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FEATURE

Optimizing patient outcomes: Health plans and pharmacists summit: Meeting proceedings

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ABSTRACT

Objective: To convene a group of experts to define the value pharmacists provide to health plans, barriers to covering pharmacists' patient care services, and scalable solutions to cover pharmacists' services, specifically in the medical benefit.

Methods: The American Pharmacists Association (APhA) convened 31 experts, including physicians and pharmacists representing health plans (HPs), and pharmacist practitioners (PP) or organizations representing PPs for a strategic summit on May 16 to May 17, 2022, in Washington DC and Arlington, VA. A presummit survey was conducted to identify participants' perspectives on the value proposition of pharmacists and barriers to coverage for services. Day 1 of the summit featured a keynote presentation focused on the future of pharmacist-provided care. The second day included a framing session on the current state of coverage for pharmacists' services and the results of the presummit survey; four panel presentations on innovative HP program coverage; three breakout sessions to gather participant feedback on their experiences; and a final session prioritizing action items into an initial timeline of goals. A postsummit survey was fielded to rank feasibility and importance of opportunities and next steps for advancing coverage of pharmacists' services.

Result: In general, there appeared to be consensus throughout the summit on the need to expand payer programs covering patient care services provided by pharmacists and the importance of continued collaboration between PPs and HPs to increase patient access to care. Participants highlighted a need for legislative and regulatory changes at the state and federal level for the expansion of some programs; however, there were many opportunities to expand programs without the need for public policy changes.

Conclusion: The summit was a groundbreaking meeting between PPs and HPs that provided the foundation for collaboration and expansion of programs covering pharmacists' patient care services under the medical benefit. Key takeaways from the summit focused on the need for scaling programs; establishing mutually beneficial programs for patients, PPs, and HPs; and the need for partnership and flexibility from PPs and HPs as programs continue to establish and expand.

Background

Financial coverage for pharmacists' time and expertise in the delivery of patient care services is critical for the creation of scalable, sustainable services profession-wide that meet patients' health and wellness needs. While pharmacists are well-positioned in knowledge, expertise, and accessibility to address increasing barriers and disparities for patients to obtain optimal health care, the ability for pharmacists to meet this need is hindered by the widespread lack of coverage for services provided.[1,2]

Common financial models for pharmacists' patient care services include fee-for-service (FFS) payment from a variety of payers, value-based payments, blended FFS/value-based payments, direct contracting with an employer, and patient self-pay. Depending on how payers recognize their providers, pharmacists either bill directly for their services or in the case of Medicare Part B and some other payers, a physician or other

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Key Points

Background:

- While pharmacists are well positioned in knowledge, expertise, and accessibility to address increasing barriers and disparities for patients to obtain optimal health care, the ability for pharmacists to meet this need is hindered by the widespread lack of coverage for services provided.
- Over the past 10 years, there has been significant movement at the state level to require that pharmacists' services be covered in Medicaid and commercial health plans. The movement by payers to cover pharmacists' patient care services in the medical benefit presents an exciting opportunity to capitalize on the creation of scalable, sustainable payment models.

Findings:

- Expansion of programs covering pharmacists' patient care services in the medical benefit is crucial and should continue.
- Widespread and consistent communication about the value of pharmacists is essential for recognition.
- Programs should be scalable, requiring alignment of pharmacists' scope of practice across states for consistent services. Strong partnerships and mutually beneficial programs between pharmacist practitioners and health plans are vital for program evolution.

qualified provider bills for the pharmacist's services under "incident to physician services" arrangements.[3]

Pharmacy is unique in that pharmacists' patient care services could be covered in either the pharmacy benefit and paid by a pharmacy benefit manager or the medical benefit and paid by a health plan. Payment through the pharmacy benefit is primarily applicable to pharmacists in community-based pharmacies. There are pros and cons to payment through each type of payer.[4] The pharmacy profession's current provider status efforts at the federal level are directed at securing recognition and coverage for pharmacists' services in Medicare Part B, the medical benefit where all other health care providers of outpatient services are paid. The Future of Pharmacy Care Coalition has spearheaded current legislation in Congress to amend the Social Security Act to cover specific pharmacists' services in Part B.[5] Over the past 10 years, there has been significant movement at the state level to require that pharmacists' services be covered in Medicaid and commercial HPs. Services covered range from those that address public health needs to chronic condition management and comprehensive medication management services. These services are usually covered in a HP's medical benefit where all other health care providers are paid. The movement by payers to cover pharmacists' patient care services in the medical benefit presents an exciting opportunity to capitalize on the creation of scalable, sustainable payment models.

Purpose of the stakeholder summit

APhA is committed to increasing sustainable access to pharmacists' patient care services, a top priority in APhA's strategic plan. As a leader in advancing coverage for pharmacists' services, APhA convened an invitational conference of 31 experts (Appendix A) on May 16 to May 17, 2022, in Washington, DC, for the *Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.* The summit brought together approximately equal representation from physicians and pharmacists representing HPs and PP or organizations representing PPs. Summit objectives included:

1. Defining the value pharmacists provide to HPs
2. Identifying barriers to coverage for pharmacists' patient care services
3. Strategizing scalable solutions to cover pharmacists' services, specifically in the *medical* benefit.

For the purpose of this paper, PPs are defined as registered pharmacists practicing in a variety of outpatient health care settings, including community pharmacies.

APhA served as a neutral convener for open and candid discussions among participants. A professional moderator facilitated the discussions, and a graphic illustrator documented the discussion, opportunities, and next steps. Discussions during the summit were informed by a presummit survey that identified HPs' and PP's' perspectives on the value proposition of pharmacists and the most substantial barriers to covering their services. Following the summit, participants completed a postsummit survey to rank the importance and feasibility of opportunities and next steps in order to prioritize efforts to expand coverage of pharmacists' patient care services.[6]

The information included in these proceedings is intended to summarize the presentations and discussions at the summit. The panel presentation summaries describe the information presented by the expert panelists. The breakout session summaries detail key information gleaned from summit participant discussions but may not reflect the views of all participants.

Overview of the summit

The first day of the summit included a keynote presentation, dinner, and networking reception at APhA Headquarters in Washington, DC. On the second day, attendees gathered at the Le Meridien Hotel in Arlington, VA, to engage in an overview of example HP programs currently covering pharmacists' patient care services, followed by identification of key barriers and opportunities for facilitating scalable expansion. An introductory framing session provided national trends on programs covering pharmacists' services across the states, along with the results of the presummit survey. Following the framing session, four panel presentations conducted by HP and PP representatives highlighted current states of their programs covering pharmacists' services, lessons learned, and future plans. The summit included three breakout sessions that focused on sharing information on additional payer programs, defining the value proposition of pharmacists from a HP and practice perspective, identifying key barriers to payers

covering pharmacists' services and strategies to overcome these barriers, and messaging needs. The final session included prioritizing action items into an initial timeline of goals that was subsequently shared with attendees in a post-summit survey to gather their feedback on the importance and feasibility of accomplishing each goal.

Day 1: May 16, 2022

APhA CEO, Scott Knoer provided welcoming comments, introducing this groundbreaking summit and the opportunities for ongoing continued collaboration among the stakeholders present.

Keynote presentation: Accelerating the future of pharmacy through HP and pharmacist collaboration

Presented by George Van Antwerp, Managing Director, Deloitte Consulting LLP

George Van Antwerp of Deloitte Consulting LLP set the tone for the summit with a thought-provoking presentation on the evolving state of the health care system and how pharmacists and HPs can collaborate to take advantage of the emerging opportunities. Participants were encouraged to align in meeting consumer needs such as the desire for personalized health care experiences, a preference for timely access to care with minimal waiting, and the need for access to mental health professionals.

