 1: Pharmacists' impact on patients' access to care, health, wellness, outcomes, and health care expenditures must be widely promoted to advance nationwide coverage and reimbursement for pharmacists' patient care services.

A robust body of evidence exists for the positive impact pharmacists can have on patients' health and outcomes, including an average 4:1 return on investment for services provided.[2,3] Yet, pharmacists are widely underutilized, and there are extensive gaps in awareness of the types of contributions pharmacists can make to patient care. Marketing efforts with consistent messaging and contemporary data are needed to raise awareness and interest in partnering with pharmacists as solutions for addressing access to care issues and medication and health-related problems. Pharmacists, pharmacy associations, employers of pharmacists, and health plans all have a vested interest in promoting and adopting pharmacists' patient care services.

Messaging should focus on:

- Enhanced access to care through pharmacies for patients in their communities, including in vulnerable and underserved populations. For health plans, pharmacists in all practice settings can increase access to care for members.
- Fully utilizing pharmacists' comprehensive medication expertise.
- Closing care gaps for unmet patient needs.
- Keeping people healthy and out of the emergency department and hospital for nonemergency-related conditions.
- Pharmacists' abilities to contribute to improving a wide array of measures leading to better patient outcomes and reduced costs.
- Pharmacists' service delivery alignment with the same principles as other health care professionals, including delivery in accordance with medical necessity.
- Lower costs associated with pharmacies as a site of care compared to urgent care or emergency department visits.
- Increasing patients' awareness of the availability of pharmacists' clinical services.
- The benefits of pharmacists' contributions to team-based care (e.g., improved physician and patient satisfaction, workload efficiencies, improvement in quality metrics).
- Patient stories about how pharmacists have helped them improve their health.
- Relevant evidence for therapeutic and economic outcomes of pharmacists' services for targeted population(s).

The entire pharmacy profession should also align around consistent terminology for pharmacists' patient care services to assist in uptake and scaling of coverage by payers.

[2] Giberson S, Yoder S, Lee MP. Improving patient and health system outcomes through advanced pharmacy practice. report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.

[3] Murphy EM, Rodis, JR, Mann HJ. Three ways to advocate for the economic value of the pharmacist in health care. J Am Pharm Assoc. 60(6): e116-e124.

RECOMMENDATION 2: **For equitable patient access to care, the pharmacy profession must advocate to state legislative bodies and regulatory agencies to align pharmacists' practice authorities with their education and training. Pharmacists' scope of practice must be standardized nationwide through state-level legislative and/or regulatory advocacy efforts.**

Pharmacists are delivering a wide array of patient care services covered by health plans' lines of business per their state scope of practice. Services covered under contracts include but are not limited to care plan-based services; comprehensive medication management; chronic condition management; hormonal contraception, naloxone, tobacco cessation, medications for opioid use disorder, and HIV post-exposure prophylaxis/pre-exposure prophylaxis (PEP/PrEP) prescribing; test and treat; preventive care, including vaccines; interventions to meet gaps in care and measures; and transitions of care. Variability in pharmacists' state scope of practice across states hinders both plans' ability to broadly cover services that meet member needs and pharmacists having the opportunity to deliver them.

Patients should expect the same access to common pharmacists' patient care services from state to state.

States should also seek opportunities for innovation that add to a base level of scope to meet patient, community, and/or health system needs. State-level advocacy to standardize and optimize pharmacists' scope of practice would greatly enhance health plans' and pharmacists' efforts to implement programs that cover and reimburse pharmacists' patient care services. Partnerships between pharmacists, health plans, pharmacy associations, and other key parties should be leveraged to assist with advocacy efforts. Federal sector programs such as Veterans Affairs and the Indian Health Service are models that can be examined for a full scope of pharmacist care.

Advocacy efforts should also include state-level medical malpractice statutory and administrative protections for pharmacists, consistent with protections established for other health care professionals.

RECOMMENDATION 3: **To expand and sustain patient access to pharmacists' patient care services nationwide, pharmacists' recognition, coverage, and reimbursement under the medical benefit in the Medicare program must be achieved through federal legislative and regulatory advocacy by pharmacists and health plans. At the state level, pharmacists must be recognized, covered, and reimbursed under the medical benefit in the Medicaid program through state legislative and/or regulatory advocacy by pharmacists and health plans.**

Pharmacists' recognition as medical benefit providers is needed across all payer programs nationwide as part of a comprehensive solution to address physician and other health care professional shortages and access to care issues, including in medically underserved and vulnerable populations. Failure to standardize coverage for services risks greater perpetuation of disparities and inequities in care.

In the Medicare program, pharmacists are not covered as qualified health care professionals (QHPs) because pharmacists' patient care services are not included in the service definitions of the Social Security Act (SSA). This omission prevents pharmacists from being able to bill for services directly through Medicare Part B, inhibits physicians and other QHPs from billing for pharmacists' services under incident to physician arrangements at high enough levels to sustain a pharmacist, and precludes pharmacists from receiving attribution for their contributions to closing quality measures in Medicare's value-based programs. Also, since many state Medicaid and commercial health plans look to Medicare for coverage guidance, gaining recognition of pharmacists' patient care services in the SSA is essential, not only for the Medicare program but to have an impact on other programs nationwide. Pharmacists, health plans, pharmacy associations, and other aligned parties must advocate to Congress to achieve legislative changes to the SSA that recognize, cover, and reimburse pharmacists for their patient care services.

