NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

August 15, 2018

The Honorable Mike Kelly
United States House of Representatives
1707 Longworth House Office Building
Washington, DC 20515-3803

The Honorable Ron Kind
United States House of Representatives
1502 Longworth House Office Building
Washington, DC 20515-4903

The Honorable Markwayne Mullin
United States House of Representatives
1113 Longworth House Office Building
Washington, DC 20515-3602

The Honorable Ami Bera
United States House of Representatives
1431 Longworth House Office Building
Washington, DC 20515-0507

Dear Representatives Kelly, Kind, Mullin, and Bera:

The National Association of Chain Drug Stores (NACDS) commends the members of the Health Care Innovation Caucus for their leadership in examining innovative policy ideas that improve quality and lower costs for consumers.

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' nearly 100 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 152,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 20 countries. Please visit www.NACDS.org.

As the Health Care Innovation Caucus explores innovative approaches to improve health care quality and lower costs, NACDS urges the Caucus to consider how community pharmacies can assist in achieving these important health system goals. In particular, we request the Caucus' support on the following policy proposals:

- New quality-based payment models that incentivize the incorporation of community pharmacy solutions into the care continuum
- Pharmacists as health care providers and corresponding pharmacy-led patient care solutions; especially for the medically underserved population

I. Introduction: The Value of Pharmacy

Over the last several decades, community pharmacies have evolved into patient-centered healthcare destinations offering a wide range of accessible and affordable clinical care services including chronic care management and disease state monitoring, smoking cessation programs, transitions of care

coordination, minor ailment care, immunization screening and administration, chronic and acute disease screening, mental health services, medication management, health and wellness programs, lifestyle counseling, and more. The community pharmacy is an accessible, patient-centered healthcare destination that reaches the majority of communities across the United States, nearly 9 out of 10 Americans live within 5 miles of a community pharmacy.[1] Further, a study of high-risk Medicaid patients found that patients visited their pharmacies 35 times per year, compared to seeing their primary care doctors 4 times per year, and specialists 9 times per year.[2]

In the landscape of an expanding and aging population, increased chronic disease and projected shortages of healthcare workers, including physicians, and rising healthcare costs, new models of care are needed.[3]

As a trusted member of the healthcare team, community pharmacists collaborate with others to positively address patient outcomes and mitigate rising healthcare costs.[4] Healthcare spending on non-optimal medication therapy (estimated at $528.4 billion per year) [5] and medication non-adherence (estimated at $100-290 billion per year and attributed to 10% of hospitalizations)[6] could be significantly decreased with the development of more purposeful policies and programs that fully leverage patient touch points in the community setting that fully utilize the skillset of community pharmacists.

To fully leverage the potential impact of pharmacists as a driver of value and outcomes, sustainable models must be built to support and recognize community pharmacists as healthcare providers who are integral to the patient care continuum. Community pharmacist-provided patient care can further evolve if incentives for deployment and reimbursement of pharmacy care are established (leveraging site neutrality) and/or the tremendous value derived from pharmacy care services are fully recognized.[7]

At a national level, the current payment mechanism for pharmacies is limited to the dispensing of a medication product, without regard to clinical services that optimize patient care. Pharmacists routinely counsel patients on new medications as part of the dispensing process, but innovative, new payment structures are needed to support pharmacists as they delve deeper into transitions of care, disease state management, medication optimization, and other valuable preventive services. Today, limited opportunities exist for pharmacies to be compensated for such clinical services and lack of remuneration imposes a major barrier for pharmacist participation in innovative models of care and

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[1] NACDS Economics Department, 2017.
[2] Moose J, Branham A; "Pharmacists as Influencers of Patient Adherence;" *Pharmacy Times*; August 21, 2014. https://www.pharmacytimes.com/publications/directions-in-pharmacy/2014/august2014/pharmacists-as-influencers-of-patient-adherence-
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041380/
[4] Accreditation Council for Pharmacy Education (ACPE); "Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree;" Accessed July 2018. https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf.
[5] Watanabe JH, McInnis T, Hirsch JD; "Cost of Prescription- Drug Related Morbidity and Mortality;" *Annals of Pharmacotherapy;* March 26, 2018. http://journals.sagepub.com/doi/10.1177/1060028018765159
[6] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" New *England Journal of Medicine*; August 22, 2013. Shrank WH, Polinski JM; "The Present and the Future of Cost-Related Non-Adherence in Medicare Part D;" *J Gen Intern Med* 30(8):1045–6. Pretorius RW, et al. "Reducing the Risk of Adverse Drug Events in Older Adults;" *American Family Physician*; March 1, 2013. https://www.aafp.org/afp/2013/0301/p331.html.
[7] Developing Trends in Delivery and Reimbursement of Pharmacist Services; Avalere Health, LLC; October 2015. Accessed July 2018; https://naspa.us/resource/developing-trends-in-delivery-and-reimbursement-of-pharmacist-services/.

needlessly limits the number and types of care services pharmacists provide. **H.R. 592/S. 109, the *Pharmacy and Medically Underserved Areas Enhancement Act*, would recognize pharmacists as providers in medically underserved areas, thus creating better access to services for these vulnerable populations.** Not only would recognition of pharmacists as healthcare providers improve access to care, but it would lead to reduced healthcare costs as pharmacists would provide already-covered Medicare services at 85% of the physician fee schedule.

Value of Pharmacy Care:
The literature supports pharmacists' impact on quality of care and costs associated with chronic care management, immunizations, point-of-care testing, transitions of care, minor ailment care, preventive screening, and more. A leading example is the Pennsylvania Project, which evaluated a pharmacy-based medication adherence initiative across 283 pharmacies. The intervention, which included pharmacist-led screening for medication non-adherence and counseling for those at an increased risk, led to statistically significant improvement in medication adherence for all medication classes that were studied, and an annual per patient cost savings of $241 dollars for improved adherence to oral diabetes medications and $341 related to improved adherence to statin medications.[8]

A subset of additional examples is included in the chart below:

Author	Title of Article	Brief Description of Intervention	Results
Tran MT, et al.	"Modeling the Cost-Effectiveness of a Smoking Cessation Program in a Community Pharmacy Practice"	The cost effectiveness of a pharmacist-directed smoking cessation program that achieved abstinence of at least 1 year in 25% of patients was studied.	Depending on the smoker's age at the time of cessation, the incremental discounted *cost-effectiveness was $720-1,418/life-year saved.*
Brennan TA, et al.	"An Integrated Pharmacy-Based Program Improved Medication Prescription and Adherence Rates in Diabetes Patients"[9]	Pharmacists provided counseling for adherence to diabetes medications and recommendations for other medications often used in tandem with diabetes medications aimed at reducing the risk of cardiovascular disease (ACE-inhibitors or ARBS and/or statins). Patients were identified by a PBM for the intervention.	Pharmacist-based interventions are effective in improving medication adherence and encouraging patients to start taking medications they need as part of an evidence-based treatment regimen. *The return on investment of the initiative was estimated at 3:1.*
Vegter S, et al.	Improving Adherence to Lipid-Lowering	The pharmaceutical care program, Medication Monitoring and Optimization, was initiated in	Patients in the program had a lower risk for discontinuing therapy and in a cohort of 1,000 patients, the intervention

[8] Pringle JL, et al.; "The Pennsylvania Project: Pharmacist Intervention Improved Medication Adherence and Reduced Health Care Costs;" *Health Affair*s; August 2014; https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.1398.
[9] Brennan TA, et al.; "An Integrated Pharmacy-Based Program Improved Medication Prescription and Adherence Rates in Diabetes Patients.;" *Health Affairs*; Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0931?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed; Last Accessed June 13, 2018.

