NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Recommendations for Payment
for Pharmacist Clinical Services in New Mexico

Pharmacy Care: Improving Patient Experiences and Outcomes & Reducing Healthcare Costs

Community pharmacists are well-situated in local communities and are oftentimes the most readily accessible healthcare provider. Research has shown that nearly all Americans (89%) live within five miles of a community retail pharmacy. Such access is especially critical in reaching the medically underserved and patients in rural communities. From helping patients take their medications effectively and safely, to providing preventive services, pharmacist services help keep people healthier and reduce costs. Given their accessibility and expertise, pharmacists are often cited as a seriously underutilized asset to improve health and patient care experiences and reduce healthcare costs. Healthcare researchers, thought leaders and policymakers more and more are advocating for pharmacist-provided clinical patient care as one strategy to advance the "Triple Aim."[1]

Significant evidence indicates that the inclusion of pharmacists in patient care teams – as healthcare professionals utilizing their clinical judgment – can lead to significant improvements in patient care and reductions in total healthcare expenditures.[2] Not only does care improve and avoidable total costs decrease, but patients experience greater choice in healthcare options that are accessible and more affordable for them.

For the greatest impact on healthcare delivery access and reduction of downstream costs, all pharmacists should be eligible to provide, not just clinicians"

While primary and preventive care services have traditionally been provided by primary care physicians, nurse practitioners, and physician assistants, the role of pharmacists has expanded in the last several years to include screenings, health and wellness care, immunizations, treatment for minor illnesses, chronic care management, medication optimization, and more.[1] It would be in the best interest of the state to re-evaluate the burdensome administrative efforts the "Pharmacy Clinician" certification presents to the Board of Pharmacy and other involved organizations. In order to greatly impact health care and utilize all healthcare professionals to their fullest ability, it is beneficial for the state and general public health to authorize all practicing pharmacists in New Mexico the ability to deliver and receive the appropriate coverage for patient care services delivered within the community.

Reviews by the U.S. Public Health Service (PHS) and other federal organizations have highlighted the improved clinical outcomes and healthcare savings that result when pharmacists provide clinical care, services and tests. A Centers for Disease Control and Prevention (CDC) review found that "pharmacist engagement in interdisciplinary health management with physicians and other providers significantly improved patients' blood pressure,

[1] The Institute for Healthcare Improvement (IHI) defines the Triple Aim as a framework to describe an approach to optimizing health system performance, with the belief that new designs must be developed to simultaneously pursue three dimensions: improving patient experience (quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare.http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx#targetText=The%20IHI%20Triple%20Aim%20is,to%20optimizing%20health%20system%20performance.&targetText=Improving%20the%20patient%20experience%20of,capita%20cost%20of%20health%20care.

[2] Dalton K, Byrne S. Role of the pharmacist in reducing healthcare costs: current insights. Integr Pharm Res Pract. 2017;6:37–46. Published 2017 Jan 25. doi:10.2147/IPRP.S108047. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5774321/

hemoglobin A1c" among other things, and those pharmacists' "care services also reduced fragmentation of care, decreased health expenditures, and optimized health outcomes."[3] Leading healthcare policymakers echoed this sentiment in highlighting the critical need to integrate pharmacists into collaborative and emerging care models, noting that the inclusion of all skilled clinicians in the team improves patient care experience and outcomes.[4] Thus, NACDS presents the following recommendations related to payment of pharmacist clinical services through state government programs:

Recommendation 1: Payment for Pharmacist Clinical Services	**Recommendation 2: Leverage Retail Community Pharmacists to Improve Access to Substance Use Disorder Treatment for Medicaid Patients**	**Recommendation 3: Expansion of Community Pharmacy Inclusion in Value-Based Payment Models (VBPM)**
• Test and Treat • Statins in Patients with Diabetes • Tuberculosis (TB) Testing • Emergency and Hormonal Contraceptive Drug Therapy • Tobacco Cessation Drug Therapy • PrEP/PEP • Chronic Care Management • Preventive Services – Screening • Preventive Services – Immunization • Naloxone for Opioid Overdose	• Screening, Brief Intervention, and Referral to Treatment Services • Medication Assisted Treatment Services • Medicaid Coverage for Medication Assisted Treatment Services	• Pharmacy Product Reimbursement Should not be Included in Value-Based Payment Models

Recommendation 1: Payment for Pharmacist Clinical Services

In New Mexico, pharmacists have authority to prescribe, pursuant to statewide protocols, for vaccines, tobacco cessation drug therapy, tuberculosis (TB) testing, naloxone for opioid overdose, emergency and hormonal contraceptive drug therapy.[5] These protocols are implemented statewide, thus bringing an additional benefit of consistency as well as convenience for patients to receive services regardless of the location within the state.[6]

[3] Centers for Disease Control and Prevention. Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Doctors, Nurses, Physician Assistants, and Other Providers. Atlanta, GA: US Dept. of Health and Human Services, Centers for Disease Control and Prevention; 2013. https://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Providers.pdf

[4] Manolakis PG, Skelton JB. Pharmacists' contributions to primary care in the United States collaborating to address unmet patient care needs: the emerging role for pharmacists to address the shortage of primary care providers. Am J Pharm Educ. 2010;74(10):S7. doi:10.5688/aj7410s7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3058447/