In the Medicaid program, the 21st Century Cures Act requires providers, including pharmacists, to be known by the state Medicaid program. For Medicaid or Medicaid Managed Care Organizations (MCOs) to be able to work with pharmacists, the pharmacist must be known by Medicaid through the Medicaid enrollment process, and therefore must be a recognized provider. If an MCO processes a claim for a provider's National Provider Identifier (NPI) number not known by the state Medicaid program, then it risks having the claim rejected and other negative consequences. In addition, there is variability between states in how pharmacists' patient care services are covered and reimbursed in Medicaid programs, contributing to inequities in care, especially for vulnerable and underserved populations. Advocacy to achieve pharmacist recognition as a provider under the medical benefit is needed in those states that have not already recognized pharmacists as Medicaid providers.

There are several different mechanisms that pharmacists, health plans, pharmacy associations, and other aligned parties can pursue for pharmacist recognition, coverage, and reimbursement in the Medicaid program. A commonly used approach is advocacy to state legislatures to pass legislation covering and reimbursing pharmacists' patient care services. Another pathway relates to Medicaid's construct as a shared state and federal program. State Medicaid departments can submit a state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) requesting that pharmacists be added as an Other Licensed Practitioner in the state's Medicaid program. SPAs are used to gain CMS approval to offer those services considered optional by the federal government. The SPA specifies the services, and where needed in the state, the payment parameters for pharmacists' patient care services in the Medicaid medical benefit. As an example, the Nevada Department of Health and Human Services Division of Health Care Financing and Policy, which administers the state Medicaid program, has received approval of several SPAs to allow pharmacists to bill for certain services. When implementing these programs, the state Medicaid program is allowing pharmacists to bill evaluation and management (E&M) office or other outpatient services CPT® codes, similarly to how other health care professionals would bill for providing comparable services.[4] Delaware's Medicaid program received approval from CMS to allow pharmacists to bill for services within their scope of practice. The approved program will cover any service within the pharmacists' state scope of practice and reimburse pharmacists at 100% of the Medicaid physician services fee schedule.[5]

Finally, depending on the state, existing legislation may enable a regulatory agency to use the regulatory process to authorize coverage and reimbursement for pharmacists' patient care services under the Medicaid medical benefit.

[4] Nevada Provider Type 91 Billing Guide. Accessed at https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT91.pdf. (October 31, 2024)

[5] Delaware State Plan Amendment (SPA) 24-0008. Accessed at https://www.medicaid.gov/medicaid/spa/downloads/DE-24-0008.pdf?utm_source=MarketingCloud&utm_medium=email&utm_campaign=Leg-Reg+9-20-24&utm_content=Leg-Reg+9-20-24. (October 31, 2024)

RECOMMENDATION 4: Commercial health plans and employer groups do not require the same regulatory and legislative mandates seen in Medicare and Medicaid and, therefore, must partner with pharmacists in the provision of covered patient care services under the medical benefit to improve care and lower costs.

Unlike Medicare and Medicaid, commercial health plans and employer groups (e.g., Employee Retirement Income Security Act plans) have the latitude to cover and reimburse pharmacists' patient care services under the medical benefit without any legislative or regulatory mandates. However, while not required, many states are pursuing legislative mandates that require commercial health plans to cover pharmacists' patient care services. Commercial plans and employer groups should collaborate with pharmacists, employers of pharmacists, and clinically integrated networks to cover and reimburse services that meet member/employee needs. Pharmacists provide medication-related, preventive, and other health care services that can address gaps in care, improve access to care, help meet quality measures, lower medical loss ratios, and improve patient satisfaction and retention. Examples of pharmacists' patient care services covered by commercial health plans and employer groups include:

- In Arkansas, a commercial health plan is credentialing and contracting with pharmacists as network providers and allowing them to bill under the medical benefit to improve access to care in underserved areas of the state. Reimbursable services include test and treat services for COVID-19, strep, and influenza; and prescribing of oral contraceptives, naloxone, and tobacco cessation medications. These services are billed using E&M office or other outpatient services CPT® codes, as well as CLIA-waived laboratory codes.
- A commercial health plan in North Carolina is contracting with community pharmacists to cover and reimburse diabetes and hypertension management services provided to health plan members under the medical benefit. There is no copay for patients, and the commercial plan is conducting outreach to patients to make them aware of the program.
- A clinically integrated network of pharmacists and pharmacy technicians in Illinois is contracting with an entity that represents 44 employer groups under a unified commercial health plan to cover and reimburse diabetes management services and diabetes prevention program (DPP) services provided by pharmacists and DPP services provided by pharmacy technicians.
- A commercial health plan in Michigan allows pharmacists to bill care management codes for collaborative patient-focused care provided in primary care and specialty clinics. In addition, this plan has supported pharmacist integration into practices by providing up-front funding support of the pharmacist salary/benefit, guidance on billing opportunities, and value-based reimbursement for the participating practice in an effort to support interprofessional care.