The significant impact of technology and digital health on pharmacy and HPs was highlighted. For pharmacies, automation will continue to impact aspects of the dispensing process, freeing pharmacists to focus on other responsibilities, including opportunities to partner with telehealth providers for seamless care. For HPs, technology platforms could better connect patients with pharmacists and provide tools to members with better price transparency.

As pharmacists' scope of practice increases to align with their expertise and training, they will be able to provide services across a spectrum from medication dispenser to medication management to care management to pharmacist as a provider. Financial support for pharmacists' services could be derived from population health management funds, redirected HP spending such as member communication expenses, and demonstrated cost savings from pharmacists' services such as deprescribing.

A series of illustrative cases on bipolar disease, pain management, and diabetes demonstrated a reimagined model of care where the pharmacist collaborates with the provider to determine the right drug, navigates the patient's benefits and personal needs, addresses barriers and matches the patient with support, including digital technology to support the patient when and where they need it. The pharmacist helps coordinate polypharmacy and care transitions and uses data to develop and monitor a digital plan with the patient's care team. Ongoing interventions occur, in person, virtually, digitally, and in the home. Technology infrastructure must be built to support this model. Recommended actions to accelerate the "Future State Pharmacist" included the following:

HPs:
- Reimburse pharmacists for clinical services
- Leverage pharmacists as caseworkers in the field
- Develop an integrated electronic medical record platform bolstering continuity of care

PPs:
- Integrate technological innovations into clinical workflow
- Create more opportunities for the pharmacist to focus on clinical tasks
- Establish collaborative relationships with other health care providers

HP/PP collaboration can lead to a realized value of improved patient satisfaction, reduced adverse drug events, improved clinical outcomes, enhanced medication adherence, and enable equitable health access.

Day 2: March 17, 2022

APhA President Theresa Tolle introduced day 2 with the theme, "Today is the Day," and highlighted the significant impact her independent community pharmacy has had on the community she serves. She called on participants to use collaboration, creativity, and innovation in exploring mechanisms to better support and leverage pharmacists.

Review of the national landscape and presummit survey report out

Presented by Anne Burns BSPharm, Vice President, Professional Affairs, APhA, and E. Michael Murphy, PharmD, MBA, Advisor for State Government Affairs, APhA

An overview of internal APhA data on current programs covering pharmacists' services under the medical benefit and results from the presummit survey were presented. In recent years, a number of states have passed laws to expand reimbursement for pharmacist services under Medicaid or commercial insurance. Other states have found success through simply making regulatory changes to expand reimbursement under Medicaid programs. While states have passed legislation to either permit or mandate commercial insurance cover services provided by pharmacists, there is no explicit requirement legislative action needed for commercial insurance to reimburse pharmacists for their services as this decision can be made at an individual internal organizational level. A summary of trends was provided showcasing states where legislation and/or regulations were passed covering pharmacists' services under Medicaid and commercial insurance as well as states where prominent commercial insurance contracts exist without these actions. It is important to note that passage of legislation or implementation of regulations does not necessarily equate to implementation of programs.

Within current programs covering pharmacists' services, there is a large amount of variability from program to program. This variability is also present within the Medicaid and commercial business lines of an individual HP between different states.

Medicaid and commercial insurance

Under Medicaid, the general trend of program coverage allows pharmacists to render and be reimbursed for services provided to both Medicaid FFS and Medicaid managed care beneficiaries. Services are being reimbursed under the medical benefit using Healthcare Common Procedure Coding System

Level I and Level II codes similar to those used by other health care professionals providing outpatient services, in settings such as pharmacies, physician offices, homes, walk-in retail health clinics, federally qualified health centers, rural health clinics, skilled nursing facilities, assisted living facilities, or other places of service.

The scope of reimbursable services under Medicaid is variable from state-to-state. Services include, but are not limited to, acute disease state management, chronic disease state management, drug administration, diabetes self-management training services, hormonal contraceptive services, medication management services, services related to furnishing and education on opioid overdose antagonists, test and treat for minor ailment services (influenza, Group A Streptococcus Pharyngitis, COVID-19, etc.), tobacco cessation services, and transitions of care services.

In order to implement these programs, state medical assistance programs are applying to the United States Department of Health and Human Services for amendments to their state Medicaid plan and requesting any necessary Medicaid waiver to implement programs to reimburse pharmacists for their services. State Medicaid programs can submit state plan amendments (SPAs) to add pharmacists as "Other Licensed Practitioners (OLPs)," allowing reimbursement of pharmacists' services under the medical benefit. For example, pharmacists in Nevada recently were granted the authority to prescribe human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) through a statewide protocol, and the state Medicaid program submitted a SPA which was approved by the Centers for Medicaid and Medicaid Services to allow pharmacists to bill for services associated with the assessment and prescribing of HIV PrEP and PEP.

In 10 states, legislation has also been signed into law that pays pharmacists in "parity" with other health care professionals in commercial HPs. In these states, pharmacists are being enrolled and credentialed in HP provider networks similar to OLPs in Medicaid programs. In addition to these programs, commercial HPs are voluntarily recognizing the value of pharmacists' services and contracting with pharmacists to reimburse them for their services. Some of these programs are being established as FFS, however, a growing number are being established as hybrid programs which also include a value-based component. Similar to Medicaid programs, pharmacists are commonly being reimbursed under the medical benefit of commercial HPs using comparable billing codes as other health care professionals. Additionally, similar types of services to those being reimbursed by Medicaid programs are being included in commercial insurance programs.

Beyond general trends seen in Medicaid and commercial programs, there are differences in programs, including restrictions in the scope of covered services, how services are rendered, who the billing provider is, the billing codes included in fee schedules, and the geographical areas where services can be rendered, among other nuanced restrictions. The extreme variability in programs from state to state can possibly create challenges in the expansion of consistent scalable programs across the country in Medicaid and commercial insurance.

Following the summary of national trends, presummit survey results were shared with attendees. Attendee information, presented in Table 1, was gathered to understand the perspective of attendees and their involvement in current programs covering pharmacists' services. A majority of attendees representing HPs and PPs responded that their patient care service involvement was focused on administration of immunizations and delivery of comprehensive medication management. These services, and others were more commonly covered under the pharmacy benefit, however, 70% of pharmacist respondents and 50% of HP representatives reported services being covered under the medical benefit. Programs covering pharmacists' services were most commonly established within FFS payment models, however,

Table 1
Demographic information for summit attendees and programs covering pharmacists' patient care services

Pre-meeting questions	Pharmacist practitioners & other respondents N (%)	Health plan respondent N (%)
Perspective representing at summit	Pharmacist 9 (29) Other[a] 12 (39)	10 (32)
Coverage for pharmacists' patient care services: Services covered		
Chronic disease management	13 (62)	5 (50)
Comprehensive medication management	17 (81)	6 (60)
Immunizations	15 (71)	9 (90)
Prevention and wellness services	9 (43)	2 (20)
Test and treat	8 (38)	2 (20)
Other	1 (5)	2 (20)
Coverage for pharmacists' patient care services: Benefit type		
Medical benefit	15 (71)	5 (50)
Pharmacy benefit	16 (76)	8 (80)
Coverage for pharmacists' patient care services: Payer type		
Medicare	13 (62)	6 (60)
Medicaid	15 (71)	6 (60)
Commercial	16 (76)	6 (60)
Other	4 (19)	0 (0)
Coverage for pharmacists' patient care services: Payment model		
Fee-for-service	16 (76)	6 (60)
Value-based	11 (52)	2 (20)
Hybrid	11 (52)	5 (50)

[a] Other respondents include: Pharmacists with dual HP/PP role (3); Representatives from academic institutions (2); Representatives from employers paying for health care benefits (2); Representatives from networks of providers/pharmacists (2); Consultants (1); Representatives from associations (1); No comment submitted (1).