[5] New Mexico Administrative Code. 16.19.26: Pharmacist Prescriptive Authority. https://www.nmpharmacy.org/resources/Documents/TITLE%2016-19-26%20%20pharmacist%20prescribing%20protocol%20regulations.docx

[6] Weaver KK. Policy 101: Statewide protocols increase patient access to public health services. Pharmacy Today. July 2016. https://www.pharmacytoday.org/article/S1042-0991(16)30537-0/pdf

Pharmacists can also provide a variety of other services, including test and treat via point-of-care tests and chronic care management, through collaborative practice agreements with prescribers in the state. Ensuring adequate coverage and reimbursement for all care services that pharmacists can provide helps expand patient access to convenient, accessible healthcare options in communities across the state, while sustaining pharmacy practice and encouraging the offerings of such services at pharmacies as another option for evidence-based care delivery, which is especially important given rural areas and among populations without access to primary care practitioners.

Deemed the most accessible and most frequently visited member of the healthcare team,[7] community pharmacists are well-positioned to provide care in communities throughout the state. When prescribing, pharmacists must evaluate each patient and determine whether or not treatment is appropriate and for each patient where treatment is appropriate, pharmacists must provide counseling. Thus, **New Mexico pharmacists and pharmacies should be paid for both the products and care services they provide to patients, especially the services and expertise of the pharmacist when prescribing, pursuant to statewide protocols.** Detailed below is evidence and information to support pharmacist involvement and impact within direct patient care services.

Test and Treat: Test and treat services provided by pharmacists not only increase access to care for patients but also support community antibiotic stewardship efforts. Several studies indicate that convenience of accessible locations and extended hour served by pharmacies allowed pharmacists to increase access to these services to the community.[8,9,10,11] Especially with the annual influenza season, pharmacists stand ready with other members of the healthcare team to protect patients from the unwanted effects of the flu. For certain anti-viral therapies, timing of when the medication is taken is crucial in order to lessen the severity of the disease. Thus, the accessibility and convenience of pharmacies allow patients, who cannot afford to wait in traditional healthcare settings to alleviate their discomfort, to receive the necessary timely care. Additionally, approximately over 20% of outpatient antibiotic use has been noted as inappropriate.[12] Test and treat services are conducted in pharmacies using evidence-based protocols to ensure the appropriate antibiotic therapy is used and indicated. A 2018 study determined that within a sample of over half a million antibiotic prescriptions, roughly 46% were prescribed without an infection-related diagnosis.[13] Antibiotic resistance is a pressing public health problem, which has cost the nation's economy approximately $20-35 billion in direct healthcare costs per year;[14] pharmacists are well-positioned and capable to help increase accessible, quality care to the community and reduce unnecessary, overwhelming healthcare costs.

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[7] Manolakis PG, Skelton JB. Pharmacists' Contributions to Primary Care in the United States Collaborating to Address Unmet Patient Care Needs: The Emerging Role for Pharmacists to Address the Shortage of Primary Care Provider. Am J Pharm Educ. Dec 2010. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3058447/

[8] Klepser ME, Adams AJ, Klepser DG. Antimicrobial Stewardship in Outpatient Settings: Leveraging Innovative Physician-Pharmacist Collaborations to Reduce Antibiotic Resistance. Health Security. 2015;13(3):166-173. doi:10.1089/hs.2014.0083

[9] Klepser DG, Klepser ME, Smith JK, Dering-Anderson AM, Nelson M, Pohren LE. Utilization of influenza and streptococcal pharyngitis point-ofcare testing in the community pharmacy practice setting. Research in Social and Administrative Pharmacy. 2018;14(4):356-359. doi:10.1016/j.sapharm.2017.04.012

[10] Klepser DG, Klepser ME, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Community pharmacist–physician collaborative streptococcal pharyngitis management program. Journal of the American Pharmacists Association. 2016;56(3):323-329.e1. doi:10.1016/j.japh.2015.11.013

[11] Klepser ME, Klepser DG, Dering-Anderson AM, Morse JA, Smith JK, Klepser SA. Effectiveness of a pharmacist-physician collaborative program to manage influenza-like illness. Journal of the American Pharmacists Association. 2016;56(1):14-21. doi:10.1016/j.japh.2015.11.008

[12] Chua K, Fischer MA, Linder, JA. Appropriateness of outpatient antibiotic prescribing among privately insured US patients: ICD-10-CM based cross sectional Study. January 2019. https://www.bmj.com/content/364/bmj.k5092

[13] Linder JA, Brown T, Lee Jy, et al. Non-Visit-Based and Non-Infection-Related Ambulatory Antibiotic Prescribing. Oral Abstract Session: ID Week. October 2018. https://idsa.confex.com/idsa/2018/webprogram/Paper71530.html

[14] President's Council of Advisors on Science and Technology. Report to the President on Combating Antibiotic Resistance. Executive Office of the President. September 2014. https://www.cdc.gov/drugresistance/pdf/report-to-the-president-on-combating-antibiotic-resistance.pdf

Statins in Patients with Diabetes: CMS recently adopted the Statin Use in Persons with Diabetes (SUPD) quality measure for inclusion in the Part D star ratings in 2019.[15] This national quality measure is also recognized as an NQF measure, MIPS Quality measure, ACO measure, HEDIS measure and a CPC+ measure.[16,17] The measure builds off of the evidence-based recommendation of the American College of Cardiology and the American Heart Association that diabetic patients receive cholesterol-lowering statins to decrease the risk of heart disease irrespective of whether cholesterol levels are elevated.[18] Despite these recommendations underpinned by decades of supportive evidence, statins are often overlooked and not started in patients who need this therapy. NCQA shared that only 46% of patients with commercial health plans, and 71% of Medicare patients were dispensed any statin in an analysis of commercial and Medicare Advantage health plans' diabetes populations aged 40-75 years of age.[19] Thus, there is significant room for quality improvement.