For long-term sustainability, it's important that pharmacists' patient care services are integrated into the standard medical benefit offerings of commercial health plans and employer groups as it is difficult to sustain and scale services if covered outside of regular health benefits. The pharmacy profession can assist health plans and employer groups by translating published studies into a list of pharmacists' patient care services with associated return on investment, providing information on how and when to use pharmacists, and describing how data will be used to track success. Commercial health plans and employer groups can use this information to analyze their own data to see how pharmacists could impact the health outcomes of members/employees.

Health insurance brokers represent a potential target audience for outreach to influence employer groups. Brokers are often engaged by employer groups to assist in selecting a health insurance plan for their employees. Brokers serve as intermediaries between health plans and employer groups and work to identify a benefit package that meets the employer's needs and costs. Educating brokers about pharmacists' patient care services in general, outcomes on patients' health and costs, and the evolving landscape of coverage and reimbursement for pharmacists' patient care services will help to increase broker awareness of the importance of including pharmacists' services in various employer benefit packages. Finally, some chain pharmacy organizations have taken a leadership role by implementing coverage for pharmacists' patient care services as a health benefit offering for their own employees. All employers of pharmacists are encouraged to require coverage and reimbursement of pharmacists' patient care services in their employee benefit plans to create additional evidence of value for payers.

RECOMMENDATION 5: Pharmacists should be prepared to evaluate and engage in multiple types of payment models and assume responsibility for potential risk across any health plan lines of business when exploring coverage and reimbursement opportunities for patient care services under the medical benefit. Health plans must cover pharmacists' patient care services under the medical benefit regardless of practice setting and align coverage and reimbursement with that of other provider types.

While fee-for-service (FFS) models are the most predominant payment type reported between health plans and pharmacists and pharmacies, hybrid payment models that combine FFS and incentive bonuses, and value-based models such as per member per month (PMPM), and models with upside and downside risk are also occurring. Pharmacists need to understand what these payment models are and how they work, including the benefits and risks to participation. For value-based models, pharmacists will need to know how risk-based financial arrangements work, including what it means to assume responsibility for meeting certain quality and cost metrics as part or all of the payment.

Depending on the health plan and the state, opportunities to explore coverage for services in the medical benefit exist across multiple plan lines of business, including Medicaid, Medicaid MCOs, commercial, and Medicare Advantage. To justify the fixed cost investment of providing these services, pharmacists and employers of pharmacists should anticipate the number of contracts to reach the number of patients needed to obtain appropriate resources, including technology, for sustaining pharmacists' patient care services. It's likely this will require participation in multiple payment contracts.

It's important to know how each health plan line of business is structured because that's how the plan dictates the process for paying for clinician-delivered services.

Member demographics can vary among plan lines of business as well as the quality measures that pharmacists may be asked to impact. Mechanisms need to be implemented, especially in community pharmacies to assist pharmacists in easily identifying a specific patient's medical plan type, group member ID, and member cost share responsibility.

Pharmacists and pharmacies will need to invest in the infrastructure needed to drive positive outcomes that will be covered by multiple payment modalities. This includes technology systems that support documentation of direct patient care, performing an eligibility check to see if the patient's service is covered, an efficient billing process, and the ability to conduct continuous quality improvement for the care provided.

Pharmacists' patient care services in all settings should be recognized, covered, and reimbursed comparable to other health care professionals. To optimally incentivize participation by pharmacists, it will be necessary for the coverage of outpatient pharmacists' patient care services to be available in a variety of practice settings (e.g., community-based pharmacies, physician offices, clinics, hospital/health systems) and not be dependent on one specific place of service. Additionally, health plan policies should incorporate pharmacists as a provider type into existing medical benefit programs, as opposed to establishing programs and policies unique to pharmacists.

RECOMMENDATION 6: **Health plans and pharmacists should collaborate with health plan accreditors (e.g., AAAHC, NCQA, and URAC) to support the integration of pharmacists as a clinician type into their accreditation processes and communications for patient care services delivered under the medical benefit.**

The federal government's health insurance marketplace and many states require that participating health plans be accredited as a mechanism for ensuring that the plan meets national standards. CMS recognizes the Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC as approved accrediting entities for health plans participating in federal government programs. Accreditation is also required in many state Medicaid and commercial plans, and states may also designate the approved accrediting entity(ies).

Health plans must follow accreditors' standards that can pose barriers when plans attempt to enroll pharmacists in the medical benefit. Health plans and pharmacists have a unique opportunity to broadly impact pharmacist inclusion in health plan networks by working with accreditors to evaluate pharmacists' needs and then creating accreditor-approved materials for pharmacists where needed. An example could be the development of a universal pharmacist enrollment application form approved by the accreditor for any health plan to use.

Health plan accreditors should also update their technology systems and communications materials to include pharmacists as a clinician type within a health plan's health care professional network. Lack of information about pharmacists in accreditors' systems and materials is a barrier when health plans considering inclusion of pharmacists do not see them acknowledged by the accreditor.