	Therapy in a Community Pharmacy Intervention Program: A Cost-Effectiveness Analysis[10]	community pharmacies to focus on lipid-lowering therapy in new patients. The follow-up period was 1 year.	resulted in a reduction of 7 nonfatal strokes, 2 fatal strokes, 16 nonfatal heart attacks, 7 fatal heart attacks, and 16 revascularizations over patients' lifetimes. *The intervention also produced considerable net cost savings.*
Spence MM, et al.	Evaluation of an Outpatient Pharmacy Clinical Services Program on Adherence and Clinical Outcomes Among Patients with Diabetes and/or Coronary Artery Disease[11]	An outpatient pharmacy clinical service (OPCS) program targeted nonadherent diabetes mellitus (DM) and/or coronary artery disease (CAD) patients with hemoglobin A1c (HbA1c) and/or low-density lipoprotein cholesterol (LDL-C) outside clinical goals.	Patients who received the outpatient pharmacy clinical service program were more likely to be adherent with their diabetes medications (53.5% compared to 37.4%). This group was also more likely to continue taking their medication, less likely to have an emergency department visit, and *the return on investment for this program was estimated at 5.79:1*.
Lee JK, et al.	Effect of a pharmacy care program on medication adherence and persistence, blood pressure, and low-density lipoprotein cholesterol: a randomized controlled trial[12]	Comprehensive pharmacy care program for elderly patients aged 65 years and older with coronary risk factors to improve medication adherence and its associated effects on blood pressure (BP) and LDL levels	Pharmacy care program led to increases in medication adherence, medication persistence, and clinically meaningful reductions in BP. After 6 months of intervention, medication *adherence increased from baseline of 61.2% to 96.9% and associated with significant improvements in systolic BP (133.2 to 129.9) and LDL-C levels (91.7 to 86.8).*
Van Boven JF, et al.	Medication monitoring and optimization: a targeted pharmacist program for effective and cost-effective improvement of chronic therapy adherence[13]	Medication Monitoring and Optimization (MeMO) program is a platform for monitoring and improving therapy adherence through facilitation of targeted and continuous patient-centered pharmaceutical care around chronic medications.	For osteoporosis, therapy discontinuation after 1 year was 16.1% in the MeMO patients, compared with 31.7% in the control patients. Over a modeled time-window of 3 years, MeMO osteoporosis was found to be cost-effective in 52,000 patients yearly, initiating osteoporotic therapy with an incremental cost-effectiveness. For dyslipidemia, the therapy discontinuation rate was 13.6%

[10] Vegter S, et al.; "Improving Adherence to Lipid-Lowering Therapy in a Community Pharmacy Intervention Program: A Cost-Effectiveness Analysis;" *Journal of Managed Care & Specialty Pharmacy*; Available at https://www.jmcp.org/doi/10.18553/jmcp.2014.20.7.722; Last Accessed June 13, 2018.
[11] Spence MM, et al.: "Evaluation of an Outpatient Pharmacy Clinical Services Program on Adherence and Clinical Outcomes Among Patients with Diabetes and/or Coronary Artery Disease*;" Journal of Managed Care & Specialty Pharmacy*; Available at https://www.jmcp.org/doi/10.18553/jmcp.2014.20.10.1036; Last Accessed June 13, 2018.
[12] Lee JK, et al.; "Effect of a Pharmacy Care Program on Medication Adherence And Persistence, Blood Pressure, and Low-Density Lipoprotein Cholesterol: A Randomized Controlled Trial;" *Journal of the American Medical Association*; Available at https://jamanetwork.com/journals/jama/fullarticle/204402.
[13] Van Boven JF, et al; "Medication monitoring and optimization: a targeted pharmacist program for effective and cost-effective improvement of chronic therapy adherence"; *Journal of Managed Care & Specialty Pharmacy*; Available at https://www.jmcp.org/doi/10.18553/jmcp.2014.20.8.786. Last Accessed June 13, 2018.

			in the MeMO cohort and 25.9% in the control group. *The cost-effective aspect was favorable for the primary prevention population and significant for the secondary prevention population (lower costs and more health gains).*
Klepser DG, et al.	Cost-effectiveness of Pharmacist-Provided Treatment of Adult Pharyngitis	Community pharmacists used a rapid antigen detection test for strep throat and provided medication for positive results through the research project. The cost associated with providing the treatment was compared to 5 physician-provided treatment strategies for strep throat.	Pharmacist treatment of strep throat was *the most cost effective*.
Cranor CW, et al.	The Asheville Project: Short-term outcomes of a community pharmacy diabetes care program.	Patients scheduled consultations with pharmacists over 7-9 months. During the appointments, pharmacists provided counseling and education, training on the use of blood glucose monitors, and clinical assessment of the patients' diabetes including monitoring, follow-up, and referral.	Patients' A1c measurements (a 3-month assessment of blood sugar) were significantly reduced. *Researchers observed a 16% decrease in all-diagnosis costs*.

Given the growing evidence that community pharmacists are uniquely positioned to advance medication optimization and decrease total costs of care as a member of patient care teams, **NACDS advocates for the expansion and the alignment of incentives to support community pharmacy inclusion in value-based models, and that pharmacists be recognized as healthcare providers.**

II. Value-based Payment Models (VBPM): Community Pharmacy

As value-based payment models continue to evolve, NACDS urges the consideration of including community pharmacies directly into their design. Successful outcomes for value-based models and other coordinated care programs will be dependent on ensuring multiple provider types are able to provide disease state management, medication management, and preventive services to beneficiaries.[14] Importantly, the Caucus should note the vital role that face-to-face interaction with community pharmacists can play in reducing overall healthcare costs. This is even more important when considering those patients with chronic diseases that require high-cost specialty medications. Access to retail community pharmacies is vitally important for patients with complex, chronic, and progressive medical conditions. These patients often have an increased need for follow-up and often the community pharmacist is the most readily accessible provider for them. While there are many available options to control prescription drug spending and related medical condition costs, it is imperative that patients maintain access to their medications and the professionals who can best

[14] Choudhry NK, Fischer MA, Smith BF, et al; "Five Features of Value-Based Insurance Design Plans Were Associated with Higher Rates of Medication Adherence"; *Health Affairs*; March 2014.https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0060; Roebuck MC; "Medical Cost Offsets from Prescription Drug Utilization Among Medicare Beneficiaries"; *J Manag Care Spec Pharm*. 2014;20(10):994-995. doi:10.18553/jmcp.2014.20.10.994.

ensure medications are used correctly. By allowing patients to use the provider of their choice for medication-related needs, avoidable medical condition costs can be greatly minimized.

Examples of Value-based Models in Pharmacy

1. Wellmark Blue Cross Blue Shield Value Based Pharmacy Program (VBPP)

Payor: Medicare, Medicaid, and Commercial

Background: In July 2016, Wellmark identified high performing independent and chain pharmacies in Iowa and South Dakota to participate in a new value-based model, focused on better serving patients with asthma, diabetes, hyperlipidemia, and depression. Goals of this program include ensuring that the patient is on the right drug and is adherent, and in the longer-term, to reduce emergency department visits, hospital readmissions, and total cost of care.

Program Details: For inclusion in the network, participating pharmacies must offer multiple clinical services (e.g. year-round immunization program, comprehensive medication reviews, health screenings, and medication synchronization appointments). Participating pharmacies are also required to formally document services delivered and actively communicate information to patients' providers, provide adequate space for private or semi-private consultations, develop a service plan based on community-specific needs, establish formal immunization protocol and/or collaborative practice agreement(s), and ongoing pharmacist training.

Eligible members for the program include those with ≥1 chronic medication or diagnosed with a chronic condition. Example metrics to evaluate pharmacy performance vary by disease state and include:

- Diabetes – blood sugar control and blood pressure control
- Depression - readmissions
- Cardiovascular risk - cholesterol goals, is patient on correct statin intensity?
- Asthma - assess how often patient is utilizing rescue inhaler

Payment Structure: Wellmark's VBPP network is structured outside of the Pharmacy Benefit Manager (PBM) relationship. VBPP payment structure is per member per month (PMPM) with bonuses. Bonus from shared savings is received based on Wellmark's evaluation of costs.