Not only does statin therapy for patients with diabetes improve quality of patient care delivery, but leads to reduced avoidable health care costs. According to a 2017 study conducted by Heller and colleagues, it was estimated that throughout a 10-year period, the 2013 ACC/AHA cholesterol guidelines would result in a gain of 183,000 quality-adjusted life-years (QALYs) and savings of approximately $3.8 billion.[20] Within these guidelines, it is recommended for statin therapy to be initiated as primary prevention in individuals with diabetes or risk factors of diabetes.[21] Evidence has proven that pharmacists are capable of identifying and initiating the appropriate statin therapy for patients with diabetes. A 2016 study found that identification for the need of statin therapy and pharmacist prescribing, via collaborative practice agreement, led to a 25% absolute increase in patients achieving goal LDL targets.[22] Additionally, a 2017 study was conducted for pharmacists to prescribe or adjust statins and medications for diabetes and hypertension using lab results and medication management review. It was observed that pharmacist intervention resulted in reduced risk of 21% for patients experiencing a cardiovascular event related to the chronic condition.[23] It is in the best interest of the state to allow pharmacists to initiate statin therapy as a covered service within Medicaid to bridge gaps in care so that their beneficiaries may receive the quality patient care they deserve.

Tuberculosis (TB) Testing: Tuberculosis (TB) disease, despite being preventable and curable, continues to impact thousands of lives throughout the nation. Prophylaxis, early diagnosis, and treatment results in reduced transmission and increased protection of patients' health. In 2018, approximately 9,029 new cases of TB were

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[15] Medicare 2019 Part C & D Star Ratings Technical Notes. March 2019. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2019-Technical-Notes.pdf

[16] Quality ID #438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_438_MIPSCQM.pdf

[17] 2019 HEDIS Measures: Statin Therapy for Patients with Diabetes. https://www.aetnabetterhealth.com/pennsylvania/assets/pdf/provider/notices/quality-improvement/ABH%20-%202019%20Statin%20Therapy%20for%20Patients%20With%20Diabetes%20SPD.pdf

[18] American College of Cardiology/American Heart Association. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease. March 2019.

[19] NCQA. Statin Therapy for Patients With Cardiovascular Disease and Diabetes. https://www.ncqa.org/hedis/measures/statin-therapy-forpatients-with-cardiovascular-disease-and-diabetes/

[20] Heller DJ, Coxson PG, et al. Evaluating the Impact and Cost-Effectiveness of Statin Use Guidelines for Primary Prevention of Coronary Heart Disease and Stroke. Circulation. September 2017. https://www.ncbi.nlm.nih.gov/pubmed/28687710

[21] Stone NJ, Robinson JG, et al. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. Circulation. November 2013. https://ahajournals.org/doi/full/10.1161/01.cir.0000437738.63853.7a

[22] Tsuyuki RT, Rosenthal M, Pearson GJ. A randomized trial of a community-based approach to dyslipidemia management: Pharmacist prescribing to achieve cholesterol targets (RxACT Study). Can Pharm J (Ott). 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5032933/

[23] Al Hamarneh YN, Hemmelgarn BR, Hassan I, Jones CA, Tsuyuki RT. The effectiveness of pharmacist interventions on cardiovascular risk in adult patients with type 2 diabetes: the multicentre randomized controlled RxEACH Trial. Can J Diabetes. 2017. https://www.sciencedirect.com/science/article/abs/pii/S1499267117303325?via%3Dihub

reported within the United States.[24] More notably, more than 80% of US TB cases documented in 2017 were associated with the reactivation of untreated latent TB infection.[25] It has been noted that testing and treating latent TB infections is effective in preventing future occurrences of TB disease. NACDS applauds New Mexico's efforts to include pharmacists within the team of healthcare professionals who have the authority to provide tuberculin skin tests (TSTs) to patients. New Mexico community pharmacies implemented a TB testing program, via authorized ability to prescribe and administer TSTs, and observed that approximately 57% of surveyed patients lived more than five miles away from their PCP, whereas approximately 77% lived within five miles of the pharmacy where they received the TST and only 60.4% of patients reported having a primary care physician (PCP). Also, roughly 19% of patients had received their TST and read outside of traditional clinic office hours.[26] A 2015 study conducted by the same researcher, noted that prices for TSTs in community pharmacies run about $30 whereas private clinics tend to charge between $70 and $150 for the service.[27] The increased accessibility, increased convenience, and reduced cost of care indicate how pharmacists are well-positioned to provide this service for the community.

Emergency and Hormonal Contraceptive Drug Therapy: New Mexico pharmacists have prescriptive authority for both emergency contraceptive and hormonal contraceptive drug therapy. Pharmacists use their knowledge to counsel women on the use of emergency contraceptives. Evidence supports the pharmacist's role in hormonal contractive drug therapy. In Oregon, pharmacists can autonomously prescribe hormonal contraceptives for patients, and one study showed that 73.8% of patients who received a prescription from their pharmacist had never previously had a contraceptive prescription, thereby expanding access to care. The study also showed that the safety profile of pharmacist initiation was equal to physician prescribing.[28] We urge New Mexico to include this service within Medicaid in order to provide increased access to care for their beneficiaries.