RECOMMENDATION 7: **When coverage and sustainable reimbursement for pharmacists' patient care services are available under the medical benefit, pharmacists and pharmacies should begin actively partnering with health plans to deliver services and drive collective patient care outcomes.**

Despite growing opportunities for pharmacists to partner with health plans for covered services under the medical benefit, current pharmacist participation has room for improvement. Resources are needed to prepare pharmacists, pharmacy teams, postgraduate trainees, and student pharmacists to engage with health plans and deliver contracted services in their practices. Employers of pharmacists should consider leveraging postgraduate trainees and student pharmacists to support the implementation of service development. Pharmacy technicians and other support staff can assume responsibility for aspects of the patient visit such as scheduling appointments and handling the medical claims billing, thereby freeing the pharmacist to deliver patient care.

Trust and relationship building between health plans and pharmacists is critical to overcoming barriers related to delivery and payment for contracted services. Health plans that offer new contracting opportunities for pharmacists have experienced some pharmacist and pharmacy resistance to participation due to a lack of understanding that the program is under the medical benefit. Health plan representatives report that some pharmacists and pharmacies mistakenly think that the covered program is in the pharmacy benefit administered by a PBM when it is part of the health plan's medical benefit. Concerns with retroactive and point-of-sale fees associated with pharmacists' patient care services in the pharmacy benefit and not realizing that the offered program is in the medical benefit are primary barriers cited. More work is needed through education and communications to overcome these barriers.

Health plans, employers of pharmacists (in pharmacies, physician offices and clinics, and other settings), clinically integrated networks, and other convening parties are working to increase pharmacist engagement and overcome barriers to entry. Examples include:

- Health plans are pilot testing enrollment materials with a small number of pharmacists to learn about challenges prior to broadly rolling out education programs for pharmacists.
- Health plans are marketing the availability of tools in their provider portal so pharmacists can access information needed to engage with the plan.
- Health plans and employers of pharmacists are updating technology systems to include the pharmacist's credentials as a provider and to facilitate the ability to exchange data.
- Billing boot camps are being held for pharmacists and pharmacy teams who want to engage in a payer's program under the medical benefit.
- Fireside chats are being conducted where pharmacists who are interested in engaging in a payer program can hear from and interact with pharmacists who are delivering services under the payer program.
- Employers of pharmacists are working on change management with their pharmacists to help them to think differently about their services, workflow, and charging for assessments.
- Employers of pharmacists and other aligned parties are working to change how pharmacists are perceived as part of the care team, including that they can serve as a resource and help improve quality.
- Employers of pharmacists who are embedded in outpatient clinics are working to support billing and credentialing departments' integration of billing for pharmacists' services into their workflows.
- Employers of pharmacists are working on patient change management to shift how patients view pharmacists in expanded patient care roles. This includes changing the environment in the pharmacy, through both space and workflow to help visually communicate changes to patients without the pharmacist and pharmacy team needing to take as much time to do so. Patients also need to know about new patient care services and how to engage in the pharmacy's processes once services are live.
- Academic institutions, state pharmacy associations, and other convening parties are providing education and communications to prepare pharmacists and their teams to be ready to go when a contract is signed. Communication is not only with pharmacists but also pharmacy personnel and other support team members.

Finally, it is critical that pharmacists engage with plans to partner and deliver those covered services that are aligned with their patient population and available resources. Not every payer program is for every pharmacist. This approach ensures that value is delivered to the health plan and pharmacy practice and that appropriate expectations are set on both sides.

RECOMMENDATION 8: Best practices must be shared to facilitate contracting for pharmacists' patient care services between health plans and pharmacists under the medical benefit. Pharmacists, health plans, and other convening parties must collaborate to foster optimization of contracting opportunities for coverage and reimbursement of pharmacists' patient care services under the medical benefit.

When approaching contracting, many health plans examine state authorities with requirements such as any willing provider, coverage parity laws (payers are required to cover pharmacists' services if they cover similar services provided by other health care professionals), and payment parity (payers are required to pay pharmacists at the same rate as other health care professionals providing comparable services), as well as pharmacists' scope of practice to determine the state(s) where efforts should be focused. Health plans are also contracting with pharmacists and pharmacies for services to meet access to care needs, gaps in care, and measures for value-based payment programs.

Trust and communication are essential to fostering collaboration and building relationships between pharmacists and health plan representatives. While individual pharmacists may have the opportunity to contract with a health plan, generally a network of pharmacists or pharmacies administered by entities, such as chain pharmacy organizations, health systems, and clinically integrated networks, is desirable to provide adequate service coverage for the health plan's members. Pharmacists working in physician offices, clinics, and long-term care settings will likely be part of their organization's existing contracting processes, where pharmacists working in community-based settings such as pharmacies or in consultant practices may consider exploring becoming part of a network for the contracting process. Representatives of the pharmacists' network generally negotiate the contract on behalf of the pharmacists or pharmacies.

Identifying the appropriate individuals at the health plan who are key to contracting processes significantly helps in facilitating the process. Those individuals can include:

- Health plan pharmacists championing coverage for pharmacists' services
- Chief medical officer or medical director
- Health plan pharmacy director
- Individuals on the quality team
- Procurement team responsible for signing contracts
- Legal representatives
- Underwriters
- C-suite champion

Best practices are needed for navigating the contracting process, which can be complicated and time-consuming. Some employers of pharmacists report a minimum of 6 months from initial discussions to contract execution, especially with legal teams' involvement. Using a boilerplate contract for pharmacists or pharmacies with the opportunity for addendums can be useful for standardizing and simplifying the contracting process. Contracts have data security and data transfer requirements that require the pharmacy practice to have a safe and secure place to house and transfer data. This can be a barrier for smaller practices that may not have the infrastructure to meet these requirements. Contracts should also contain provisions for clinical and metric-related bi-directional data exchange necessary for contract fulfillment.