Table 2
Prioritized goals for summit per presurvey respondent group. Numbers represent rankings with 1 being the highest and 6 being the lowest

Pre-meeting questions	Health plans	Pharmacist practitioners and other
Learning how HPs are providing coverage for pharmacists' patient care services in general and across the country	1	1
Confirmation and strategies to convey that coverage for pharmacists' patient care services drive value	2	3[a]
Strategies for implementing programs that provide coverage for pharmacist's patient care services	3[a]	2
General strategies for pharmacists and HPs to partner	3[a]	3[a]
Strategies for scaling pharmacist's patient care services to populations	3[a]	4
Strategies for HPs and pharmacists to share patient data	4	5

Abbreviations used: HP, health plan; PP, pharmacist practitioners.
[a] HPs and PPs ranking of prioritized goals resulted in a three-way tie for third prioritized goal in the HP group and a two-way tie for the third prioritized goal in the PP & other group.

around 50% of HP and PP respondents reported coverage of pharmacist services in hybrid payment models, encompassing both FFS and value-based components.

In addition, attendees were asked to identify the perceived value proposition for pharmacists' patient care services and barriers to covering those services. PP and HP respondents agreed on two of the top three value propositions, that pharmacists help plans meet their metrics, and that pharmacists help to meet unmet care access needs in underserved areas. PP and HP respondents differed on the third area of highest value, where PPs felt the value proposition was the need for pharmacist medication expertise, but HP representatives attributed value to greater beneficiary/member satisfaction. Respondents' top three barriers to covering pharmacists' patient care services varied more, with HPs and PPs only agreeing on 1 shared top barrier, which was variability in pharmacist scope of practice from state-to-state. HP representatives felt that the two other largest barriers to covering pharmacists' patient care services were scaling the patient care services and plan credentialing of the pharmacists. PPs' other two highest-ranking barriers were the process of billing for services and contracting for pharmacists' services. Finally, respondents were asked what their goals for the summit were. Goals were themed by APhA staff, and a prioritized list of goals is included in Table 2.

Panel presentation 1: A view from a vertically integrated health care model

Presented by Kyu Rhee, MD, MPP, Senior Vice President and Aetna Chief Medical Officer, CVS Health; and Sandra Leal, PharmD, MPH, FAPhA, Vice President, Collaborative Innovation and Clinical Strategy, CVS Health

This session focused on the evolving role of the pharmacist within the health care ecosystem and efforts to include pharmacists' services within a vertically integrated health care organization. The accessibility of pharmacists in community pharmacies and the frequency that patients visit a pharmacy, on average 35 times a year compared to 4 times a year to visit their medical provider was highlighted. This presents an opportunity for greater use of pharmacists' expertise in addressing health care needs and gaps. Providing patients with an integrated care team that includes a pharmacist, is instrumental for effective primary care, public health, and prevention services. Pharmacists' valuable contributions during the pandemic have further solidified their role on the team. Dr Rhee also advocated that it was important to value pharmacists and recognize their expertise and calling them Doctors since the PharmD is a doctorate degree may help address this.

Various initiatives underway at CVS Health to expand the role of the pharmacist were presented. As ready access points, pharmacists are using innovative tools to identify unmet social needs, such as food insecurity, that are instrumental to patients' overall health. Current CVS Health pilot programs include a hormonal contraception assessment and prescribing service in some states and a Community Pharmacy Enhanced Services Network (CPESN) pilot program for services with Aetna Medicaid. Future planned programs in the pipeline include expanded scope services like tobacco cessation and medication management services, as well as exploring virtual/primary care opportunities. CVS Health envisions a virtual primary care team that includes CVS Health pharmacists and provides accessible services, a shared electronic health record (EHR), mental health services, options for in-person services, and guidance and engagement. In order to be successful, collaboration between science, education, practice, and policy stakeholders is needed to realize this vision.

Panel presentation 2: A view from a HP/pharmacist collaborative care model

Presented by Amy McKenzie, MD, MBA, FAAFP, Associate Chief Medical Officer and Vice President of Clinical Partnerships, Blue Cross Blue Shield of Michigan (BCBSM); Hae Mi Choe, PharmD, Associate Chief Clinical Officer for Quality and Care Innovations, University of Michigan Health and Associate Dean and Clinical Professor, University of Michigan College of Pharmacy; and Emily Mackler, PharmD, BCOP, Director of Pharmacists Optimizing Oncology Care Excellence in Michigan, Michigan Oncology Quality Consortium and Michigan Institute for Care Management and Transformation (MICMT)

BCBSM's Provider-Delivered Care Management Program (PDCM) was profiled. This program uses a patient-centered medical home (PCMH) model where primary care physicians (PCPs) lead multidisciplinary teams, including pharmacists. Team members provide services to patients with chronic diseases with goals of improving care gap closure and quality of care and reducing emergency department (ED) and inpatient hospitalization utilization. BCBSM PCMH practices using PDCM as compared to PCMH only practices have demonstrated 7.2% lower primary care sensitive ED utilization and 11.5% lower ambulatory care sensitive inpatient utilization. In 2018, the estimated PDCM cost savings in a commercial population was 4% or $17-$23 per member per

month. A care coordination fee is paid directly to the practice for pharmacists' care coordination and medication management services that can include various care delivery modalities including face-to-face, telephonic, video, and team conferences. There is also value-based reimbursement directly to PCPs based on meeting patient engagement, chronic condition quality metrics, and improvement in ED and inpatient hospitalizations.

Pharmacists have been integrated into primary care practices across the state through the innovative Michigan Pharmacists Transforming Care and Quality (MPTCQ) program. MPTCQ has a network of pharmacists with an expanded scope of practice who provide value to primary care practices by improving clinical outcomes (e.g., glycosylated hemoglobin {A1c} and blood pressure control), closing care gaps, improving medication adherence, and addressing medication costs. MICMT supports the implementation of payer programs such as BCBSM's PDCM program. This institute operates on 4 pillars that include:

- Collaborating with physician organizations
- Rewarding team-based care efforts
- Evaluating the impact of team-based care
- Identifying and engaging with partners to expand

MICMT has future plans to develop partnerships with community pharmacies, further expand the role of the community health worker in team-based care, implement a patient activation measure, and develop an educational resource on PDCM for physicians. A Centers for Disease Control and Prevention analysis of University of Michigan's hypertension program found that patients receiving pharmacist-provided hypertension management were more likely to achieve hypertension control at 3 and 6 months, and physicians had more time to see complex patients.[7]

Finally, pharmacists are impacting specialty care through the Pharmacists Optimizing Oncology Care Excellence in Michigan (POEM) program. This initiative is part of the BCBSM Value Partnerships program, and specialty trained oncology pharmacists support oncology practices across the state. The practice bills a care coordination fee for pharmacists' services. Inclusion of a pharmacist starts with 100% financial support from the practices, and then declines over time as the billing of care coordination fees increases the financial support of the pharmacist. Outcomes tracked to determine pharmacist value include number of encounters and interventions, patient satisfaction, care management billing optimization, meeting site-specific metrics, and reimbursement for services. Common pharmacist interventions include education and referrals, medication modification, and comprehensive medication reviews or medication reconciliation. Preliminary data was presented showing that ED visits and hospitalizations are lower with pharmacist management of oral anticancer agents than nonpharmacists.