Preliminary Results: As of July 2018, researchers are collecting and analyzing VBPP data to determine the impacts of this program. However, the **Continuous Medication Monitoring (CoMM) pharmacy pilot**, which informed the creation of the ongoing Wellmark VBPP model, had significant results. Specifically, the CoMM pilot was designed to assess the effects of continuous medication monitoring (CoMM) on total costs of care, proportion of days covered (PDC) rates and the use of high-risk medications by elderly patients. The pilot results demonstrated lower total costs of care and meaningfully better medication adherence. *Per member per month (PMPM) costs were approximately*

$300 lower for patients who received medications only from the pharmacy offering the CoMM program as compared to patients receiving medications from other pharmacies. This pilot validated that paying pharmacists to proactively address the safety, effectiveness, and adherence of medications at the time of dispensing can support optimization of medication therapy and decrease costs. [15]

2. Wisconsin Pharmacy Quality Collaborative (WPQC)[16]

Payors: Medicaid, Medicare Part D, Medicare, Commercial, and SeniorCare

Background: Established in 2008, the WPQC is an initiative of the Pharmacy Society of Wisconsin (PSW), which connects community pharmacists with patients, physicians, and health plans to improve the quality and reduce the cost of medication use across Wisconsin. In 2012 the PSW received a $4.1 million Health Care Innovation Award from the Centers for Medicare & Medicaid Services (CMS) to expand the WPQC statewide. Currently, over 500 pharmacists are actively certified through WPQC. Current health plan partners include the Wisconsin Medicaid and SeniorCare programs and the United Way of Dane County, representing approximately 20% of the state population, or over 1 million Wisconsin lives.

Program Details: WPQC is a network of pharmacies with pharmacists who provide medication therapy management (MTM) services, such as comprehensive medication reviews (CMRs) to complex, high-risk patients. This model leverages pharmacists to reduce medication complexity and errors, improve adherence, and empower patients to safely manage their medication regimens. WPQC and its health plan partners facilitate the provision of MTM services for patients taking multiple medications to treat chronic conditions, those at risk of falls and adverse drug events (ADEs), and those recently discharged from the hospital. The UWDC CMR program supports community and senior center case managers to identify older adults at risk of falls and ADEs, and intervene by scheduling WPQC-provided CMRs and offering home falls safety assessments. Services can also be provided at the pharmacy or the patient's residence. Similarly, a partnership in Milwaukee between WPQC pharmacies and UniteMKE trains community health workers in medication adherence screening. The community health workers then make CMR referrals to WPQC pharmacies.

Eligible patients must meet at least one of the following criteria to receive WPQC CMR services: take four or more prescription medications to treat/prevent two or more chronic conditions, diagnosis of diabetes, have multiple prescribers, or low health literacy. Patients also qualify for a CMR in the 14 days following discharge from a hospital or long-term care facility to prevent a readmission to the

[15] Pilot: While some of the pharmacy services promoted and measured are different between the current Wellmark Blue Cross Blue Shield VBPP and the CoMM pilot, in the CoMM, pharmacists assessed each of the medications being dispensed, identified, and resolved any medication-related problems, and then documented their actions. Examples of drug therapy problems include doses too high or low, duplicate therapy, omissions in drug therapy, etc. Doucette, William R, et al.; "Pharmacy performance while providing continuous medication monitoring.", *Journal of the American Pharmacists Association;* Volume 57, Issue 6, 692-697. https://www.japha.org/article/S1544-3191(17)30788-4/fulltext

[16] http://www.pswi.org/wpqc
http://www.pswi.org/WPQC/About-WPQC/About-WPQC
https://www.dhs.wisconsin.gov/publications/p01558.pdf
http://www.pswi.org/WPQC/WPQC-Payers/Benefits-to-Payers

hospital. Additionally, a referral from a prescriber automatically qualifies any patient covered by a participating health plan for WPQC services.

Preliminary Results: In 2016, the Wisconsin Department of Health Services Division of Health Care Access and Accountability completed an evaluation of the project work. The evaluation showed that patients who received a CMR at some point prior to hospitalization exhibited a decrease of $524 in inpatient costs per hospitalized patient in comparison with a control group that had not received a CMR. This finding suggests that CMRs provided through WPQC may have been impacting health care utilization between 2012-15. Results from the pilot phase of WPQC (2008-2010), which included Unity Health Insurance and Group Health Cooperative of South Central Wisconsin showed:

1) 10:1 Return on Investment (ROI) for services which directly impacted medication cost;
2) ROI was maintained at 2.5:1 when combining services which directly impacted medication cost and comprehensive medication reviews; and
3) Facilitating the use of health plan formularies to ensure the least expensive equivalent medication, pharmacists can save payers and patients 3-4 times the cost of medications.

Payment Structure: Compensation for the CMR service is provided by participating health plans on a fee-for-service basis and includes one initial visit and three follow-up visits with the pharmacist annually at no cost to the patient.

3. Community Care of North Carolina – Enhanced Pharmacy Services Network[17]

Payor: Medicare and Medicaid Innovation Grant

Background: In 2014, Community Care of North Carolina (CCNC) was awarded a 3-year grant from the CMS Center for Medicare & Medicaid Innovation (CMMI) to test payment reform in community pharmacies for Medicaid, Medicare, and dually eligible Medicare-Medicaid and NC Health Choice beneficiaries by using a collaborative care model where community pharmacy is part of the medical home team.

Program Details: Participating pharmacies are given access to CCNC information that allows pharmacists to review prescription claims data, adherence data, and population management tools. Pharmacies are allowed to participate in the CPESN-NC framework as long as they deliver enhanced services, document interventions, and meet minimum established criteria. CPESN-NC pharmacies must provide a proactive waste management program that prevents medication waste by verifying patient need prior to each fill, patient counseling and adherence coaching, and assistance with

[17] https://www.communitycarenc.org/
https://www.cpesn.com/
https://issuu.com/iowapharmacyassociation/docs/2016q2_journal_web
https://cpesn.com/payors

medication reconciliation especially after hospital discharge.

Preliminary Results: Outcomes from this grant have not been published yet. Based upon preliminary results, high-risk Medicaid patients supported by CPESN pharmacies are:

- 45% less likely to have an inpatient hospitalization admission,
- 35% less likely to have a preventable hospital admission or readmission,
- 15% less likely to experience an emergency department visit,
- 25% more likely to engage their primary care provider (PCP), and
- 20% more adherent to their medications.

Primary goals of this grant were to improve quality and reduce costs while enhancing the ability of the primary care provider (PCP) to improve care outcomes for patients with chronic diseases.

Payment Structure: The payment structure is per member per month (PMPM) based on the patient risk or complexity and pharmacy performance score. Pharmacy performance score is based upon the following metrics: risk-adjusted total cost of care, risk-adjusted inpatient hospitalizations, risk-adjusted emergency department visits, adherence to antihypertensive medications, adherence to statins, adherences to DM medications, and patients' adherence to multiple chronic medications. Payment is based on current Medicare Chronic Care Management codes.

Patients must have high preventable risks. For example, a patient with high preventable risk is a 55-year-old with diabetes and high cholesterol who has a history of two previous ER visits and is nonadherent to their cholesterol medication. A pharmacist can help this patient become more adherent to the cholesterol medication and reduce the likelihood of a $3,000 or significantly higher ER visit.

4. *Community Pharmacy Enhanced Services Network of United States of America (CPESN-USA)*[18]

Results of the CMMI grant have informed the creation of CPESN-USA, which is made up of 1,600 pharmacies and owned by a partnership of the National Community Pharmacists Association (NCPA) and Community Care of North Carolina (CCNC). Goals are to encourage state networks of pharmacies to provide enhanced services such as Medication Therapy Management, adherence packing, and more, and to offer guidance on establishing value-based payment contracts. The company contains a growing network of 35 local networks in 32 different states in varying stages of implementation or pre-implementation. One example of a functional state-based networks participating in CPESN, USA is CPESN-Iowa.

[18] https://www.cpesn.com/

5. Community Pharmacy Enhanced Services Network of Iowa (CPESN-IA) [20]

Payors: Medicare, and others

Background: CPESN-IA was the second state to join CPESN-USA after CPESN-NC. As of July 2018, CPESN-IA consists of 91 pharmacies across Iowa including independently owned, small chains, and large chains, and has a core service set that every pharmacy must agree to provide as part of the network.