Contract terms should require pharmacists to bill for their services using the same billing process the health plan uses to pay other provider types, but pharmacists and pharmacies should be able to use the documentation and billing software systems of their choice. Some plans are paying pharmacists through invoice billing where instead of submitting a medical claim, the pharmacist or pharmacy submits an invoice to the plan. The Pharmacist eCare Plan Standard may be used as a tool for pharmacists to send SNOMED CT Codes to the health plan for clinical services rendered. These codes may be cross walked to CPT® codes as part of the invoicing process. Invoice billing tends to be a carve out approach that may be temporary until the health plan sets up the necessary infrastructure for pharmacists to use the plan's standardized medical billing process. Invoice billing can also be used for value-based payment contracts.

It's important for pharmacists to take advantage of available contracting opportunities. Mechanisms for identifying those opportunities could assist with uptake. Pharmacists and pharmacies should learn from other health care professionals and apply those lessons to navigate the contracting process instead of trying to create best practices from the ground up. Modeling other health care professionals can be a best practice in itself. Also, encouraging pharmacist innovators to engage with health plans once coverage parity and payment parity laws are passed could help to jumpstart health plan involvement in working with pharmacists. In several states, pharmacy associations and educational institutions have played a significant role in convening pharmacists and health plan representatives to discuss successes, challenges, and barriers and providing programming for pharmacists about how to engage in contracting opportunities. For example, in Minnesota, the University of Minnesota College of Pharmacy collaborated with APhA and the Alliance for Integrated Medication Management to host the Align Summit focused on partnerships, metrics, program design, and implementation to optimize medication outcomes through provider-health plan partnerships.[6]

[6] Align Summit: Advancing Provider-Health Plan Partnerships for Optimizing Medication Outcomes. Accessed at www.pharmacy.umn.edu/align-summit. (October 31, 2024)

RECOMMENDATION 9: Processes for pharmacist enrollment, including individualized and delegated credentialing, must be aligned with other provider types within a health plan's medical benefit.

Health plans are navigating enrollment processes, including credentialing, of pharmacists into their provider networks using a variety of approaches. Under the medical benefit, individual pharmacists instead of pharmacies are enrolled and credentialed, a net new experience for many pharmacists and health plans. Enrollment as a provider in a health plan's network under the medical benefit includes two parts: completing an enrollment application form and submitting information that is used by the plan to credential the pharmacist as a network provider. Credentialing involves the health plan verifying that a health care professional has the qualifications to deliver services to patients. In the credentialing process, trusted sources are used to verify the information submitted by the pharmacist such as the pharmacist's state license number and the pharmacist's NPI number.

Enrollment processes for pharmacists within a health plan, including the application and credentialing, should be standardized with other provider types, such as physicians, nurse practitioners, and physician associates. There may be some exceptions unique to pharmacists just like there are for other provider types, but overall, these processes should align with those of other providers.

Health plans report an aim of integrating pharmacists into their existing enrollment, including credentialing, processes consistent with accreditation requirements they must meet. One area of focus for the enrollment process has been the applicability of health plans' enrollment forms to pharmacists. Pharmacists and employers of pharmacists report that many fields in the forms do not apply to them, creating barriers during legal review that can extend the time to enroll. Examples of health plan requirements for enrollment under the medical benefit that would not apply to pharmacists include but are not limited to:

- Admitting privileges to a hospital
- Two medical exam rooms
- Medical office staff
- 24-hour emergency coverage

One solution, which has been adopted by at least one plan, would be to create a pharmacist-specific enrollment form in collaboration with NCQA and other accreditors that would meet health plan accreditation requirements. The enrollment process would be consistent with other providers, but the form used would be specific to pharmacists.

There are two types of credentialing processes that can be used for pharmacists under the medical benefit. In individual credentialing, a pharmacist applies directly to the health plan and is processed individually by the plan. In delegated credentialing, an employer of pharmacists or a network administrator for a network of pharmacists works with the plan to take responsibility for the pharmacists' credentialing process. Pharmacists still must be enrolled in the plan, but delegated credentialing can take the onus off the health plan for the credential verification component. Generally, the employer or network of pharmacists must meet a minimum number of providers to be eligible for a health plan's delegated credentialing process. Third-party vendors can also assist pharmacies and employers with standardizing and streamlining the information needed for the credentialing process so that it can be used for multiple payers. The entity performing credential verification must obtain initial and periodic consent from the pharmacist to access their credentials.

Pharmacists should understand that enrollment, including credentialing processes can take longer than sometimes anticipated, which can delay finalizing the contract and implementation of coverage for patient care service programs in the practice. From the plan perspective, it can be very helpful if the enrollment process is started with those pharmacists who are likely to deliver the care initially and then enroll others over

time. This can help the plan in managing the resources needed to process pharmacist enrollment, which can be time intensive. Health plans and pharmacists also report that electronic enrollment processes create efficiencies, and one plan found that it takes less time to enroll pharmacists under the medical benefit than other provider types.