Panel presentation 3: A view from a Medicaid Managed Care Organization/pharmacist model

Presented by Angel Ballew, MBA, PharmD, BCPP, Senior Vice President, Pharmacy Clinical Services, Centene Corporation; Stuart Beatty, PharmD, FAPhA Professor of Clinical Pharmacy, The Ohio State University College of Pharmacy, Director of Strategy and Transformation, Ohio Pharmacists Association; and Meera Patel-Zook, PharmD, Vice President, Pharmacy Services, Buckeye Health Plan, Centene Corporation

An overview of the differences between payment in the pharmacy and the medical benefit was presented, including the differences between the metrics in both benefits. Metrics for the pharmacy benefit often focus on medication adherence, and medical benefit metrics often concentrate on wellness, clinical measures, utilization, and cost. Regardless of the benefit, payment should be advancing to value-based arrangements.

A summary was provided of Ohio's path to pharmacist provider status law that was passed in 2019, recognizing pharmacists as health care providers, permitting insurer coverage, and encouraging pilot programs. Four Medicaid Managed Care Organizations implemented early programs in 2020, while awaiting rules to be finalized within the state. Pharmacists are paid for services using Evaluation and Management codes under the plans' medical benefit. Preliminary results from these early programs include:

- 80% of patients had improved asthma control, with a trend toward decreased ED utilization (N=16)
- 75% of patients had a reduction in blood glucose or A1c; pharmacists also provided basic nutrition counseling and foot ulcer assessments (N=15)
- 89% of patients started on tobacco cessation therapy and there was a 50% reduction in reported tobacco use (N=9)
- For behavioral health interventions, 77% of patients reported an improved or stable Patient Health Questionnaire-9 or General Anxiety Disorder-7 score after follow-up (N=29)

Buckeye Health Plan's experiences with implementing Ohio's provider status law were described. Buckeye's pilot program included two federally qualified health centers, 1 hospital system, ten independent community pharmacies, and 1 pharmacy chain organization. The pilot program focused on holistic disease management across a variety of conditions and behavioral health with overarching goals of reducing health care spending ED visits, admission and 30-day readmission rates, overutilization, etc.), improving member experience, and enhancing provider partnerships. Buckeye Health Plan has seen more favorable outcomes metrics with pharmacist intervention versus PCP interventions on nine HEDIS measures. The top three metrics were: 1) receiving a COVID vaccine (patients were 32% more likely to receive a COVID vaccine with a pharmacist intervention); 2) risk of continued opioid use (pharmacist intervention more likely to result in a member population with lower risk of opioid use); and 3) care for older adults (patients more likely to meet the assessment and medication review components of this measure with pharmacist intervention).

Finally, an overview of Centene's medication synchronization program was presented that targeted members predicted to be nonadherent to medications used to treat five chronic disease states. The primary goals of the program were to reduce total cost of care and improve quality measures (STARs, HEDIS). This program was paid for through a value-based contract with a network of community pharmacies

nationally. The program drove longitudinal care by building on the patient-pharmacist relationship and removing barriers to medication adherence, including addressing social determinants of health. Results of the national program in 20,000 Medicare beneficiaries include:

- 50% enrollment rate, indicating a strong patient-pharmacist relationship
- 67% success rate in meeting adherence metrics
- 18% reduction in total health care costs

Success from the national program in Medicare spurred a pilot for 3000 Medicaid members in four states with the following preliminary results:

- 15% enrollment rate
- 46% success rate in meeting adherence metrics

Overarching takeaways from this panel are that pharmacists are accessible and underutilized health care professionals. Incentives should align pharmacists with existing health care professionals, including using existing codes for billing where feasible. Payment for pharmacists' services should be separate from dispensing services, telehealth and digital health services should be included, and coverage for pharmacists' services should progress toward value-based models. To scale these services, workflow and technology changes and pharmacist training will be needed.

Panel presentation 4: A view of HP/pharmacist value-based models

Presented by Joseph Albright, PharmD, Director of Commerical Pharmacy Programs, Blue Cross and Blue Shield of North Carolina (Blue Cross NC); and Troy Trygstad, PharmD, MBA, PhD, Executive Director, CPESN USA

This panel explored the current state of value-based payment models in creating sustainable financial models to support pharmacists' services in CPESN Networks and Blue Cross and Blue Cross NC. The variety of payer program types across the CPESN Networks, a clinically integrated network of over 3500 community pharmacies in 44 states, was detailed. Pharmacist interventions, data reporting, and payment models vary across payers, and implementation of outcomes measures in payer programs is still in the early stages. Of the over 100 payer programs, over 60 have a value-based component, and approximately 30% of contracts are at risk. There is a projected 2- to 5-year timeline to see a scaled mature value-based program with a positive return on investment.

Case examples of contracts within the CPESN Networks:

- Case 1: Value-based Care (VBC)/Conventional - Pharmacy Side Fulfillment Outcomes: Medicare Advantage contract focused on meeting proportion days covered metrics. Pharmacist interventions include clinical, social determinants of health, medication synchronization, and medication packaging. Medication adherence data is reported from prescription claims data. Pharmacy receives a bonus if the entire network reaches 4 stars or higher.
- Case 2: Unconventional – Plan Side Process Outcomes: Dual eligible plan focused on meeting a program requirement to administer a health risk assessment (HRA). Pharmacist intervention is to conduct a health risk assessment. Data is reported to the plan platform, and pharmacy receives a FFS payment for completing each HRA.
- Case 3: VBC/Conventional - Plan Side Therapeutic Outcomes: MCO Plan focused on HEDIS/Withhold measures. Pharmacist interventions include patient goals, medication reconciliation, identifying drug therapy problems, medical problems, and health concerns, and creating a care plan. Data is reported using the Pharmacist eCare plan. Pharmacies receive a per person per month (PMPM) payment, but 25% is withheld and paid based on meeting >80% eCare plan submission and A1c goals.
- Case 4: VBC/Unconventional - Plan Side Therapeutic and Global Outcomes: Commercial plan focused on quality metrics and cost of care. Pharmacist interventions include patient goals, medication reconciliation, identifying therapy problems, medical problems, and health concerns, and creating a care plan. Data is reported as a plan report mimicking a medical practice report. Pharmacies receive a bonus payment for meeting metrics.
- Case 5: VBC/Unconventional - Plan Side Therapeutic and Global Outcomes: MCO Plan focused on HEDIS/Withhold measures and nonpharmacy cost of care. Pharmacist interventions include patient goals, medication reconciliation, identifying therapy problems, medical problems, and health concerns, and creating a care plan. Data is reported using the HL7 eCare plan. Pharmacies receive a $PMPM fee, but also receive a 50% penalty if nonpharmacy cost of care is too high, and a bonus for meeting HEDIS measures.
- Case 6: VBC/Unconventional - Plan Side Global Outcomes: MCO Plan focused on plan goals. Pharmacist interventions include patient goals, medication reconciliation, identifying therapy problems, medical problems, and health concerns, and creating a care plan. Data is reported by the plan and includes ED visits and ED cost of care. Payment is a $PMPM fee and a 50% shared savings fee if ED cost of care metrics are met.