Program Details: The Iowa CPESN core service set includes medication reconciliation, clinical medication synchronization, adherence packaging, immunizations, and complete medication reviews with chronic care management.

Payment Structure: CPESN-IA has local contracts with Tabula Rasa and with ClaritasPSM. For the Tabula Rasa contract, pharmacists utilize their MedWise Advisor Platform to assess patients' regimens and complete Medication Safety Reviews. The ClaritasPSM contracts with preferred pharmacies to provide enhanced services to hospice patients. Core services are available to all patients who utilize CPESN-IA pharmacies. Patients enrolled in Medicare Blue Rx Part D plan are eligible for the Tabula Rasa EMTM program. Eligible patients for ClaritasPSM are hospice patients for whom ClaritasPSM is the claims processor.

CPESN-IA is a fee-for-service payment structure with bonuses. There are 2 bonus pools - if the pharmacy reaches 50% approval on doctor recommendations and/or 70% positive patient satisfaction based on brief survey. CPESN-IA mainly focuses on patient safety. Metrics include the following: patient recognizes enhanced service based on a survey, factors that require patients to spend more time with pharmacists, reduction in emergency department visits and hospital admissions, assuring the patient is taking medication at the correct time of day, reducing medication side effects, and confirm patient is on a safe therapy regimen.

Preliminary Data: Data outcomes are not yet available as of July 2018.

6. Inland Empire Health Plan (IEHP) Pharmacy P4P Program[19]

Payors: Medi-Cal and Medicare

Background: In 2013, IEHP, a Medi-Cal and Medicare health plan that provides managed care for more than 1.2 million California residents, developed the IEHP Pharmacy Pay-For-Performance (P4P) Program – one of the first programs of its kind – designed to improve pharmacy services through IEHP's 450 community pharmacy providers. The main focus of the program aimed to validate the roles of community pharmacies in promoting healthcare quality and define a pharmacy payment model for outcome-based services while improving members' health, reducing costs, and increasing the plan's star rating. IEHP has a Pharmacy Quality Star Ratings system created to help IEHP members

[19] https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-p4p-program

locate high-quality pharmacies based on data collected. The searchable system displays the rating of each participating pharmacy. The ratings range from 1 to 5 stars, with 5 stars being the best.

Program Details: The initiative began with a focus on pharmacist review of member's Proportion of Days Covered (PDC), which is a measure of medication adherence. Pharmacists worked to achieve members' adherence goal of PDC ≥80%. In a later phase, the Pharmacy Home Program began, which provided reimbursement for pharmacies that reached PDC member adherence goals, and included medication therapy management (MTM) services to provide care for diabetes, high blood pressure, high cholesterol, and/or asthma. The most recent phase of the program, Safe Rx Network, commenced with a focus on medication safety, and requires pharmacists to review all relevant drug utilization review (DURs) alerts, and determine the most appropriate interventions. DUR alerts and appropriate intervention can mitigate the risk of adverse or medication-related events. There are four DUR alert categories in the program: drug-drug interactions, high dose exceeding maximum recommended dose, therapeutic and ingredient duplication, and high-risk medications for the elderly. To evaluate the program, IEHP measures DUR interventions, percentage (%) of total processed claims with safety DUR alerts, and percentage (%) of overall inappropriate claims avoided. IEHP is preparing to expand their quality-focused initiatives with a Point-of-Care (POC) MTM Pharmacy Program with expected launch date in 2019.

Preliminary Results: Prior to current phase of the DUR program, pharmacists were able to significantly increase medication adherence rates. Likewise, based on current DUR program data collection and calculations, overridden DUR alerts are trending down from baseline. Therefore, pharmacists are intervening on DUR alerts more often: this process helps to optimize medication therapy and ensure that only safe and effective medications reach patients.

Payment Structure: Pharmacies are paid a certain amount of dollars per prescription claim that is processed with an overridden DUR alert providing that a payable PSC code is included. The P4P payment per claim will be determined based on final paid prescription volume. Furthermore, there is a bonus payment associated with not filling a prescription after receiving a DUR notification or alert. A pharmacy will receive bonus payment if the percentage of paid prescription volume associated with overridden DUR alerts of the total paid prescription is lower than IEHP threshold. Pharmacies can also earn payment for participating in a Text Message Incentive Program. Monetary support will be allocated to encourage pharmacies to implement a text message system to provide notification to IEHP members. For pharmacies to meet the requirement for opt-in, IEHP members much opt-in >50%. Pharmacies may also earn payment based on member satisfaction survey results.

7. Express Scripts Performance-based Retail Pharmacy Network[20]

The Express Scripts Performance-based Retail Pharmacy Network is a 12-month pilot that will be launched in the fall of 2018. The pilot will examine the impact of rewarding pharmacies that fill prescriptions for Express Scripts members and demonstrate a positive improvement on individual

[20] https://www.prnewswire.com/news-releases/express-scripts-launches-innovative-pilot-program-for-performance-based-retail-pharmacy-network-for-commercial-plans-300628608.

members' medication adherence for conditions such as diabetes, hypertension, and asthma. It is designed to optimize medication therapy, improve medication adherence, and promote better outcomes. Participating pharmacies will be able to track their own performance and identify gaps in care via a web portal. For this pilot, participating plan sponsors, such as employers and health plans, will have the ability to select the four therapy classes where they would like to see an improvement in medication adherence - for example, diabetes, cholesterol, hypertension or asthma - which will be used to measure each pharmacy's performance.

In addition to those already listed above, other payors who have started to engage in limited innovative value-based models include United Healthcare, SCAN, Health First, Aetna, Anthem, and BlueCross BlueShield, among others.

Moving forward, when establishing value-based agreements, both private sector and public-sector healthcare payors should recognize the cost savings and patient care benefits of pharmacist provided services and recommendations for cost-effective prescription drug treatment. Payors should also recognize that services provided by community pharmacists help to lower prescription drug costs and reduce overall healthcare costs by decreasing the use of more costly services such as avoidable emergency room visits and hospitalizations.

In sum, despite promising examples, more must be done to incorporate community pharmacist care into innovative payment and delivery models. Current barriers include the lack of recognition of pharmacists as healthcare providers, misaligned system incentives, lack of patient care coordination, lack of transparency between payors and providers and medication cost sharing, and increased DIR fines where money is unjustly retracted from pharmacies, all of which makes advancing a patient care business in pharmacy increasingly difficult.

NACDS therefore urges the Caucus to encourage the Centers for Medicare & Medicaid Innovation to advance community pharmacy participation in innovative care delivery and care coordination models, including aligning incentives to ensure patient care across the care continuum.

III. MIPS: Quality Measurement and Community Pharmacists (Physician Extenders)

A growing body of evidence suggests that when physicians, nurses, pharmacists, and other healthcare professionals work collaboratively, better health outcomes are achieved. Recent systematic reviews have highlighted the beneficial role of the pharmacy-based services in team-based care.[21] Yet experts have noted the present lack of integration of community pharmacy services into emerging models of care such as accountable care organizations (ACO) and medical homes.[22]

In testing alternative payment methods for determining Medicare Advantage Quality Bonus Payments (QBPs), CMS has noted that linking QBPs with quality standards measured under the Medicare five-

[21] http://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf
[22] http://content.healthaffairs.org/content/32/11/1963.full; https://www.ncqa.org/Portals/0/Homepage/The_Future_of_PCMH.pdf

star quality rating system has aligned incentives for health plans and delivered better patient care outcomes. Medicare's quality rating system heavily weighs measures related to medication outcomes, and, as such, plans are increasingly turning to community pharmacies within their networks to improve drug optimization and quality assurance.