Health plans that are early adopters of pharmacist enrollment, including credentialing, under the medical benefit are taking proactive steps to build and support the pharmacist/pharmacy network through:

- Hiring pharmacy network liaisons to work directly with pharmacists and pharmacies to help with enrollment and billing.
- Streamlining pharmacist enrollment across the health plan's lines of business, including updating technology systems to include pharmacists as a provider type.
- Offering educational programs to pharmacists on how to enroll and become credentialed.
- Educating internal health plan staff in call centers who interface with pharmacists to understand that they are eligible to enroll in the plan.
- Collaborating with other health plans in the geographic area to align credentialing processes for pharmacists.
- Creating pharmacist-specific enrollment forms that meet accreditation requirements while integrating pharmacists into the plan's existing processes.

Educational programs and resources are needed to inform and assist pharmacists and health plan representatives in navigating the pharmacist enrollment process, including completing the application and the credentialing process. Health plans should support pharmacists in the same manner as other provider types. It is common for health plans to have a provider manual that contains comprehensive information for clinicians in the health plan's network. Pharmacists should consult this manual, and health plans should market the manual to pharmacists to increase awareness. Some health plans have created websites with information specific to pharmacists to assist them with meeting plan requirements.

There are also opportunities for health plans, pharmacy associations, educational institutions, and other aligned parties to create educational programs and resources for pharmacists, pharmacy teams, and health plan representatives, either stand-alone or through collaborative efforts. Educational programs are also needed to teach student pharmacists and postgraduate trainees about enrollment, including credentialing, and other aspects of coverage and reimbursement for pharmacists' patient care services under the medical benefit.

RECOMMENDATION 10: Health plans and pharmacists must collaborate to implement successful billing processes under the medical benefit for pharmacists' patient care services.

Payment for pharmacists' patient care services billed under the medical benefit instead of the pharmacy benefit has many advantages, including placing clinical service delivery by pharmacists in the same health plan budget lines as other providers, greater visibility of pharmacists' patient care data for outcomes measurement, separating payment for pharmacists' patient care services from payment for medication products, and avoiding potential PBM retroactive and point-of-sale fees being applied to pharmacists' clinical services. Challenges with medical billing include lack of real-time patient eligibility status and claims adjudication, types of data needed for clinical service claims submission, the need for revenue cycle management programs to manage payment, and having the technology in place to submit medical claims.

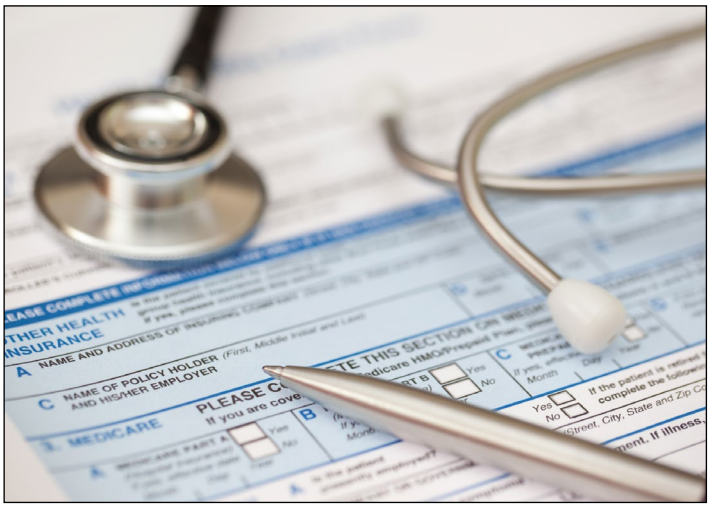
Medical benefit billing is used by physicians and other qualified healthcare professionals, and examining these providers and the processes they use can be informative to pharmacists entering this space. Health plans should standardize and align pharmacists' billing processes with the other provider types in their networks, as much as possible, recognizing that there may be some variability in billing processes from plan to plan. Aligned with other provider types, pharmacists and pharmacies should be able to choose the documentation and billing software system of their choice and use it for medical claims billing across all health plan contracts instead of being required to use plan-specific vendors.

Medical claims are more complex than pharmacy claims, requiring information such as the correct billing code for the service delivered, diagnosis code(s), and place of service codes. Current procedural terminology (CPT®) codes developed by the American Medical Association (AMA) are the most common billing codes used for clinical services and procedures. CMS also develops codes for those Medicare program services that do not have assigned AMA CPT® codes. Generally, health plans determine the billing codes that are to be used for the services they are covering. For state Medicaid programs, it may be a state agency that determines which codes are to be used, especially when implementing requirements for pharmacists' patient care services specified in legislation. There is currently significant variability in the billing codes being used for pharmacists' patient care services across states and payer programs, and health plans and employers of pharmacists desire greater consistency in the use of billing codes for pharmacists' patient care services, especially for efficiencies in the billing process and measurement of pharmacists' impact broadly. Commonly used codes for pharmacists' patient care services include:

- E&M office or other outpatient services CPT® codes
- Medication Therapy Management (MTM) CPT® codes
- Care management codes
- Anticoagulation CPT® codes
- Vaccine administration codes

Pharmacists are using additional CPT® codes to bill for items such as laboratory tests, point of care testing, and supplies that may be billed in conjunction with professional service codes.