Dr Albright shared Blue Cross NC's Blue Premier Accountable Care Organization (ACO)/Health System payment model. Blue Premier is a network of 10+ organizations that account for over 50% of Blue Cross NC's members. Blue Premier's payment model has three overarching components:

- Quality bonus – tied to overall quality performance using physician and hospital measures. Blue Premier provides resources for provider infrastructure and innovation
- Total Cost of Care Target – shared savings payments when lower total cost of care targets are met. Starting in year 3, if total cost of care exceeds target, health system pays negotiated share of excess cost.
- Quality tied to financial performance - a minimum quality threshold must be met to realize any payment, and the higher the quality score, the more provider payments

Pharmacists bring value to Blue Premier through their abilities to improve quality of care and decrease costs, with a special focus on medications. Blue Cross NC has implemented

an innovative program where plan pharmacists have developed relationships with practicing pharmacists in various ACO organizations to share data focused on improving metrics and reducing costs. The model is based on shared priorities, communications, and technology. Plan pharmacists have population-level data, and pharmacists within the ACO organizations have relationships with patients and the patient's health care team. Focused tactics to address cost of care include value prescribing, diabetes deprescribing, site of care and infused products (use of office vs. hospital-based infusions and biosimilar products), and the real-time benefit check to review cost and coverage at the point of prescribing. Over 9 months working on 2 initiatives with 8 ACO's, there were $3 million in claims reductions. The percentage of ACO's achieving HEDIS metrics for A1c and blood pressure control increased significantly after implementation of this program.

Future plans to expand on this initial project will be based on the theme: Expand, Collaborate, and Compete. This includes expanding plan team members and influencing ACO's to hire pharmacists to support this work and collaborating to develop ACO best practices and conduct ACO-led lunch and learns. There will also be a focus on healthy competition by sharing blinded quality and cost savings information.

Breakout sessions

Breakout session 1: Sharing information/identifying strategies

Breakout session 1 was conducted after the first two panel presentations with participants organized in small groups using a roundtable format. Participants discussed the types of payer programs they were aware of, what information would be useful to others, and the takeaways from the first two panels that would help their work moving forward. Many different pharmacist-provided services that were being covered directly or indirectly through Medicare, Medicaid, and commercial plans were shared. Examples include comprehensive medication management, tobacco cessation, HIV PEP/PrEP, Annual Wellness Visits, chronic care management, opioid management, and oral contraception services. Value-based examples with a focus on meeting STARs and HEDIS measures and closing care gaps were highlighted, as well as providing value through medical loss ratio management.

Small group discussions uncovered many issues needing to be addressed that would be helpful to others in scaling this work. There is a need for a keep it simple approach related to how pharmacists' services are described. Currently, the various terms used for pharmacists' services are causing confusion in the marketplace and are a barrier to creating consistent expectations for the services delivered. Payer processes such as contracting for services, credentialing pharmacists in a payer network, and submitting claims to the medical benefit continue to be barriers that need better solutions, as well as the need for standardized billing codes that are aligned with those used by other providers, where appropriate. Participants emphasized the importance of technology and having EHR-capable systems for documentation and sharing information.

Takeaways from the panel presentations that will help participants' work moving forward include:

- Start a new HP-pharmacist payment model with financial incentives in place
- Leverage the champions within an organization, and empower pharmacists who want to move from dispensing roles to providing clinical services
- Showcase best practices and real cases that demonstrate the value pharmacists provide
- Aggregate data and make it broadly available
- Get employer groups more involved
- Better understand pharmacists' impact across different sites of care
- Need more pharmacists at the table at HPs and employers influencing decisions
- Find a way to recognize pharmacists for what they do to improve HEDIS measures
- Address laws and regulations that limit pharmacists' scope of practice

Breakout session 2: Pharmacists' value proposition, overcoming barriers, messaging

In this breakout session, one-half of the small groups discussed the value proposition for pharmacists' services and the other half talked about strategies for overcoming barriers to coverage for pharmacists' services. All groups addressed messaging that would be helpful to promote the value proposition and overcome barriers.

It is important to consider the value proposition to different stakeholders — HPs/payers may have different interests than physicians and other health care providers or patients. Pharmacists' accessibility — they are everywhere — and their trusted relationships with patients are of value to HPs. HPs value pharmacists who can improve member satisfaction, demonstrated by improvements in Consumer Assessment of Healthcare Providers and Systems survey scores and patient activation measures. Pharmacists bring value in their ability to meet quality measures, impact total cost of care, improve formulary compliance, and provide health risk assessments. Participants also discussed pharmacists' role in improving net promoter scores.

To overcome barriers to coverage for services, participants advocated for a roadmap that would guide individuals through legislative and regulatory factors and the various aspects of setting up coverage models. There was strong support for increasing the number of pharmacists working at HPs who can influence policy decisions that facilitate coverage for pharmacists' services. The need for understanding and sharing sustainable business model(s) in pharmacy practices was also discussed. Having a dashboard of consistent metrics across HPs would also help in scaling patient care services across practices.

Finally, demonstrating to physicians the value of collaborative practice agreements in expanding pharmacists' autonomy in caring for patients is important for fully using pharmacists as part of the patient's care team. There also was discussion around the need for reasonable training hour requirements for pharmacists.

Participants rallied around the need for simple, predictable, marketable messaging to promote pharmacists' value to all stakeholders. Increased access to care through pharmacists translates to increased patient engagement in their health. As health care moves to a community-based care model,