With the implementation of the Medicare Access and CHIP Authorization Act of 2015 (MACRA)-based, merit-based incentive payment system (MIPS) and alternative payment models (APMs), it seems abundantly clear that community pharmacists are well equipped to directly influence many physician payment quality measures. Specifically, "Quality MIPS" measures account for 50% of the MIPs Composite Score, and 25% of these are related to medications. Likewise, the "Improvement Activities" measures account for 15% of the total score, and 25% of these are related to medications. Also, the "Advancing Care Information" measures account for 25% of the MIPS composite score and 20% of these are related to medications.[23] Two measures specifically mention pharmacists, including metrics around medication reconciliation after discharge in the quality category, and population management of medications in the clinical improvement category.[24]

Similarly, many APM quality metrics are dependent upon improvements affected by optimized medication use as well. These include metrics regarding controlling high blood pressure, comprehensive diabetes care, preventive care, tobacco use, and more. Furthermore, many ACOs' top priority quality metrics can be impacted by medication optimization. And, using the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse, it has been estimated that there are 79 clinical quality metrics for which pharmacists have or should have primary responsibility as the health professionals most closely involved in service delivery - many of which involve medication management, adherence, and medication safety.[25]

Examples of such quality metrics are outlined in the chart below: [26]

MIPS #	ACO #	Other	Description of Measure
134	18	HEDIS	*Medication Reconciliation Post-Discharge*
46	12	HEDIS	*Persistence of Beta Blocker Treatment After an MI*
442	-	HEDIS	*Preventative Care and Screening: Influenza Immunization*
110	14	HEDIS	*Controlling High BP (9%)*
001	27	CPC+ 122	*Medication Management in Patients with Asthma*
444	-	HEDIS	*Use of High Risk Meds in the Elderly*
238	-	CPC+ 156 HEDIS	*30-Day All Cause Readmission After Discharge*
458	8	HEDIS	*Antidepressant Medication Management*
318	13	CPC+ 139	*Initiation & Engagement of Substance Abuse or Dependence Treatment*

[23] "Payment Methods in Outpatient Team-based Clinical Pharmacy Practice, Part 2: MACRA for Pharmacists."; *American College of Clinical Pharmacy*; October 2017.
[24] "A Whirlwind Tour of Value-Based Payment Models- with Pharmacists as your guide;" *Pharmacy Today*; June 2018. https://www.pharmacytoday.org/article/S1042-0991(18)30783-7/fulltext
[25] Carmichael J, Gurbinder J, Nguyen PA; "Healthcare Metrics: Where do Pharmacists Add Value?" *Am J Health-Syst Pharm*; 2016; 73:1537-47. https://www.ncbi.nlm.nih.gov/pubmed/27521240
[26] CMS; "Consensus Core Set: ACO and PCMH/Primary Care Measures." https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/ACO-and-PCMH-Primary-Care-Measures.pdf

Community pharmacists can therefore have a significant impact on the improvement of patient outcomes related to existing quality measures. Because pharmacists are not recognized as providers by CMS, and are not MIPS eligible providers, there is serious misalignment between providers who can substantially contribute to the improvement of patient care and related-metrics and who is incentivized/reimbursed to do so**.**

For the above reasons, NACDS submits that the Caucus should give due consideration to directly supporting community pharmacists directly in MIPS and APM programs as a mechanism to control costs and improve outcomes.

NACDS also encourages policy makers to focus initiatives that integrate pharmacist-provided care across the care continuum. With the establishment of any type of value-based payment reform and agreement, the Caucus should ensure that community pharmacists can provide the greatest value to patients by ensuring patient access to care through innovative care models integrating community pharmacies.

NACDS further urges the recognition of pharmacists as healthcare providers in CMS programs, in addition to the following action items:

- ***Demonstration Projects***: We urge the Caucus to consider new, value-based models of care in which QBPs would be provided to high-performing community pharmacies that achieve medication and patient care-related quality measures. This model could also provide payment accountability to community pharmacies for evidence-based screenings, preventive care and wellness services. Such a demonstration would further align incentives across the continuum of care, producing significant clinical gains at a lower overall healthcare cost.

- ***Harmonization of Measures*****:** To develop better outcomes measures that accurately reflect quality, safety, and value without burdening innovation, the Caucus should support efforts that encourage measure harmonization and synchronization. In the current marketplace, there are numerous duplicative measures that overlap resulting in isolated quality initiatives that focus on different settings or different patient populations. Because these measures are to apply across the same target populations, a lack of measure harmonization and synchronization will foster misunderstanding about how such measures and measure results are to be interpreted and used, unnecessarily increasing the data collection burden, inhibiting the ability to compare measure results to determine if there is a valuable outcome, and hindering the ability to adequately identify areas of needed improvement. Better harmonization of measures will not delay or create barriers for the development or utilization of measures, but instead, would eliminate duplication and overlap as well as eliminate inadvertent variances among related measures that could ultimately affect the outcomes that these metrics are intended to measure.

IV. Cross-Sector Collaboration / Partnerships

The value of community pharmacy can be leveraged through cross-sector collaboration and partnerships with public health entities to further improve patient outcomes, especially for preventive health. A *Health Affairs* study reported that an estimated 8% of adults over 35 years old receive all the high-priority preventive services recommended, and 5% do not receive any of these services.[27] Given accessibility in the community and adequate clinical training, community pharmacists can have a substantial impact on improving the uptake of high-priority preventive care services such as screening for chronic diseases, counseling on tobacco and other substance use, providing vaccinations, recommending medication changes to physicians, and others.[28]

Examples of pharmacist impacts on patient care outcomes, often within cross-sector and public health collaborations, are illustrated in the chart below:

	Author	Title of Article	Brief Description of Intervention	Results	Collaborators
Opioids	DiPaula BA, et al.	Physician-pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients[29]	Opioid-dependent patients were managed using a drug therapy management model where intake assessments and follow-up appointments were conducted by pharmacist. The pharmacist debriefed with physician and documented each interaction.	The health department program improved care through expansion of treatment options. The program demonstrated a 91% attendance rate, 100% 6-month retention rates, an estimated savings of $22,000.	Community Mental Health Centers / Physicians / Health Department
Mental Health	Wright WA, et al.	Integrated Pharmacies at Community Mental Health Centers: Medication Adherence and Outcomes[30]	A retrospective cohort analysis of medication adherence rates, hospital and emergency department (ED) use, and related costs between patients of	Pharmacies integrated within community mental health centers (CMHCs) had higher medication adherence rates, lower hospitalization rates (20 per 1,000 were readmitted from the study group vs 17 per 1000 from patients who fill prescriptions at CMHCs),	Southwest Behavioral Health

[27] https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1248
[28] Carmichael J, Gurbinder J, Nguyen PA; "Healthcare Metrics: Where do Pharmacists Add Value?"; *Am J Health-Syst Pharm*; 2016; 73:1537-47. https://www.ncbi.nlm.nih.gov/pubmed/27521240
[29] DiPaula BA, et al.; "Physician-Pharmacist Collaborative Care Model for Buprenorphine-Maintained Opioid-Dependent Patients."; *Journal of the American Pharmacist Association*; March 2015. https://www.ncbi.nlm.nih.gov/pubmed/25749264
[30] "Integrated Pharmacies at Community Mental Health Centers: Medication Adherence and Outcomes;" *Journal of Managed Care and Specialty Pharmacy (JMCP)*; November 22, 2016.

			community mental health centers versus community pharmacies	and lower ED use (87 ED visits from the study group vs 82 ED visits for patients who fill prescriptions from CMHCs). This led to a cost savings of $58 per member per month.	
Transitions of Care	Luder HR, et al.	TransitionRx: Impact of community pharmacy post-discharge medication therapy management on hospital readmission rate[31]	A study was conducted in which patients who had been discharged from local hospitals with a diagnosis of congestive heart failure, COPD, or pneumonia, were referred to the community pharmacy for MTM services with the pharmacist within 1 week of discharge.	Patients who received MTM services from the pharmacist experienced significantly fewer readmissions than patients who received usual care. Approximately 20% of patients who received usual care were re-admitted within 30 days compared to 6.9% of the patients who received the MTM services.	Community Hospital / Council on Aging-for-profit organization / Primary Care Provider
Chronic Medication Management	Prudencio J, et al.	The Effect of Clinical Pharmacist-Led Comprehensive Medication Management on Chronic Disease State Goal Attainment in a Patient-Centered Medical Home[32]	Clinical pharmacy services were initiated at 7 clinics within primary care network designated as a patient-centered medical home. Patients met with clinical pharmacist through clinic or telephone appointments, in addition to physician appointments as needed. The effect of pharmacist-led comprehensive medication management was assessed through analysis of therapeutic goal attainment rates for glycemic, BP, and dyslipidemia outcomes.	Patients receiving this service had significant increases from baseline in percentage of patients achieving individual goal attainment for A1C (54% vs. 36% in usual care group), blood pressure (93% vs 77%) and statin use (79% vs 63% in usual care group). The intervention group had an average of 1.4% reduction in A1c and a decrease in BP of 7.4mmHg, whereas the usual care group had an average reduction of 0.8% in A1c and a decrease in BP of 1.7mmHg.	Patient Centered Medical Home

