Part B Comprehensive Medication Management Coverage vs. "Provider Status": Examining the Difference

ACCP has gone to great lengths to emphasize the importance of defining its Medicare Initiative as an advocacy effort to pursue legislation that would recognize the direct patient care services of qualified clinical pharmacists as a covered benefit under Medicare Part B, rather than a campaign to achieve "provider status."

There is, of course, a political aspect to this definitional nuance. Our experience working to address Part B coverage in 2001 as part of the multi-organizational "Pharmacist Provider Coalition" taught us that focusing on patients, rather than providers, and on "the what" (the specific services to be provided), rather than "the who" (the practitioner who provides the services), will undoubtedly resonate better with policy-makers. But the distinction we draw is much more than just a public relations exercise. It also reflects the recognition that Medicare doesn't make payments to providers simply because they are included "on the list" of practitioners who may comprise a health care team. Medicare pays for specific covered services delivered to patients by eligible providers. A legislative proposal that would add pharmacists to the list of eligible providers under section 1861 of the Social Security Act would do little to expand opportunities for delivering care to patients unless it were to include coverage for a defined process of care that pharmacists could bill for, whether under the existing fee-for-service structure or through evolving payment and delivery models.

While advocating for our initiative on Capitol Hill during the past 12 months, we have encountered several proposals from policy-makers and other key stakeholders that would recognize pharmacists as providers without addressing covered patient care services or the payment structure. ACCP believes that pursuing this "quick-fix" approach is the wrong tactic. We are committed to the ACCP Medicare Initiative because we believe it is right for the profession and right for patients. Simply "getting on the list" without addressing the specific types of services pharmacists can reliably provide would do little to advance the profession or to benefit patient care.

The Better Care, Lower Cost Act

On Capitol Hill, activity around Medicare payment reform clearly highlights the need to focus on coverage for services, rather than "status" for providers. A recently introduced piece of legislation would establish an integrated chronic care delivery program (Better Care Program or BCP) that promotes accountability and better care management for chronically ill Medicare patients while encouraging investment in infrastructure and redesigned care processes that result in high-quality, efficient service delivery for the most vulnerable and costly population.

This bipartisan, bicameral initiative, introduced by Senators Wyden (D-OR) and Isakson (R-GA) (S. 1932) and Reps. Paulsen (R-MN) and Welch (D-VT) (H.R. 3890), would allow groups of providers to establish "better care practices," which would in turn receive newly calculated, risk-adjusted, capitated payments rewarding better health outcomes for enrolled beneficiaries. Of importance, pharmacists were included on the list of BCP-eligible professionals, an indication of the growing awareness among lawmakers of the need to

incorporate pharmacists as fully integrated members of the health care team responsible for managing complex medication regimens.

However, the legislative language—as currently written—states that only services currently included under Parts A and B of the Medicare program would be eligible for coverage under the proposed Better Care Program. So, although pharmacists would be recognized as "providers," the medication management services that pharmacists typically deliver would not be covered. In terms of improving patient care and advancing the profession, the provider "status" granted under the legislation seems more symbolic than substantive.

A Potential Legislative Vehicle?

ACCP has met with the offices of the original cosponsors of the Better Care, Lower Cost Act to thank them for their work to improve patient care for chronically ill Medicare beneficiaries and for their recognition that pharmacists should be incorporated into integrated patient-centered teams. During those meetings, we also highlighted the fact that without coverage for a defined set of services, the program will struggle to achieve its goal of enabling all members of the team to practice at the top of their licenses.

Recognizing that these recently introduced bills are unlikely to move forward until 2015 at the earliest, we believe the goals of this legislative proposal are entirely consistent with our own Medicare Initiative. We will continue to work with the cosponsors to discuss the possibility of incorporating our language into this much broader bill as it eventually emerges from committee.

The California Experience

The California law (S.B. 493) that recognizes pharmacists as health care providers and expands opportunities for pharmacists to deliver medication management services in formal collaboration with other members of the health care team went into effect on January 1, 2014. ACCP welcomed the passage of this important new law, which will improve patient access to basic health care services and establish recognition as Advanced Practice Pharmacists (APPs) for practitioners who earn certification in a relevant area of practice, complete a postgraduate residency program, or provide clinical services to patients for 1 year under a collaborative practice agreement.

However, the California law does not establish coverage for services under the state Medicaid program (Medi-Cal), nor does it include any mandate that would require private payers to cover pharmacists' services. The absence of any coverage requirement or payment structure in the California law highlights the important distinction between a legislative effort to achieve provider status and ACCP's initiative, which seeks to establish a new benefit under Medicare for a defined set of services.

In highlighting this distinction, ACCP does not intend in any way to detract from the achievement of pharmacists in California in securing passage of their bill, nor does ACCP question its importance in helping improve patient access to pharmacists' services. However, in the context of the Medicare program, ACCP believes that its own advocacy efforts are best focused on trying to ensure coverage for comprehensive medication management services, including payment structures, rather than on simply seeking recognition as providers.

Positioning for Alternative Payment Models in a Fee-for-Service Structure

ACCP's Medicare Initiative is designed to position clinical pharmacists to participate as fully integrated members of the health care team in evolving care delivery and payment models. The process of care we propose is consistent with the vision for medication management in the Patient-Centered Medical Home (PCMH) endorsed by the multidisciplinary Patient-Centered Primary Care Collaborative (PCPCC) and is a component necessary to achieve many of the quality measures that Accountable Care Organizations (ACOs) must meet. We have made it clear that our proposal is not designed to encourage individual pharmacists practicing in silos to "hang out their shingle" and bill Part B.

Positioning the profession for the future of the Medicare payment structure inevitably raises an important question from policy-makers wary of the potential political and financial consequences of adding a new benefit to an already overburdened Medicare program. If we expect that clinical pharmacists will provide direct patient care services as fully integrated members of health care teams under new payment models in the future, why is it necessary to amend section 1861 of the Social Security Act to add this new benefit in the first place? If the team values the contribution of clinical pharmacists in helping patients achieve clinical outcomes, won't market forces dictate that medication management services be included and pharmacists be compensated through the team-based payment structure?

The answer to this question is that despite all the hard work Congress has undertaken to replace the Sustainable Growth Rate (SGR) and develop new Medicare payment structures that reward outcomes rather than volume, Medicare is still operating under a fee-for-service structure, and it is unlikely that the program will entirely abandon this approach for many years.

In addition, as various proposals for alternative payment models emerge in Congress, section 1861 is almost invariably referenced as the guideline for the services that will be covered under the new models. As a result, ACCP remains committed to amending section 1861, not to facilitate clinical pharmacist participation in siloed, fee-for-service billing, but to remove any remaining obstacles to the full integration of clinical pharmacists (delivering comprehensive medication management services to chronically ill Medicare patients who need them) under all the new payment and delivery models that Medicare adopts.

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