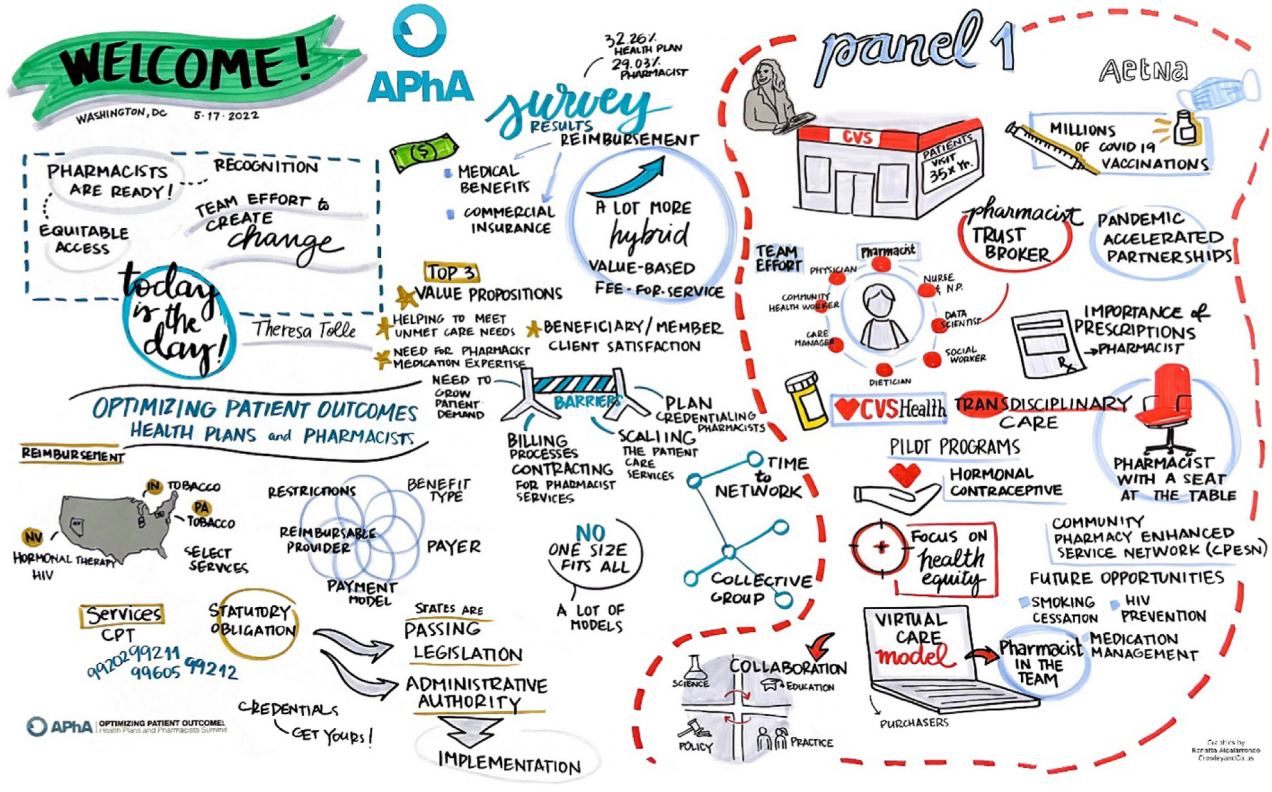

Figure 1. Graphical illustration on discussion at the Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.

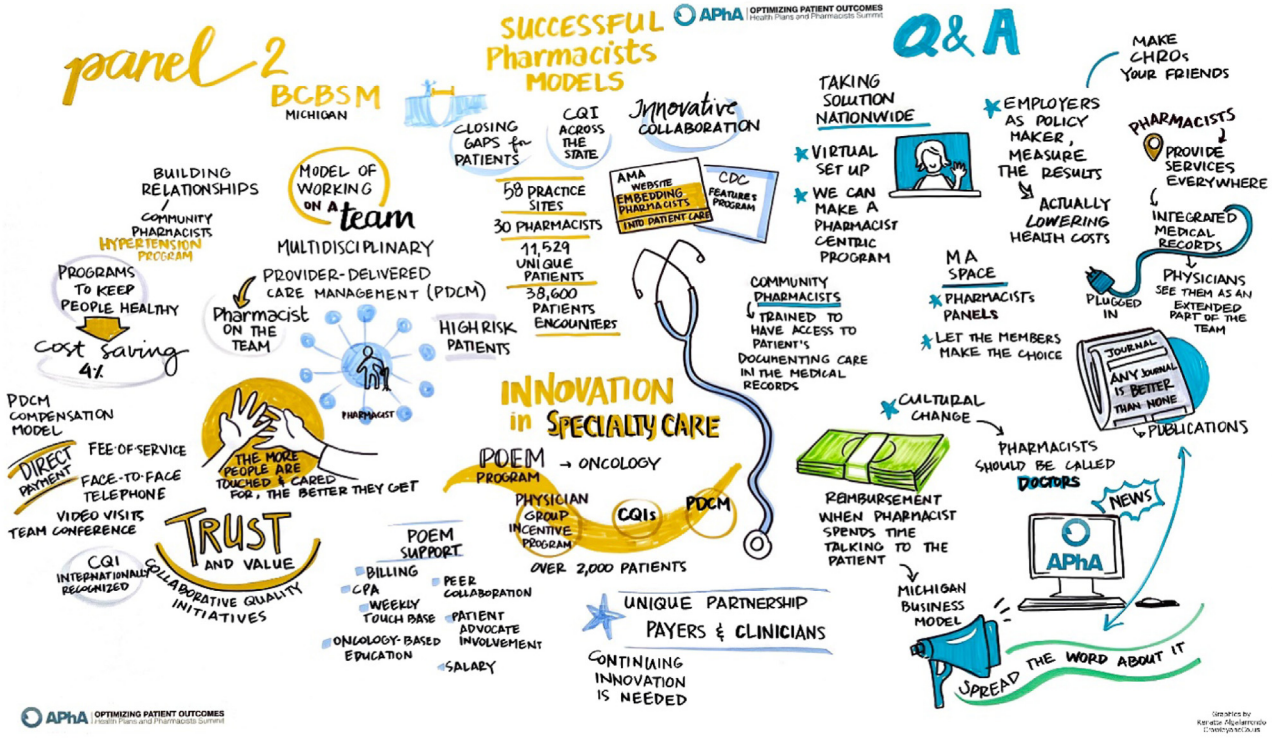

Figure 2. Graphical illustration on discussion at the Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.

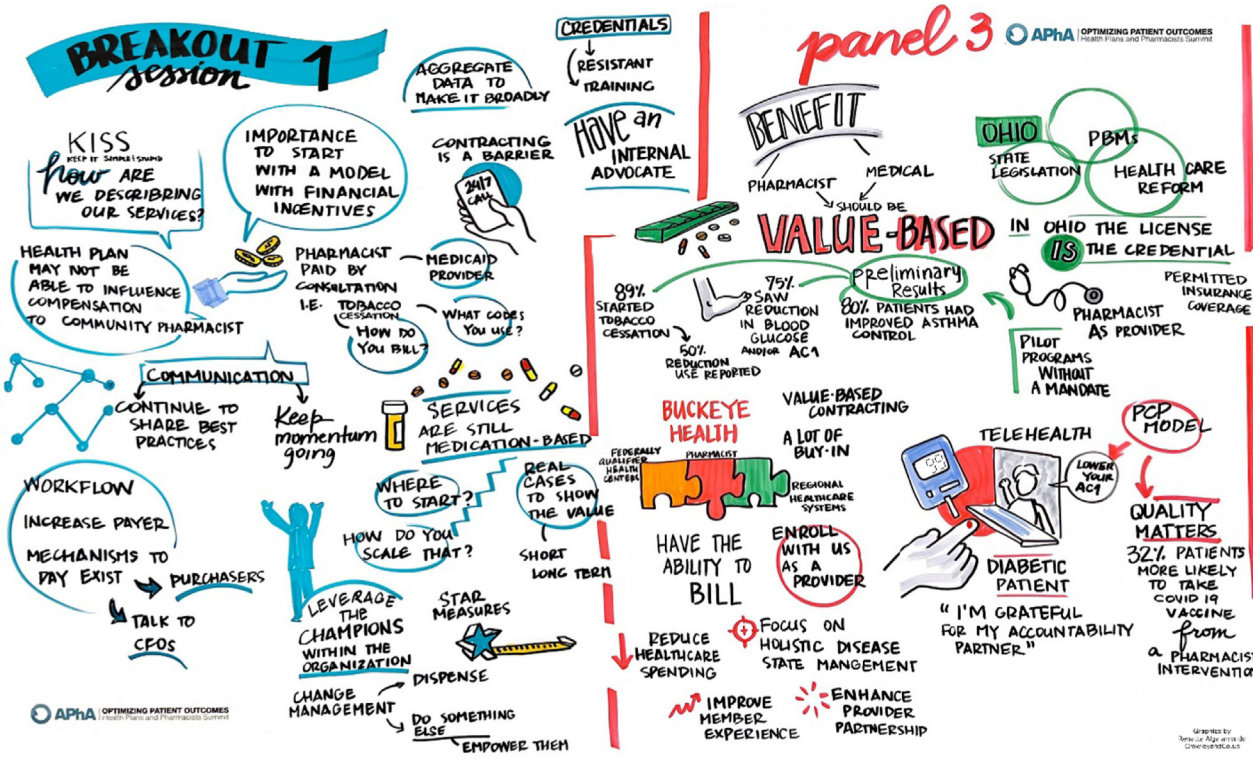

Figure 3. Graphical illustration on discussion at the Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.