[31] Luder HR, et al.; "TransitionRx: Impact of Community Pharmacy Postdischarge Medication Therapy Management on Hospital Readmission Rate."; *Journal of the American Pharmacists Association*; June 2015. https://www.sciencedirect.com/science/article/pii/S1544319115300558

[32] Prudencio J, et al.; "The Effect of Clinical Pharmacist-Led Comprehensive Medication Management on Chronic Disease State Goal Attainment in a Patient-Centered Medical Home." *Journal of Managed Care and Specialty Pharmacy*; May 2018. https://www.jmcp.org/doi/full/10.18553/jmcp.2018.24.5.423

	Fikri-Benbrahim N, et al.	Impact of a community pharmacists' hypertension-care service on medication adherence[33]	Antihypertensive medication adherence was compared in patients enrolled in a 6-month intervention program, consisting of specific education, versus patients receiving usual pharmacy care.	The percentage of adherence for patients receiving the intervention increased between baseline and the end of the study (86.0% vs 96.5%) whereas the control group did not have a significant change (86.5% vs 85.4%). The odds of adherence to antihypertensive drug therapy in the intervention group was three times higher than the control group.	
Hepatitis C	Isho N, et al.	Pharmacist-initiated hepatitis C virus screening in a community pharmacy to increase awareness and link to care at the medical center[34]	Pharmacist-initiated HCV screening in community pharmacy can assist with identifying patients at risk for HCV infection and provide patients with linkage to care in health system.	Pharmacist-led HCV screenings were implemented successfully. All patients had a negative antibody result, thus not requiring linkage to care.	Medical Center/ Physicians
HIV	Darin KM, et al.	Pharmacist-provided rapid HIV testing in two community pharmacies[35]	In Michigan, a pharmacist-provided HIV testing model, which incorporated rapid HIV testing, counseling, and linkage to confirmatory HIV testing services, was developed and implemented.	Approximately 42% of the participants stated it was their first HIV test, many of whom reported high-risk behaviors in prior 6 months. This project demonstrated the acceptability and feasibility of pharmacist-provided rapid HIV testing and increase access of care within the community.	Health Department /Physicians Group
Immunizations	Drozd EM, et al.	Impact of Pharmacist Immunization Authority on Seasonal Influenza Immunization	Investigating the impact of policy changes allowing pharmacists to immunize on immunization rates. Influenza immunization rates	The average percentage of people receiving influenza immunizations in states was 35.1%, rising from 32.2% in 2003 to 40.3% in 2013. The policy changes resulted in long-term increase of 2.2% to 7.6% in number of adults	Public Health

[33] Fikri-Benbrahim N, et al.; :Impact of a community pharmacists' hypertension-care service on medication adherence."; *The AFenPA study. Research in Social and Administrative Pharmacy*. Available at https://www.ncbi.nlm.nih.gov/pubmed/23391845. Last Accessed June 13, 2018.

[34] Isho N, et al.; "Pharmacist-initiated hepatitis C virus screening in a community pharmacy to increase awareness and link to care at the medical center."; *Journal of the American Pharmacists Association*; March 2017. https://www.japha.org/article/S1544-3191(17)30136-X/pdf

[35] Darin KM, et al.; "Pharmacist-provided rapid HIV testing in two community pharmacies;" *Journal of the American Pharmacists Association*; Feb 2015. https://www.japha.org/article/S1544-3191(15)30015-7/pdf

		Rates across States[36]	across states were compared before and after policy changes allowing pharmacists administration authority.	between 25-59 years old receiving influenza vaccines.	
Tuberculosis	Jakeman B, et al.	Evaluation of a Pharmacist-performed Tuberculosis Testing Initiative in New Mexico[37]	In New Mexico, 43 pharmacists were certified for TB testing and 25 were actively prescribing and performing TB testing at eight community pharmacies.	Approximately 528 of the 623 patients followed up to have their TSTs read. A total of 18 positive tests were identified and appropriately referred. Pharmacist-performed TB testing had a valuable public health benefit. TB testing follow-up rates at community pharmacies in New Mexico were high, most likely due to convenient hours, accessible locations, and no required appointments.	Health Department /Primary Care Physicians
Underserved Populations	Shireman TI, et al.	Cost-Effectiveness of Wisconsin TEAM model for improving adherence and hypertension control in black patients[38]	Chain pharmacies in Wisconsin used tools to improve adherence and feedback to patients and physicians as compared to information-only control group	The results for 6-month systolic BP reading showed significantly decreased rates for the intervention group versus the control group (-11.8mmHg vs -6.2mmHg) and slightly smaller, but observable changes of diastolic BP in the intervention group versus the control group (-8.4 vs -6.2mmHg). Percentage of patients achieving good refill adherence was larger for the intervention group compared to the control group (59.7% vs 36.1%).	Primary Care Providers
	Skinner JS, et al.	Assessing the effectiveness of pharmacist-directed medication therapy	A retrospective review was conducted to compare medication adherence rates and type 2 diabetes	Pharmacist-directed MTM in a community health center was associated with better medication adherence (64.6% pts in MTM group vs 10% pts in	Primary Care Providers

[36] Hamm N.; "Pharmacists Increase Vaccination Rates;" *Drug Topics*.; August 22, 2017. http://www.drugtopics.com/latest/pharmacists-increase-vaccination-rates
[37] Jakeman B, et al.; "Evaluation of a Pharmacist-performed Tuberculosis Testing Initiative in New Mexico."; *Journal of the American Pharmacists Association*; June 2015. Accessed July 2018.
[38] Shireman TI, et al.; "Cost-effectiveness of Wisconsin TEAM model for improving adherence and hypertension control in black patients;" *Journal of the American Pharmacists Association*; March 2016. https://www.ncbi.nlm.nih.gov/pubmed/27184784

		management in improving diabetes outcomes in patients with poorly controlled diabetes[39]	health outcomes in a sample of underserved patients with suboptimally controlled diabetes who received pharmacist-directed MTM to usual care of pharmacy.	non-MTM group) and lower HbA1C versus the patients in the non-MTM group (7.5 vs. 10.6).	
	Rodis JL, et al.	Improving Chronic Disease Outcomes Through Medication Therapy Management in Federally Qualified Health Centers.[40]	Multisite, prospective, descriptive pilot study with Federally Qualified Health Centers with established pharmacist MTM services to care for patients with uncontrolled diabetes and/or hypertension (BP).	Pharmacist-provided MTM can improve chronic disease intermediate outcomes for medically underserved patients. Of the 422 with uncontrolled diabetes, 52.84% (n = 223) had an A1c <9%; 72 patients (17.06%) achieved an A1c between 8% and 9%, 19.19% (n = 81) of patients achieved an A1c <8% and ≥7%, and 16.59% (n = 70) of patients achieved an A1c <7%. The percentage of patients with BP <140/90 mm Hg improved to 65.21%.	Community Health Centers /Providers /Social Worker/ Diabetes Educators

Preventive Care - ACIP Recommended Vaccinations: Since H1N1 flu epidemic, the Centers for Disease Control and Prevention (CDC), public health entities, non-profits, and community pharmacies have partnered on increasing Advisory Committee on Immunization Practices (ACIP) recommended vaccination rates.