Place of service (POS) categories required for medical claims submission can be a barrier when the payer does not recognize this information in their systems. Educating payers about the need to include pharmacy-related place of service categories (the POS for a pharmacy is 1) within their systems should be a component of outreach to payers when new payment programs are initiated. Additionally, pharmacists should not be limited to billing



to certain POS, and billing expectations should align with other health care professionals.

The infrastructure for medical billing requires technology, including a clinical documentation system, interoperability capability for exchanging clinical and claims information, and cybersecurity to protect patient health information. If the patient care services are being provided in a pharmacy, there are additional considerations for submitting the claim in a manner that can be received by a health plan. Pharmacy-based software systems use National Council for Prescription Drug Program Standards for submitting prescription drug claims to pharmacy benefit managers for claims adjudication and payment. Medical claims use Health Level–7 standards (HL7), and contain more extensive data fields for the claim such as CPT® codes, diagnosis codes, etc. In general, pharmacy software systems are not set up for the data fields or capability to submit medical claims, and most pharmacies work with a third-party vendor that can accommodate the data requirements for the claim and submit the claim in a format that can be received by the health plan.

Pharmacists, pharmacies, physician practices, and other employers of pharmacists must also be prepared for revenue cycle management and plan audits of medical claims submitted for pharmacists' patient care services. Processes must be in place to bill the patient for expenses not covered by the health plan and for handling rejected claims. Patients must be educated on the difference between the customary pharmacy billing processes for prescriptions (i.e., real-time adjudication which provides a copay/true cost at the pharmacy) and medical billing processes (i.e., what they are more accustomed to from their other health care providers by receiving a bill after the fact). The health plan can conduct audits of the pharmacy practice's medical claims to ensure fidelity with plan requirements.

Significant efforts are needed to assist pharmacists, pharmacies, and health plans with implementing the infrastructure and processes for pharmacists to successfully bill under the medical benefit. Efficient claims submissions processes are essential for sustaining pharmacists' services and scaling payer coverage. Education and resources are needed for pharmacists, pharmacy teams, student pharmacists, and postgraduate trainees on all aspects of the medical billing process, including but not limited to the required information for a medical claim, an understanding of CPT® and other service or procedure codes, diagnosis codes, revenue cycle management, documentation requirements, and more. Similar to resources available in other health care professions, pharmacy associations should consider developing a national pharmacist billing support center. Pharmacies are adding staff members, often technicians with expertise in medical billing, to handle medical claims processes. In some states, partnerships between aligned parties such as health plans, pharmacists, pharmacy associations, and educational institutions are fostering the development of educational programs and resources on medical billing.

RECOMMENDATION 11: **Value-based payment programs for pharmacists' patient care services represent new, evolving opportunities, and pharmacists and health plans must partner to deliver programs that are mutually beneficial for patients, pharmacists, and health plans. Education and resources on value-based programs, such as quality measurement, bi-directional data exchange, attribution, and risk management are needed to foster uptake of these programs in the health care marketplace.**

Health plans are interested in partnering with pharmacists and pharmacies in value-based contracts as a mechanism to help meet health plan measures and address care and access gaps. Value-based contracts reward providers for meeting quality and cost measures and provide a mechanism for recognizing a health care provider's value. Pharmacists in a variety of practice settings, such as clinics, physician offices, and community pharmacies are contributing to meeting quality and cost measures in their practices as part of value-based contracts with health plans.

There are many different types of value-based payment programs that come with varying levels of risk to the provider. The most common type of value-based payment program for pharmacists and pharmacies involves contracts that pay an FFS fee with an added bonus or incentive payment such as care coordination fees, pay for reporting data (e.g., social determinants of health, BP readings), or pay for performance by meeting specified quality measure(s). This model is relatively low risk to the provider with the primary downside being time expended to meet measure(s) that may not yield a bonus or incentive payment if the measure(s) is not achieved.

Some pharmacists and pharmacies participate in value-based contracts based on payment for managing a population of patients. In this scenario, the payment is often per member per month (PMPM), per member per year (PMPY) or similar type of negotiated rate to manage a population with single or multiple conditions. These types of programs come with higher risk. Because these contracts often don't have an FFS component, it's important to consider the resources needed to deliver the services and whether the contracted rate is sustainable to cover the resources required to manage the population, especially since actual patient needs over the measurement term are not entirely known. Financial payment on a monthly or quarterly basis is more conducive to sustaining the practice under a value-based arrangement than contracts that pay at the end of the calendar year, provided that the resource allocation needed to trigger more frequent payments is not onerous.

It's important that contract parameters provide a reasonable time period for pharmacists to longitudinally influence patients' progress toward meeting the metrics for payment. There may be some more urgent situations in which health plans build on established relationships with pharmacists and pharmacies to offer additional payment opportunities for assisting with meeting end of the year metrics. However, the preference is for a reasonable time period to longitudinally build the pharmacist-patient relationship and impact outcomes.

Quality and cost measures play a critical role in value-based programs. Some value-based programs are based solely on meeting quality measures, while others also include a provision to be held accountable for costs. Measures used in value-based arrangements should align with the criteria in the Blueprint for the CMS Measures Management System, which focuses on measure importance, scientific acceptability, feasibility, and usability.