Tobacco Cessation Drug Therapy: Highly addictive and harmful to nearly every organ of the body, tobacco products cause many diseases and reduce the health of individuals who use tobacco. Smoking is the leading preventable cause of death in the United States.[29] The use of tobacco cessation drugs is one approach that has proven successful at helping individuals quit using harmful tobacco products. Increasing availability to tobacco cessation drugs via pharmacists makes it easier for individuals who want to quit using tobacco products to access these helpful medications. A study conducted in New Mexico assessed tobacco quit rates among smokers who participated in a 6-month community pharmacist-based program. Patients were scheduled for an initial visit with a pharmacist and then seen for follow-up visits at 1 month, 3 months, and 6 months from the initial visit. Average quit rates were 25% at the end of 6 months— comparable to similar programs headed by providers. The study concluded that a community pharmacist-led smoking cessation program with prescriptive authority is an effective approach to reduce smoking.[30] The incorporation of pharmacist-provided tobacco cessation programs within Medicaid is crucial to best improve patients' overall health outcomes and quality of life.

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[24] Morbidity and Mortality Weekly Reports (MMWR): Tuberculosis-United States. Centers for Disease Control and Prevention. March 2019. https://www.cdc.gov/mmwr/volumes/68/wr/mm6811a2.htm

[25] Burden of TB in the United States. Centers for Disease Control and Prevention. November 2018. https://www.cdc.gov/features/burden-tb-us/index.html

[26] Acosta J, Logothetis S, Jakeman B, et al. Patient Survey of a Tuberculosis (TB) Testing Program in New Mexico Community Pharmacies. Poster Presentation at 2017 American Pharmacists Association Annual Conference.

[27] Jakeman B, Gross B, et al. Evaluation of a pharmacist-performed tuberculosis testing initiative in New Mexico. Journal of the American Pharmacists Association. May-June 2015. https://www.sciencedirect.com/science/article/pii/S1544319115300650?via%3Dihub

[28] Anderson L, Hartung DM, Middleton L, Rodriguez MI. Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population: Obstetrics & Gynecology. 2019;133(6):1231-1237. doi:10.1097/AOG.0000000000003286. https://www.ncbi.nlm.nih.gov/pubmed/31135739

[29] Smoking & Tobacco Use. Centers for Disease Control and Prevention. February 2019. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm

[30] Khan N, Anderson JR, et al. Smoking Cessation and Its Predictors: Results from a Community-Based Pharmacy Tobacco Cessation Program in New Mexico. The Annals of Pharmacotherapy. September 2012. https://naspa.us/wp-content/uploads/2018/10/Khan.-Smoking-Cessation-New-Mexico.pdf

PrEP/PEP: These critical medications for HIV/AIDS prevention represent low risk, high value opportunities for pharmacists to better serve at-risk populations and expand the use of this important therapy. The use of PrEP has increased dramatically since 2012. However, the CDC has estimated that while 1.2 million people in the US could benefit from HIV prevention like PrEP, there were only 77,120 PrEP users in the US in 2016.[31] Further, in 2016 in New Mexico, 3,286 people were living with HIV and in 2017, 114 people in New Mexico were newly diagnosed with HIV.[32] This gap in care can be filled by expanding the ability of pharmacists to provide these interventions via autonomous prescribing. These medications can be difficult for patients to obtain for many reasons, as individuals who need these medications may not have access to or be able to afford a visit to a provider. To combat this shortcoming, it is imperative that community pharmacists are able to provide these medications to patients who need them in a convenient and welcoming manner, which can lead to reduced HIV/AIDS transmission. Many states, including New Mexico, Iowa, and Washington, have piloted studies that show pharmacist-run, or pharmacist-involved, PrEP clinics are an effective way to increase uptake of the medication, which can then lead to decreased HIV transmission.[33,34,35] Implementing this service within Medicaid will allow beneficiaries to have increased access to care and reduce opportunities for gaps in care.

Chronic Care Management: According to the National Health Council, 133 million Americans, more than 40% of the total population, are affected by chronic diseases;[36] and approximately 50% of patients with chronic illness do not take their medications as prescribed, leading to morbidity, mortality, and costs of approximately $100 billion per year.[37] Medication adherence for most chronic conditions are reported to be suboptimal and present an opportunity for cost savings and improvement of health for the nation. A 2019 study assessed levels of medication nonadherence for four chronic disease conditions within a random sample of Medicare Fee-for-Service (FFS) beneficiaries. Results showed that medication nonadherence ranged from 35% for diabetes, 23% for heart failure, 38% for hyperlipidemia, and 25% for hypertension. Within the latter category, it was noted that if nonadherent patients were to become adherent, it would result in 117,594 less Emergency Department visits and over 7 million fewer inpatient hospital days per year.[38] Another review reported that the US spends more on health care than any other country, with noted estimates of $27.2 billion to $78.2 billion worth of health care waste due to failure of care coordination, and approximately $75.7 billion to $101.2 billion tied to overtreatment or low-value of care.[39]