It has estimated that the economic burden in 2015 attributable to vaccine-preventable disease among U.S. adults was $9 billion for a single year. This was related to 10 vaccines recommended for adults 19 and older.[41] Estimations of U.S. vaccination rates are often low and well below goals. According to an article in *The Economist*, the U.S. measles vaccination rate has fallen below the "herd immunity threshold" [42] and for the 2016-2017 season, the uptake of the influenza vaccine among adults 18

[39] Skinner JS, Poe B, Hopper R, Boyer A, Wilkins CH; "Assessing the effectiveness of pharmacist- directed medication therapy management in improving diabetes outcomes in patients with poorly controlled diabetes;" *The Diabetes Educator*; 2015;41(4):459-465. doi:10.1177/0145721715587563.
[40] Rodis JL, Sevin A, Awad MH, et al.; "Improving Chronic Disease Outcomes Through Medication Therapy Management in Federally Qualified Health Centers;" *Journal of Primary Care & Community Health*; 2017;8(4):324-331. doi:10.1177/2150131917701797
[41] Sachiko Ozawa, et al.; "Modeling the Economic Burden of Adult Vaccine-Preventable Diseases in the United States."; *Health Affairs*; November 2016. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0462 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0462
[42] Winegarden W.; "Promoting Access and Lowering Costs in Health Care: The Case of Empowering Pharmacists to Increase Adult Vaccination Rates."; Pacific Research Institute; April 2018. http://www.pacificresearch.org/wp-content/uploads/2018/04/AdultVaccination_F_web.pdf

years and older was only 43.3%. [43] In 2015, unimmunized individuals caused an estimated $7.1 billion in preventable health care costs -- $5.9 billion due to influenza and $1.9 billion due to pneumococcal infections.[44] Further, CDC estimated that for the 2016-2017 influenza season, flu vaccine prevented 5.3 million illnesses, 2.6 million medical visits, and 85,000 hospitalizations.[45] In an effort to increase adult vaccination rates, many states have expanded immunization authority to pharmacies. Research suggests that pharmacies increase immunization delivery and awareness through extended hours of operation, convenient locations, and ease of access. States allowing pharmacists vaccination has increased vaccination rates, and the rates continue to increase over time. For example, in 2013, about 5.1 million vaccinations could be attributed to the passage of laws allowing pharmacist vaccination. Another study estimated that community pharmacies increase vaccine administration rates by 41.4% (over 6 months) when they were given access to patient immunization records, through immunization registries.[46] Additionally, in 2014 the average cost of zoster vaccination provided at physicians' offices was $208.72, compared with $168.50 at pharmacies. The report also cites a survey published in 2012 in which only 31% of family physicians and 20% of internists reported stocking all vaccines recommended for adults.[47]

To advance the health of our nation, it is important for community pharmacists to be able to administer the full suite of ACIP recommended vaccinations, [48] and to be able to receive reimbursement for administering all ACIP recommended vaccines. Creating a sustainable ACIP community pharmacy vaccination model will substantially improve vaccination rates across the spectrum of vaccine-preventable diseases.

V. Technology and Health IT: Enhanced Care & Care Coordination

In order to better participate in value-based payment models and collaborative care, community pharmacies need to have access to accurate systems that allow for appropriate documentation, collection, and reporting of specific data elements needed for clinical assessment.[49] This can be challenging without an integrated, interoperable health information system. Despite the fact that community pharmacy was instrumental in pioneering health IT via e-prescribing and corresponding interconnectivity with physicians, pharmacists rarely have access to full patient records and are not generally connected via electronic health records.

By connecting pharmacies to the broader healthcare system through electronic information sharing, pharmacists can provide even more valuable engagement by supporting physician-initiated treatment monitoring and follow-up, transitions of care, identifying gaps in therapy and lacking immunizations

[43] "Flu Vaccination Coverage, United States, 2016-2017 Influenza Season."; The Centers for Disease Control and Prevention; https://www.cdc.gov/flu/fluvaxview/coverage-1617estimates.htm
[44] Patel, AR, et al.; "The Impact of Pharmacy-based Immunization Services on the Likelihood of Immunization in the United States."; *Journal of the American Pharmacists Association*; May 2018. https://www.japha.org/article/S1544-3191(18)30231-0/pdf
[45] "The Benefits of Flu Vaccination 2016-2017 Infographic."; The Centers for Disease Control and Prevention; https://www.cdc.gov/flu/resource-center/freeresources/graphics/flu-vaccine-protected-infographic.htm
[46] Hamm N.; "Pharmacists Increase Vaccination Rates." *Drug Topics*; August 22, 2017. http://www.drugtopics.com/latest/pharmacists-increase-vaccination-rates
[47] Winegarden W.; "Promoting Access and Lowering Costs in Health Care: The Case of Empowering Pharmacists to Increase Adult Vaccination Rates."; *Pacific Research Institute*; April 2018. http://www.pacificresearch.org/wp-content/uploads/2018/04/AdultVaccination_F_web.pdf
[48] "Pharmacists should have full authority to immunize, says think tank."; *Pharmacy Today*; June 2018. https://www.pharmacytoday.org/article/S1042-0991(18)30770-9/fulltext
[49] https://www.drugstorenews.com/pharmacy/cleansed-data-enables-safer-efficient-care/

and screenings, and better support the patient in their overall health and wellbeing among other actions.[50] Improving information sharing and documentation systems for pharmacists can also contribute to additional involvement in value-based payment mechanisms for pharmacists to understand the entire clinical picture of a patient to tailor and personalize their care.

Sharing EHR records with community pharmacies can improve patient efficiencies and quality of patient care,[51] and NACDS supports such efforts through its involvement in the Pharmacy HIT Collaborative.[52] **NACDS supports the connection of pharmacies to EHRs and other patient records, since such connectivity positions pharmacists to more meaningfully contribute toward higher quality of care, reduced cost, and decreased inefficiencies and waste**. **The Caucus should undertake initiatives that support team-based care through information sharing with pharmacists, and should also support pharmacist-inclusion in value-based payment models to improve quality of care and reduce costs.**

The following are examples of advancement in Health IT that allow for data sharing with pharmacists and other providers. However, some of these solutions are incomplete or inadequate as currently designed, and more could be done to allow for full integration of pharmacists into existing Health IT systems to advance patient care.

The Chesapeake Regional Information System for our Patients (CRISP) CRISP: CRISP is a regional health information exchange serving the Maryland and District of Columbia area. The CRISP platform delivers clinical information to be shared through various health information systems, allowing for a more wholesome collaboration between health care professionals and ultimately safer, more efficient, patient-centered care.[53] Work is currently underway to integrate pharmacies into this system, but has not yet been operationalized.

Transitions of Care: Transitions of care can be greatly impacted through advances in health IT and data sharing across hospital/health systems and community pharmacies. One study showed improved 30-day readmission rates for patients who participated in a community pharmacy transitions of care program where the pharmacist was connected to the Kansas health information exchange, and therefore had access to the patient's electronic medical record.[54]

Medication Synchronization (Med Sync): Med sync is the process of working to get all of a patient's refills to be due on the same day each month enabling a single visit to ease issues such as transportation to the pharmacy, and attempt to simplify the patient's medication regimen, potentially improving medication adherence and decreasing hospitalizations.[55] The model also helps pharmacies to estimate workload requirements if they know that certain patients come in on certain days to

[50] "Empowering Community Pharmacies to Improve Care Coordination and Health Outcomes with Use of Electronic Care Plans."; CPESN; Accessed on August 8, 2018 from: https://cpesn.com/ecare-plan/
[51] Keller ME, Kelling SE, Cornelius DC, Oni HA, Bright DR; "Enhancing Practice Efficiency and Patient Care by Sharing Electronic Health Records."; *Perspectives in Health Information Management*; 2015;12(Fall):1b. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4632871/
[52] https://www.pharmacyhit.org/
[53] https://www.crisphealth.org/
[54] https://www.ncbi.nlm.nih.gov/pubmed/29625912
[55] "Medication Synchronization Programs Improve Adherence To Cardiovascular Medications And Health Care Use;" *Health Affairs*; January 2018.

receive all their prescriptions. Med Sync is often supported via electronic systems which help pharmacy staff to initiate this process for patients.