There are many payer measures that pharmacists can impact in all practice settings. The primary cost measures pharmacists and/or pharmacies are encountering include total cost of care, reducing emergency room visits, and reducing hospital readmissions. Example quality measures included in value-based payment programs with pharmacist participation from various practice settings include but are not limited to:

- Adult immunization status
- Asthma medication ratio
- Contraceptive care measures
- Depression screening
- Diabetes—HbA1C control
- Health risk assessments (HRAs)
- Hypertension—high BP control
- Medication adherence measures
- Opioid risk reduction strategies
- Patient satisfaction/patient experience
- Statin use in persons with diabetes
- Use of multiple anticholinergic medications in older adults

Pharmacists report that in addition to focusing on quality measures, some value-based payment programs are providing incentives to prioritize engagement of pharmacists specifically to increase access to services, especially for high-risk patients in underserved areas.

With any emerging program, there are challenges and barriers. Reported barriers to pharmacist and/or pharmacy participation in value-based programs and reported learnings include:

- *Time to implement these programs for both health plans and pharmacy practices* – pharmacists and health plan participants in value-based programs report that it can take extended amounts of time to implement an initial program, but subsequent programs generally take less implementation time. Health plan representatives

report that there is often increasing interest in engaging pharmacists from other areas within the health plan after seeing how pharmacists perform in value-based programs. Pharmacists and pharmacies need to proactively have the infrastructure in place to deliver patient care services and track metrics because once the contract is signed, tracking begins immediately.

- *Data exchange* – patient data and performance data are both critical to identifying patients at the practice level, in calculating measures and in keeping the practice apprised of progress toward meeting measures goals. There is a need for more timely and better data exchange between pharmacies and health plans. Vague and inconsistent data has led to some pharmacy practices being penalized unnecessarily for not meeting metrics.
- *Attribution process* – pharmacists manage a panel of patients in value-based programs, and the process of ensuring that the patient panel attributed to the pharmacist is accurate can be burdensome. Also, in team-based care models, the pharmacist is one member of a team of providers caring for the patient. Determining the extent to which each provider impacts the patient's outcomes and then how to attribute those contributions in the distribution of incentive payments can be difficult.
- *Composition of patient panels* – pharmacists' expertise and accessibility and health plans' needs may result in pharmacists being assigned patient panels that contain greater proportions of high-risk patients than other patient panels that contain a mix of patient risk profiles. High-risk patients inherently require more intensive interventions to improve health and meet quality metrics. For sustainability, value-based payment models must align payment with the type of risk profile for the patient panel the pharmacist is assigned.
- *Starting with programs that have too high risk* – health plans and pharmacists recommend starting with value-based programs based on FFS payment with performance incentives instead of starting with population-based payment models like PMPM. Starting with lower risk programs allows the pharmacy practice to learn about value-based programs before moving to those with higher risk levels. Having more discussions about models that work, including payment approaches that are sustainable, would help in addressing some of the mysteries around these programs.
- *Support for program implementation* – once an employer of pharmacists signs a value-based contract with measures, the employer is expected to start performing immediately. Some health plans have initiated support teams to communicate with and assist employers of pharmacists in implementing these programs successfully. For example, one health plan identifies a nonclinical staff member to serve as the primary contact for all aspects of the contract. This plan also identifies and shares subject matter experts for peer-to-peer learning.
- *Provider and patient awareness* – lack of physicians' and other health care providers' awareness of value-based contracts with pharmacists and pharmacies can cause challenges with sharing data and other aspects of meeting the contract. Also, patients may be interacting with pharmacists in new ways and asked for information that they are not used to providing. While these factors can also apply to other types of pharmacist/pharmacy contracts with health plans, additional work in these areas is needed to increase familiarity and support for engaging with pharmacists in this manner.

Education and resources are needed for pharmacists, pharmacy teams, student pharmacists, postgraduate trainees, and health plan representatives on all aspects of value-based payment models. This includes education and resources about what these programs are and how they work, the role that quality measures play in care delivery and payment, the types of risk models, what it means to take on risk and how to manage it to receive payment, and how data is used and exchanged between pharmacists and health plans. Resources highlighting successful health plan and pharmacist value-based models that are working and how pharmacists provide value to patients and the health plan should be developed and broadly distributed to increase engagement in these programs.

Despite the barriers, value-based programs hold potential for pharmacy practices. Using pharmacists' successful performance in meeting measures, organizations have been able to expand the number of pharmacists working in physician office practices and clinics. Health plans also value the access and frequent interactions community-based pharmacists have with patients and are interested in novel approaches like value-based payment programs to cover and reimburse patient care services. Also, value-based contracts are generally less prescriptive in how pharmacists care for patients and encourage pharmacists to use their normal process of care, complemented by a dashboard provided by the health plan that contains information about the patient panel and ongoing data on progress toward meeting measures. This allows for incentives for pharmacists achieving outcomes instead of check the box types of activities. Finally, these programs allow pharmacists to demonstrate their value to payers, and payer interest in engaging pharmacists for value-based patient care service delivery is promising for the profession.

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The information provided in these Recommendations does not necessarily reflect the views of individual participants or the organizations they represent. This participant roster includes those participants who agreed to be listed for this publication.