At the point of dispensing, pharmacists are well positioned to deliver chronic care management services. Nearly all states now allow pharmacists to select, initiate, continue, modify, and/or discontinue drug therapy through various forms of authority.[40] Evidence supports pharmacists' ability to identify and resolve drug therapy problems,

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[31] Mapping PrEP: First Ever Data on PrEP Users Across the US. AIDSVu- Emory University Rollins School of Public Health and Gilead Sciences. https://aidsvu.org/prep/

[32] Local Data: New Mexico. AIDSVu- Emory University Rollins School of Public Health and Gilead Sciences. https://aidsvu.org/local-data/united-states/west/new-mexico/

[33] Ryan K, Lewis J, Sanchez D, et al. The Next Step in PrEP: Evaluating Outcomes of a Pharmacist-Run HIV Pre-Exposure Prophylaxis (PrEP) Clinic. ID Week 2018 Poster Abstract Session. Oct 2018. https://idsa.confex.com/idsa/2018/webprogram/Paper72194.html

[34] Hoth A, Shafer C, et al. Iowa TelePrEP: A Public-Health-Partnered Telehealth Model for HIV Pre-Exposure Prophylaxis (PrEP) Delivery in a Rural State. Sexually Transmitted Diseases. May 2019. https://www.ncbi.nlm.nih.gov/pubmed/31157732

[35] Tung EL, Thomas A, Implementation of a community pharmacy-based pre-exposure prophylaxis service: a novel model for pre-exposure prophylaxis care. Sex Health. Nov 2018. https://www.ncbi.nlm.nih.gov/pubmed/30401342

[36] About Chronic Diseases. National Health Council. July 2014.https://www.nationalhealthcouncil.org/sites/default/files/AboutChronicDisease.pdf

[37] Shearer MP, Geleta A, et al. Serving the Greater Good: Public Health & Community Pharmacy Partnerships. Center for Health Security. Johns Hopkins Bloomberg School of Public Health. 2017

[38] Lloyd JT, Maresh S, et al. How Much Does Medication Nonadherence Cost the Medicare Fee-For- Service Program. Medical Care. March 2019. https://www.ncbi.nlm.nih.gov/pubmed/30676355

[39] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA. October 2019. https://jamanetwork.com/journals/jama/article-abstract/2752664

[40] CDC "State Law Fact Sheet: Select Features of State Pharmacist Collaborative Practice Laws" updated Dec. 2012. http://www.cdc.gov/dhdsp/pubs/docs/Pharmacist_State_law.PDF

improving patient health outcomes, and reducing downstream harms and costs.[41,42,43] A retrospective chart review was conducted in the geriatric practice setting evaluating the impact of pharmacist identification of medication problems and the resulting resolution. Within a year, approximately 3,100 drug therapy issues were identified during 3,309 patient encounters. The most common issue identified were inappropriate dosages, with the most common interventions being laboratory monitoring and dosage change and an estimated financial savings of up to $270,591.[44] Pharmacist involvement in chronic care management can ultimately lead to improved patient care and reduced downstream healthcare costs.

Preventive Services – Screening: Preventive care avoids or delays the onset or progression of certain preventable diseases, conditions, and other illnesses in patients. Through preventive care, pharmacists can identify potentially serious health conditions and provide early treatment of those conditions. For example, based on supportive evidence, the CDC recognizes pharmacists have successfully implemented a variety of USPSTF recommendations, through screening, education, and recommendations to patients (folic acid supplementation, tobacco use cessation) and screening and referrals to primary care providers for follow up testing and care (osteoporosis screening, HIV screening).[45] Further, pharmacists have had a tremendous impact on improving immunization rates over the last decade;[46] but even greater healthcare value can be realized when all pharmacy care services are covered and sustained. Research demonstrates that only 8% of Americans reported receiving all the high-priority, appropriate recommended clinical preventive services; and on a further note, approximately 5% of adults reported not receiving any of the recommended services.

Preventive Services – Immunization: Pharmacists are highly qualified and well-positioned to manage and provide high quality preventive care in communities across the country to help address such gaps, improve health outcomes, and save downstream healthcare costs.[47] In particular, vaccination is recognized as a significant preventive measure towards health improvement, as well as one of the most-cost effective interventions that contribute to healthcare system efficiency.[48] NACDS applauds the state's Medicaid Fee for Service program that allows for vaccine administration to be billed for any vaccine that the pharmacist is certified to administer and that is covered under the Medicaid recipient's category of eligibility. However, while pharmacy-based vaccines are generally covered by health insurance plans across commercial, Medicare and Medicaid, pharmacy-based vaccine coverage is not always consistent and could have cost sharing, leading to patient access barriers. Currently, many insurers either do not cover pharmacy-administered vaccines, or put in place certain restrictions, such as coverage of limited vaccines or

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[41] MacDonald D, Chang H, et al. Drug Therapy Problem Identification and Resolution by Clinical Pharmacists in a Family Medicine Residency Clinic. 2018. https://pubs.lib.umn.edu/index.php/innovations/article/view/971

[42] Westberg SM, Derr SK, et al. Drug Therapy Problems Identified by Pharmacists Through Comprehensive Medication Management Following Hospital Discharge. Journal of Pharmacy Technology. June 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5998417/