Immunization Registries: Immunization registries assist healthcare providers, such as physicians and pharmacists, to view patient vaccine records and therefore make personalized recommendations when gaps are identified. There are barriers to the use of immunization registries such as difficulties with patient matching, lack of bidirectional functionality (pharmacists can input information, but cannot view the data others input), and the lack of standardization for requirements across states. Further, only 32 states allow bidirectional immunization registry information access for pharmacists.[56] Increasing pharmacy access to vaccine record information can improve patient care.[57]

PDMP: Prescription Drug Monitoring Programs share information between providers, such as physicians and pharmacists, and other key community stakeholders, regarding a patient's prescription narcotic history. The system provides information such as medication name, days' supply, number of pills received, use of insurance or cash pay, prescriber, and pharmacy utilized. Advances in PDMP include integration into the pharmacy dispensing systems to improve interoperability,[58] and integrating PDMPs across state lines. **NACDS supports the creation of a nationwide PDMP database, which is especially important to enhance existing technology solutions in the marketplace, designed to ensure safe and effective opioid use, and improve patient care.**

Telehealth/Telepharmacy: By utilizing telemedicine and mobile health technologies, pharmacists can become important members of the care team for patients with chronic diseases, especially diabetes. This technology can assist with medication management and care coordination that may improve patient outcomes and reduce costs. The technology can connect pharmacists and others to patients in real-time on their smartphones to ensure patients are taking the right medications at the right time and may work to adjust medications when needed. Seamless digital interaction allows providers to interact regularly with patients and enables doctors the opportunity to coordinate care at a higher level.[59] One example of mobile technology integration into medication management includes the use of a secure two-way messaging and digital engagement to their mobile app. The app delivered customized alerts about side effects based on the length of time the patient was on the medication, and offered immediate access to a live provider for questions. This program resulted in a 30% increase in adherence to a specialty medication. The program was expanded from 1 condition in the pilot to include 14 other conditions.[60]

PrescribeWellness: PrescribeCare MSO was created to support the value-based payment model in pharmacies by allowing pharmacies to track key measurements and follow standard care processes, along with information technology and automation tools to support reporting, coding,

[56] Hamm N.; "Pharmacists Increase Vaccination Rates."; *Drug Topics*; August 22, 2017. http://www.drugtopics.com/latest/pharmacists-increase-vaccination-rates
[57] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5065520/
[58] https://nabp.pharmacy/wp-content/uploads/2018/06/Iowa-Newsletter-June-2018.pdf
[59] "mHealth Gives Pharmacists a Powerful Diabetes Management Platform;" *mHealth Intelligence*; April 13, 2018.
[60] "How CVS Health boosted specialty medication adherence with secure messaging, digital engagement;"; *FierceHealthcare*; July 13, 2018.

billing, and other tasks necessary for participation in these contemporary models.[61] For example, this technology will been integrated into practice to allow more pharmacies to go "beyond the fill" by providing high-touch healthcare in their communities.[62]

VI. Barriers that Limit Pharmacy Impact and Innovation in Medicare and Medicaid

A. Payment and Reimbursement

Lack of provider status for pharmacists: Pharmacists are one of the only high-level healthcare professions with doctorate-level education and years of training lacking provider designation in federal law. In Medicare laws, services provided by physical therapists, dieticians, and others are rightfully covered, but services provided by pharmacists are omitted. This omission creates challenges in developing sustainable patient care models. Community pharmacists, as medication and patient care experts, with the ability to improve outcomes and save healthcare dollars, must be better supported to participate in all Medicare and Medicaid programs with other providers along the healthcare continuum to truly move the needle and progress the U.S. healthcare system. **NACDS urges Congress to support pharmacists as providers via legislation such as H.R. 592/S. 109, the *Pharmacy and Medically Underserved Areas Enhancement Act.***

NACDS also urges Medicare and Medicaid to continue to explore opportunities where community pharmacies and pharmacists are included in programs that utilize value-based payment models. Because of a lack of provider status, pharmacies are often overlooked for inclusion in such programs, when they could provide substantial benefit to the healthcare system. While pharmacists may lack provider status, in many states they have the authority to conduct several types of patient care services either autonomously or in collaboration with a prescriber. Inclusion of pharmacies in value-based payment models allows pharmacists to fully utilize their skillset, which benefits the healthcare system through improved patient care outcomes and reduced costs.

In conclusion, because the federal government influences both public and private programs, recognizing pharmacists as healthcare providers in Medicare Part B would have a dramatic impact on enhancing the role of community pharmacies throughout the healthcare system, including in private payor settings, beyond the dispensing of medications. Additionally, creating standardization of billing methods at both the federal and state levels for these services would provide a framework for states to follow and would encourage a level of consistency across states that would increase pharmacists' ability to provide and document these services as well as increase patient access to pharmacist-provided clinical services. Finally, inclusion of community pharmacies in value-based payment model pilots and programs is a viable way to improve patient care and reduce costs.

[61] https://www.prescribewellness.com/business/solutions/reimbursements
[62] https://www.chaindrugreview.com/prescribewellness-and-thrifty-white-expand-offerings/

B. Federal Anti-Kickback Statute and Civil Monetary Penalties Law Reform

Changes to current statutes and regulations is needed to make these VBP models successful. Specifically, the overly broad reach and severe penalties of the federal anti-kickback statute (AKS) and civil monetary penalties (CMP) law inhibit these types of payment models. As a result, many patient engagement activities that could lead to better health, including helping with medication adherence and health management, have been unintentionally limited.

To address this, NACDS recommends modifying the AKS safe harbors and broadening the CMP exceptions to allow for pharmacy medication adherence activities that would enhance private sector collaboration in the area of value-based care, leading to lower overall costs and improved patient outcomes in government programs. This could be done administratively by creating a safe harbor for "Preventive Care and Access to Care" under the AKS regulation , permitting incentives for activities that prevent the exacerbation of a current condition or illness by recognizing these as a form of "preventive care" under the CMP regulation, and allowing incentives for activities that promote medication adherence by recognizing these under the CMP regulation as promoting access to care just as do activities that improve a beneficiary's ability to obtain medical items and services.

C. Policy and Regulation

At the state level, uneven scope of practice laws and reimbursement policies also present significant barriers for pharmacist participation in value-based payment programs and limits the number and types of services pharmacists can provide. State-by-state regulations outline the provisions of the scope and types of services that can be delivered by pharmacists. While scope of practice regulations are expanding to recognize the value of pharmacist services and leading to an increased number of direct patient care services that pharmacists can provide in some states, lack of consistency in regulatory standards across all the states is prohibiting pharmacists from providing these services to all eligible patients in every state.[63]

Some states have taken the initiative to recognize pharmacists as providers to improve patient care within their states. Key examples include Washington state and Tennessee. In Washington state, a mandate was passed which requires commercial insurers to recognize pharmacists as medical providers and bill for the services they provide.[64] In Tennessee, rules were passed to recognize pharmacists as providers through managed health insurers.[65] **While this movement in a couple of states is promising, action is needed at the federal level to recognize pharmacists as providers through Medicare.**

[63] "Developing Trends in Delivery and Reimbursement of Pharmacist Services;." *Avalere Health, LLC*; October 2015. Accessed July 2018. https://naspa.us/resource/developing-trends-in-delivery-and-reimbursement-of-pharmacist-services/
[64] https://www.wsparx.org/page/ProviderStatus
[65] https://www.pharmacist.com/article/new-tennessee-law-formally-recognizes-pharmacists-providers

VII. Conclusion

Because medication optimization is a critical component of patient care, supporting pharmacists as medication experts and care providers to sustainably participate in modernized payment models is critical to further improving health outcomes and decreasing costs.

We thank you for the opportunity to comment and look forward to working with the Health Care Innovation Caucus on these important issues.

Tom O'Donnell
Senior Vice President, Government Affairs and Public Policy
National Association of Chain Drug Stores