LEGISLATIVE & ADVOCACY PRIORITY

AN ACT TO IMPROVE ACCESS TO PATIENT CARE SERVICES VIA COLLABORATION BETWEEN PHYSICIANS AND PHARMACISTS
(aka Expanding Collaborative Practice Agreements)

Background

The delivery of high-quality, team-based care to manage suboptimal health and chronic disease is an unmet need in North Carolina. Improving chronic disease outcomes is of high priority to improve the health and wellbeing of North Carolinians. One strategy to address this unmet need is physician-supervised medication optimization services provided by pharmacists. Medication optimization is a patient-centered, team-based approach to improve patient outcomes. Pharmacists are highly trained members of the interprofessional healthcare team who have the expertise and skills to provide patient-centered medication optimization services to ensure the safe, effective, and appropriate use of medications. Pharmacist-provided medication optimization services have been shown to improve chronic disease care, reduce health care costs, improve the patient experience, and improve physician well-being and burnout. This, in turn, would contribute to healthier, more productive citizens of North Carolina, and, ultimately, make the state of NC more competitive economically. Additionally, the need for these benefits have never been greater with the prospect of Medicaid expansion in NC.

The Proposal

To support the growth of team-based care and physician-supervised medication optimization in North Carolina, as a component of Medicaid expansion, by expanding the existing Clinical Pharmacist Practitioner (CPP) act. Physician supervised medication optimization services will be provided by CPP pharmacists who are fully or partially embedded within 'site-specific' provider clinics. Physicians will supervise CPP pharmacists, as they do currently, through a collaborative practice agreement that outlines the healthcare services protocol. The CPP act will be updated to expand the number of participating pharmacists, which in turn will increase the number of supported physicians, fulfilling a glaring need in rural areas. The majority of CPPs currently work in large, urban academic practices. Updating the CPP act will include simplifying the enrollment criteria (the who), expanding the flexibility of services (the what) based on the supervising physician's patient population, and providing a reimbursement path (the how) for physicians to bill for CPP services on behalf of the pharmacist through NC DHHS Medicaid as outlined below.

Supervising physicians with CPP pharmacist collaborative practice agreements will have explicit authority to bill for these services through the existing NC Medicaid CPP fee schedule. Physician clinics include primary care, academic health systems, FQHC and Rural Health Clinics. Consideration should also be given to expand reimbursement of CPP services to multiple payers, enabling team-based care to a broader population within the physicians' practice.

Benefits and Potential Impact:

- Addresses unmet needs in the management of chronic disease, especially in a state that ranks low relative to other states on metrics of healthcare quality. The John Locke Foundation ranked North Carolina 30 out of 51 states in health. The Commonwealth Fund 2022 scorecard on State Health System Performance ranks North Carolina 34 out of 51 states.
- Addresses the rising cost of healthcare in NC by focusing on the underuse, overuse, and misuse of medications, which has been estimated to be $528 billion/year in the US.
- As value-based care grows and more providers are assuming financial risk, we must do a better job of proactively treating and managing chronic diseases and coordinating care across settings. Pharmacists provide the missing link of proactive and coordinated care focused on the safe, effective, and appropriate use of medications to improving chronic disease outcomes.
- Aligns with the National Academies of Science, Engineering, and Medicine (NASEM) 2021 report on *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, which advocates for

interprofessional primary care teams working in sustained relationships with patients and families to ensure that high-quality is implemented and sustained. This report is inclusive of pharmacists working in any outpatient setting providing team-based, medication optimization services to improve patient care (e.g., embedded pharmacists, community pharmacists, pharmacists delivering telehealth).

- Medication optimization is a broad term that encompasses a variety of medication management services, including comprehensive medication management as well as medication-specific actions and interventions through new statewide standing orders and protocols, such as hormonal contraception and early prenatal care.
- The optimal management of chronic disease has been a key topic at the National Rural Health Association meetings over the past several years. Integrating pharmacists into rural clinics as part of team-based care is desired.

Anticipated Barriers to Overcome:

There is risk to gaining support from the professional physician associations, however several discussions with the NCAFP have been positive and there is strong support for physician-supervised medication optimization services in the provider community, especially the fact that these services will be even more beneficial to physicians in an expanded Medicaid environment.

Example Language from Existing State Legislation:

Multiple states have existing legislation that enables pharmacists to provide services to manage and improve chronic diseases (e.g., Washington, Idaho, California, New Mexico, Texas, Colorado, Minnesota, Oregon, and more).

Following are three examples of language in existing state legislation supporting the concept of team-based, collaborative practice to improve chronic disease outcomes through medication optimization.

- Texas Legislation: This legislation clarifies that a physician may delegate to any properly qualified and trained pharmacist the implementation and modification of a patient's drug therapy under protocol. This means that pharmacists, particularly those practicing in a community, outpatient, or long-term care setting, can now be part of team-based care through collaborative practice. All pharmacists may now enter into collaborative practice agreements with physicians for their patients and establish protocols to make changes to a patient's drug therapy regimen. *This change in the operations code also prompted BCBS of Texas to provide reimbursement.* Reference: https://capitol.texas.gov/tlodocs/86R/billtext/pdf/SB01056F.pdf#navpanes=0
- Colorado Legislation: This legislation represents a more direct approach to granting mandatory coverage for services provided by a pharmacist. This act requires a health benefit plan to provide coverage for health care services provided by a pharmacist if: a) the services are provided within a health professional shortage area; b) the health benefit plan provides coverage for the same services provided by a licensed physician or advanced practice nurse; and c) other conditions specified in current law are met. Two references:
  https://leg.colorado.gov/bills/hb18-1112
  https://leg.colorado.gov/bills/hb21-1275 (Medicaid reimbursement)
- Minnesota Legislation: This legislation encompasses the services provided by pharmacists (i.e., medication therapy management, MTM) as integral members of the health care team. MN has had long-standing legislation dating back many years (recent revision November 2021) whereby the practice of MTM is widely accepted, implemented, and reimbursed throughout the state. The use of the term MTM in MN predates the implementation of Medicare Part D, which also introduced the MTM terminology, but with different meaning. Thus, MTM is a term that now has multiple meanings, leading to inconsistency in how it is implemented across the country. Therefore, we opt to avoid terms such as Medication Therapy Management (MTM) and simply place the focus on the value the pharmacist brings to the team through medication optimization to improve chronic disease outcomes. Nevertheless, the MN legislation has similar and excellent language consistent with our goal of managing and improving chronic disease through medication optimization. Reference:
  https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_136889