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[44] Campbell AM, Corbo JM, et al. Pharmacist-Led Drug Therapy Problem Management in an Interprofessional Geriatric Care Continuum: A subset of the PIVOTS Group. American Health and Drug Benefits. December 2018. http://www.ahdbonline.com/issues/2018/december-2018-vol-11-no9/2678-pharmacist-led-drug-therapy-problem-management-in-an-interprofessional-geriatric-care-continuum-a-subset-of-the-pivots-group

[45] Kelling SE, Rondon-Begazo A, DiPietro Mager NA, Murphy BL, Bright DR. Provision of Clinical Preventive Services by Community Pharmacists. [Addendum appears in Prev Chronic Dis 2016;13. http://www.cdc.gov/pcd/issues/2016/16_0232e.htm.] Prev Chronic Dis 2016;13:160232. DOI: http://dx.doi.org/10.5888/pcd13.160232

[46] Drozd EM, Miller L, et al. Impact of Pharmacist Immunization Authority on Seasonal Influenza Immunization Rates across States. Aug 2017. Clinical Therapeutics. https://www.ncbi.nlm.nih.gov/pubmed/28781217

[47] San-Juan-Rodriguez A, et al. "Impact of community pharmacist-provided preventive services on clinical, utilization, and economic outcomes: An umbrella review" Preventative Medicine (2018), https://doi.org/10.1016/j.ypmed.2018.08.029

[48] The Economic Value of Vaccination: Why Prevention is Wealth. J Mark Access Health Policy. August 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4802700/

requiring patients to get vaccinated at pharmacies within their insurance network.[49] When a vaccine is not covered under pharmacy benefits, it is most likely covered under medical benefits which can be difficult for pharmacies to bill. This tends to result in patients having to find alternate settings to receive the vaccine or pay high out-of-pocket fees, ultimately leading patients to forego the vaccination altogether. It has been noted that patients prefer the convenience and accessibility that a pharmacy provides, with the extended hours and without the need for an appointment.[50,51] As the literature demonstrates, extending pharmacist authority to provide immunizations has improved vaccination coverage.[52] Amending the current infrastructure to have public or commercial insurance plans expand coverage of all adult vaccines as a pharmacy benefit would appropriately resolve the barrier that numerous patients, especially those who face socioeconomic and transportation challenges and are at high risk of vaccine-preventable disease, face in today's society.[53] For example, upon adoption of this policy to pay for a wide range of adult vaccinations at a doctor's office or local pharmacy, Medi-Cal observed that within the year, the number of administered influenza, pneumococcal, and shingles vaccines increased by 44.4%.[54] Ultimately, pharmacies have also been shown to be a cost-effective healthcare setting for providing immunization services. We encourage New Mexico to continue their efforts within this space of preventive care services and immunizations to provide the necessary support and high quality care for their beneficiaries.

Naloxone for Opioid Overdose: Drug overdose deaths continue to increase in the United States. From 1999 to 2017, more than 702,000 people have died from a drug overdose. In 2017, more than 70,000 people died from drug overdoses, making it a leading cause of injury-related death in the United States. Of those deaths, almost 68% involved a prescription or illicit opioid.[55] According to the New Mexico Department of Health, the state had the 17th highest drug overdose rate in 2017, with 2 of 3 overdoses related to an opioid.[56] To increase access to the life-saving reversal agent, the Department of Health authorized pharmacists in NM to provide naloxone therapy via a statewide standing order.[57] Unfortunately, the CDC reports that only 1 naloxone prescription is dispensed for every 70 high risk opioid prescriptions, and rural areas are even less likely to have naloxone access.[58] While it appears most insurance plans with beneficiaries in New Mexico do cover naloxone, including commercial, Medicaid, and some Medicare, we have heard anecdotally in other states that despite "preferred/generic" or tier one coverage, cost and access barriers are prevalent for patients. For example, even when covered by insurance, patients may experience high co-pays at the pharmacy which deters from uptake, and further, pharmacies may be provided inadequate reimbursement for dispensing naloxone, which may cause issues with stocking and supply of this life-saving, preventive measure. To ensure patients have life-saving access to naloxone all across New Mexico, NACDS urges complete and consistent insurance coverage for all patients with opioid prescriptions or at risk of witnessing an overdose without cost-sharing. Further, adequate reimbursement of pharmacies for dispensing naloxone, which

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[49] Requiring insurers to cover retail pharmacy vaccinations for adult Californians could save lives, study finds. UCLA Newsroom. August 2018. http://newsroom.ucla.edu/releases/requiring-insurers-to-cover-retail-pharmacy-vaccinations-for-adult-californians-could-save-lives-study-finds

[50] Bach AT, Goad JA. The role of community pharmacy-based vaccination in the USA: current practice and future directions. Integr Pharm Res Pract. July 2015 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5741029/

[51] Akinbosoye OE, Tailtel MS, et al. Factors Associated with Zostavax Abandonment. August 2016. Pharmacy Times. https://www.ajpb.com/journals/ajpb/2016/AJPB_JulyAugust2016/factors-associated-with-zostavax-abandonment#sthash.85nSmz1P.dpuf

[52] Drozd EM, Miller L, et al. Impact of Pharmacist Immunization Authority on Seasonal Influenza Immunization Rates across States. Aug 2017. Clinical Therapeutics. https://www.ncbi.nlm.nih.gov/pubmed/28781217

[53] Equils O, Kellogg C, et al. Proposal to Reduce Adult Immunization Barriers in California. UCLA Center for Health Policy Research. August 2018. http://healthpolicy.ucla.edu/publications/Documents/PDF/2018/immunizationbarriers-brief-aug2018.pdf