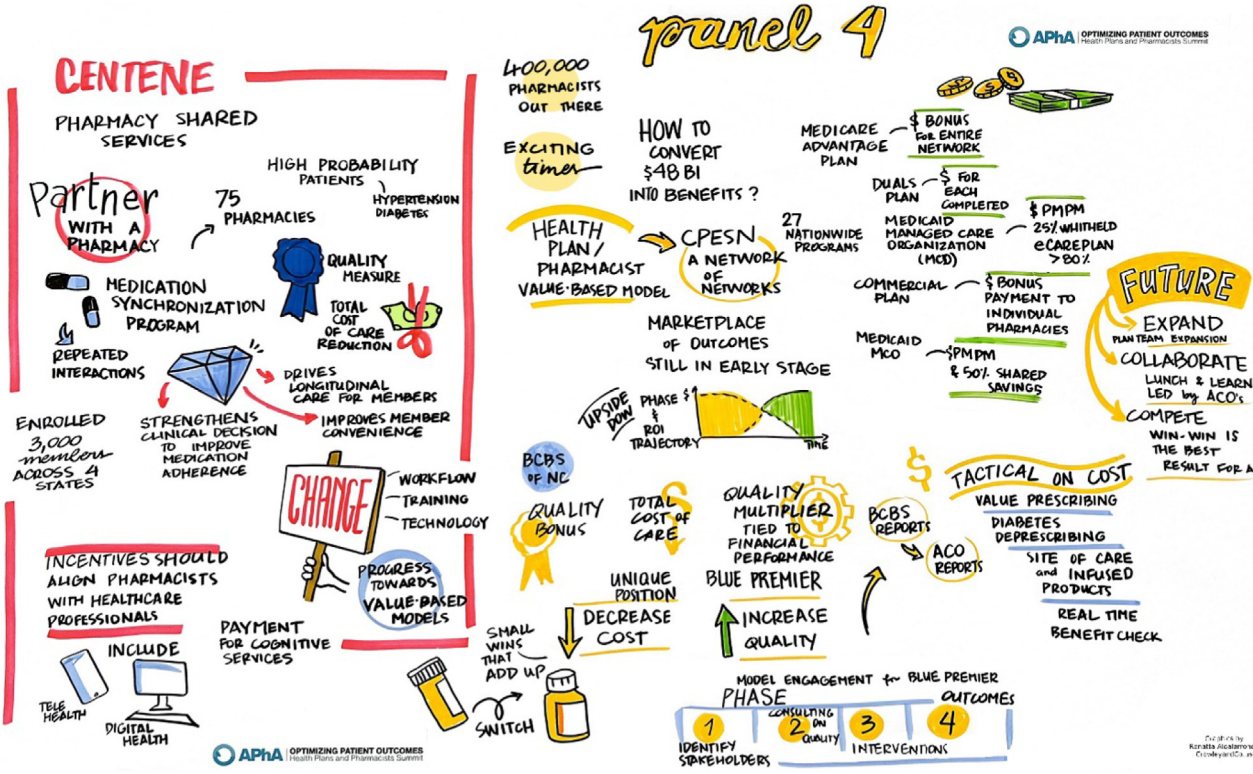

Figure 4. Graphical illustration on discussion at the Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.

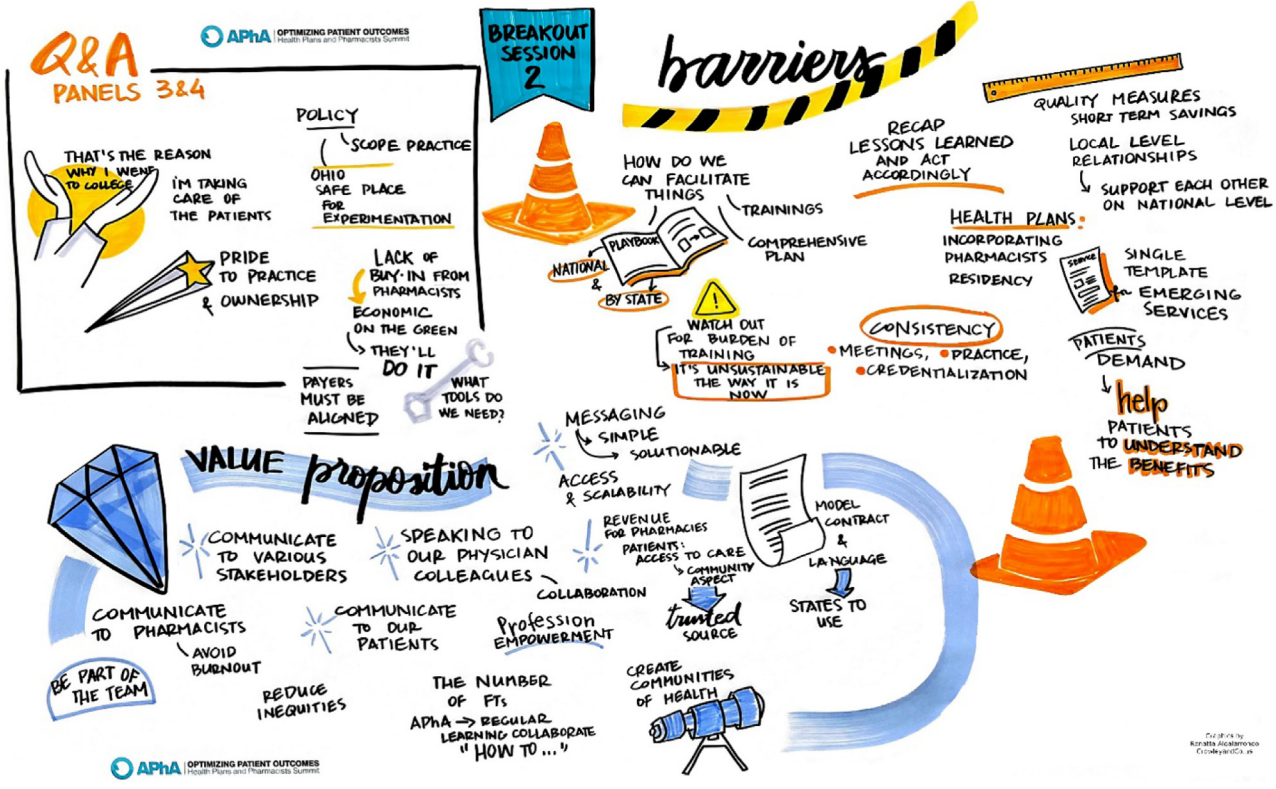

Figure 5. Graphical illustration on discussion at the Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.