[54] Requiring insurers to cover retail pharmacy vaccinations for adult Californians could save lives, study finds. UCLA Newsroom. August 2018. http://newsroom.ucla.edu/releases/requiring-insurers-to-cover-retail-pharmacy-vaccinations-for-adult-californians-could-save-lives-study-finds

[55] Opioid Overdose. Centers for Disease Control and Prevention. October 2019. https://www.cdc.gov/drugoverdose/index.html

[56] Drug Overdose in New Mexico. New Mexico Department of Health. February 2019. https://nmhealth.org/publication/view/marketing/2117/

[57] Pharmacist Naloxone Dispensing Guide. New Mexico Department of health. August 2018. https://nmhealth.org/publication/view/guide/2128/

[58] Vital Signs: Life-Saving Naloxone from Pharmacies. Centers for Disease Control and Prevention. August 2019. https://www.cdc.gov/vitalsigns/naloxone/index.html

acknowledges not only the cost of storing, stocking, and supplying the drug to patients, but also the counseling and education the pharmacist provides to ensure proper knowledge and use of the product in an emergency.[59,60,61]

Ultimately, it is of the utmost importance for New Mexico to fully comprehend the value of and execute the implementation of these various patient care services within Medicaid in order to improve access for beneficiaries so that they may receive the quality of care they deserve.

Recommendation 2: Leverage Retail Community Pharmacists to Improve Access to Substance Use Disorder Treatment for Medicaid Patients

Given the opioid epidemic that the nation continues to grapple with, holistic approaches are needed to not only to prevent misuse, abuse, diversion and addiction from taking root, but also to provide treatment options for individuals who are currently suffering from SUDs. Pharmacists have a critical role to play in this regard. As the face of neighborhood healthcare, pharmacists are trusted healthcare professionals who regularly interact with patients to provide expert advice on proper medication use and deliver a growing number of important healthcare services to the public. Pharmacists' extensive education, training and accessibility in community pharmacies throughout the state makes them uniquely suited to provide care to patients with substance use disorders (SUD).

Pharmacies and pharmacists in New Mexico are already working to help patients afflicted with SUD, including educating patients on safe opioid use, the importance of proper and safe storage and disposal of opioid products, alternatives to opioids, and dangers of mixing opioids with other medications like benzodiazepines; providing the public with naloxone for opioid overdose reversal purposes according to a protocol approved by the New Mexico Board of Pharmacy, as well as naloxone administration; and engaging in opioid awareness, management, and prevention programs. However, there are still more services that pharmacists can provide to further the advancement of SUD treatment and medication assisted treatment (MAT) in the New Mexico state Medicaid program – similar to services that pharmacists are already providing in other states.

Thus, as state policymakers consider expanding coverage under the New Mexico Medicaid program for clinical services provided by pharmacists, we strongly urge the state to pursue the necessary coverage changes to allow Medicaid beneficiaries to obtain SUD treatment services from pharmacists. Especially given the state's interest in increasing provider capacity for SUD treatment and recovery programs in Medicaid as one of the Centers for Medicare and Medicaid Services (CMS) demonstration planning grant recipients, coverage for pharmacist-provided SUD treatment services is critical to meeting the states goal of improving beneficiary access to SUD treatment.

Screening, Brief Intervention, and Referral to Treatment Services: A recent report[62] noted that by allowing community pharmacists to be more involved in direct patient care, community pharmacists can help to eliminate gaps and barriers in treatment and increase access to naloxone and other MAT drugs as well as play a critical role in implementing strategies to help reduce population opioid use disorder (OUD) risk. For example, pharmacists can

[59] Seiler N, Horton K, et al. Medicaid Reimbursement for Take-Home Naloxone: A toolkit for Advocates. GWU Milken Institute School of Public Health. 2015. https://prescribetoprevent.org/wp2015/wp-content/uploads/naloxone_medicaid_report_gwu.pdf
[60] Gorman A. Pharmacists hesitant to dispense lifesaving overdose drug naloxone. Modern Healthcare. January 2018. https://www.modernhealthcare.com/article/20180106/NEWS/180109948/pharmacists-hesitant-to-dispense-lifesaving-overdose-drug-naloxone
[61] Walley AY. Naloxone Dispensing via Retail Pharmacies. Presented at Dec 2018 FDA Meeting. https://www.fda.gov/media/121183/download
[62] Pringle JL, Aruru M, Cochran J, Role of pharmacists in the Opioid Use Disorder (OUD) crisis, *Research in Social & Administrative Pharmacy* (2018), doi: https://doi.org/10.1016/j.sapharm.2018.11.005.

contribute to reducing OUD prevalence by using Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify persons who are misusing alcohol and other drugs. Through a screening process, pharmacists identify those at risk of OUD and provide brief counseling and motivational interviewing, as well as linkage to care. This would increase provider capacity while also eliminating gaps and barriers in treatment and increasing access to naloxone and other MAT drugs.

Currently, pharmacy-based SBIRT services are being rolled out in Pennsylvania, Virginia, and Ohio. In Virginia, pharmacist provided SBIRT services are reimbursed by Medicaid. While the expansion of pharmacist provided SBIRT under Medicaid in Virginia is a positive step, further expansion in other states would improve access to SUD care. We urge New Mexico to implement this type of program in Medicaid so that beneficiaries can access this important pharmacist-provided service.

Medication Assisted Treatment Services: There are several other notable state programs that are actively leveraging community pharmacies and pharmacists to improve access to SUD treatment medications. In Rhode Island, MAT pilot program funded by a $1.6 million NIDA grant is involving six pharmacies working with 125 patients to manage their MAT.[63] In the pilot, patients receive their initial MAT prescription from a physician. After the physician determines a patient is stable on their medication, a pharmacist working under a collaborative practice agreement takes over the patient's care. Visiting the pharmacy once or twice a week, patients meet in a private room with their pharmacist who collects labs to be sent off for analysis revealing whether the patient has taken the full dose of their prescribed medication or used any illicit substances and counsels the patient about recovery goals, struggles, and successes. Pharmacists in this pilot also employ motivational interviewing, a counseling technique that helps patients overcome ambivalence and make behavioral changes. Most patients enrolled in the pilot are expected to take buprenorphine, but patients also have the option of Vivitrol, a once-a-month injection of naltrexone which blocks the effects of opioids. (Methadone is not available as it can only be obtained at federally regulated clinics.) There are other similar and notable pilot programs in Kentucky and Maryland. The Kentucky project allows pharmacists to manage patients with SUD on Vivitrol[64] and the Maryland program offers buprenorphine through a single pharmacy connected to the Health Department.[65]

Medicaid Coverage for Medication Assisted Treatment Services: Some states have initiated Medicaid program changes to utilize community pharmacies and pharmacists to perform MAT administration services at the pharmacy level. Recently, legislation was enacted by the Colorado legislature in 2018 that permits pharmacists acting under a collaborative practice agreement to administer injectable MAT for SUDs and receive an enhanced dispensing fee for the administration under the Colorado medical assistance program.[66] Similarly in Texas, the state submitted a State Plan Amendment in recent months that will expand the pharmacy benefit to reimburse pharmacists for administering Vivitrol to beneficiaries covered under Medicaid fee-for-service and Medicaid managed care.[67] We urge New Mexico to pursue similar program changes to enhance SUD treatment options for Medicaid beneficiaries.

Recommendation 3: Inclusion of Community Pharmacy Services in Value-Based Payment Models (VBPM)
Among options to help 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 ensure medications are used

[63] https://www.bostonglobe.com/metro/2019/03/12/getting-addiction-care-pharmacy/m1mcceVlLRXX1W9X3WdeOP/story.html
[64] https://www.pharmacytoday.org/article/S1042-0991(17)31120-9/fulltext
[65] https://www.bostonglobe.com/metro/2019/03/12/getting-addiction-care-pharmacy/m1mcceVlLRXX1W9X3WdeOP/story.html
[66] https://leg.colorado.gov/bills/hb18-1007
[67] https://www.sos.state.tx.us/texreg/archive/May242019/In%20Addition/In%20Addition.html#99

correctly. Any effort to improve quality and reduce costs over the long term will be difficult to achieve if patients do not take their medications appropriately and/or their adherence is poor. By allowing patients to use the provider of their choice for medication-related needs, avoidable medical condition costs can be greatly minimized. **(See Attachment 1 for Examples of VBPM in Pharmacy)**

As VBPMs continue to evolve, NACDS encourages New Mexico Medicaid to consider the benefits of coordinated care programs and VBPMs. 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.[68] Considering the growing evidence that pharmacists are uniquely positioned to improve medication management across the care continuum and provide a range of health services in the community and as part of care teams, NACDS advocates for the expansion and inclusion of community pharmacy services in VPB models.

Improved care coordination and chronic care management are the cornerstones of VBPMs, and medication management is central to both objectives. While VBPMs have primarily focused on physicians and hospitals, they are now expanding to include more providers. The goal of VBPMs is to align performance and health outcomes with compensation by assessing performance using quality and health metrics, and to provide tools and programs to improve patient health outcomes. Value-based payment model reform has the potential to improve outcomes, enhance care coordination, and create more system efficiencies and the contribution of community pharmacy in helping achieve the goal of VBPM is extremely promising.
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. However, in considering VBPM as a cost saving initiative, it is important to ensure that pharmacists can provide the greatest value to patients and reimburse pharmacies accordingly for the innovative services provided by community pharmacists to the extent pharmacists can provide those services under state law. Furthermore, this reimbursement should be based on the other valuable services that pharmacists provide and not in any way be tied to or negatively impact pharmacies' reimbursement (product and/or dispensing fees) for prescription drugs.

Conclusion: NACDS believes that there are appropriate, effective, and long-term approaches to providing quality patient care to the residents of New Mexico. Through implementation of pharmacy clinical services within Medicaid and state government programs, pharmacies will be able to feasibly and sustainably provide the care they are recognized for within communities across the nation. Each of the abovementioned initiatives have been noted as long-term cost-saving approaches proven to be cost effective in other states. Thus, we strongly urge New Mexico Medicaid program to consider these approaches in an effort to promote cost-effective delivery of healthcare and improve the health and well-being of all New Mexico residents.

[68] 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.2014.20.10.99.

ATTACHMENT 1

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.[69]

[69] 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

2. *Wisconsin Pharmacy Quality Collaborative (WPQC)*[70]

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 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

[70] 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

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[71]

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 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.

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

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. *Inland Empire Health Plan (IEHP) Pharmacy P4P Program*[72]

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 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

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

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.