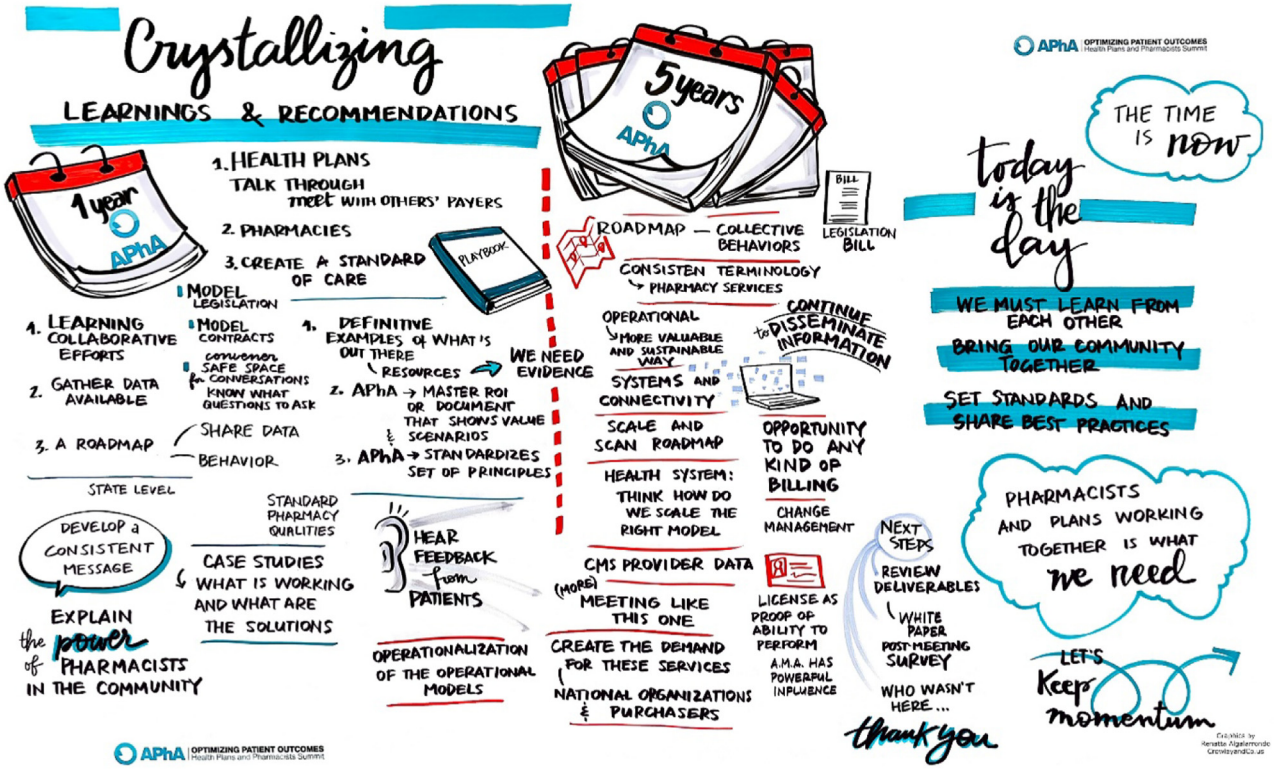

Figure 6. Graphical illustration on discussion at the Optimizing Patient Outcomes: Health Plans and Pharmacists Summit.

Table 3
Prioritization and feasibility of 1- and 5-y action items by health plan representatives and pharmacist practitioners. Numbers represent rankings with 1 being the highest and 5 being the lowest

Pre-meeting questions	HPs	PPs and other
Prioritization of 1-y action items		
Creation of a coverage of pharmacists' services roadmap	1	1
Disseminate data from programs where pharmacists' services are covered by HPs	3	2
Disseminate data showing pharmacists' therapeutic and economic outcomes	2	4
Creation of model contracts between pharmacists and HPs	4	3
Creation of model legislation for coverage of pharmacist's patient care services	5	5
Feasibility of 1-y action items		
Disseminate data from programs where pharmacists' services are covered by HPs	1	1
Disseminate data showing pharmacists' therapeutic and economic outcomes	2	4
Creation of a coverage of pharmacists' services roadmap	5	2
Creation of model contracts between pharmacists and HPs	3	3
Creation of model legislation for coverage of pharmacist's patient care services	4	5
Prioritization of 5-y action items		
Regular meetings between pharmacists and HPs	2	1
Partnership with employers and national organizations that determine components of HP programs	1	2
Development of evidence that showcases implementation of scalable coverage programs resulting in valuable and sustainable care delivery	2	4
Implementation of roadmap at the state level for pharmacists' services to be covered by HPs	5	3
Development of consistent terminology and messaging to describe services provided by pharmacists	4	5
Feasibility of 5-y action items:		
Regular meetings between pharmacists and HPs	1	1
Development of consistent terminology and messaging to describe services provided by pharmacists	3	2
Implementation of roadmap at the state level for pharmacists' services to be covered by HPs	2	4
Development of evidence that showcases implementation of scalable coverage programs resulting in valuable and sustainable care delivery	4	3
Partnership with employers and national organizations that determine components of HP programs	5	5

pharmacists have the opportunity to be part of communities of health. Messaging should focus on the patient and the value pharmacists provide in improving patient outcomes. Patients also need to better understand the benefits that pharmacists can bring to their care.

Having effective messaging directed to pharmacists is essential to creating realistic expectations and avoiding burnout. Advocating for the benefits of physician-pharmacist collaboration to physicians and working to obtain greater support from medical associations is also important to advancing greater use of pharmacists.

Breakout session 3: Crystallizing learnings and recommendations

During the third breakout session, attendees focused on crystalizing learnings and recommendations to expand coverage of pharmacists' patient care services. They identified goals for both 1- and 5-year timeframes. One-year goals centered around program implementation and assessing scalability and sustainability of programs. Five-year goals emphasized building sustainable, scalable HP programs through policy changes at the state and federal level.

Several overarching projects were identified for the first year, including a roadmap for implementing programs, a forum focused on the compilation of evidence, and a learning collaborative with PPs and HPs to share successes and lessons learned.

The 5-year goals fell into four categories: increasing connections and collaborations, gathering and disseminating evidence, optimizing coverage of pharmacists' services, and promoting pharmacists' services. Efforts included organizing future summits and meetings, defining pharmacist services across stakeholder groups, analyzing and publishing data from current programs, standardizing and expanding pharmacists' scope of practice, and measuring program value. It was noted that accessibility for pharmacists to health information technology was necessary. Promoting pharmacists' services involved creating demand through marketing to patients, national organizations, and purchasers within the health insurance industry.

Overarching directions

The summit concluded by summarizing key findings and next steps for expanding coverage of pharmacists' patient care services. Attendees reviewed graphical illustrations (Figures 1-6) and emphasized the importance of maintaining momentum. The next steps include continuous learning, collaboration, and establishing standards and best practices. A postsummit survey was sent to attendees to rank the prioritization and feasibility of 1- and 5-year action items, which were themed, based on discussions in the breakout sessions and are summarized in Table 3. The top 1-year action items agreed upon were creating a coverage roadmap and disseminating data. However, there was a difference in opinion for the top 5-year action item, with HP representatives prioritizing partnership with employers and national organizations that determine components of HP programs to encourage demand for pharmacists' services, as compared to PPs that identified regular meetings between PPs and HPs as a top priority to the expansion of programs covering pharmacists' services. APhA

Senior Vice President of Pharmacy Practice and Government Affairs Ilisa BG Bernstein closed the summit by expressing gratitude and discussing next steps.

Conclusion

The optimizing patient outcomes Health Plans and Pharmacists Summit fostered collaboration and program expansion for pharmacists' patient care services under the medical benefit. Attendees shared best practices, identified barriers, and proposed solutions for program expansion. Key takeaways include the importance of expanding medical benefit coverage, consistent messaging, and scalability; and creating mutually beneficial programs and strong partnerships between PPs and HPs. These insights emphasize the need for uniform processes, improved outcomes, cost savings, and the role of pharmacists in helping patients reach their therapeutic goals.

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Appendix A

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The information provided in the summit proceedings 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.