Key Findings:

Analysis of California Senate Bill 1285
Advanced Practice Pharmacist

Summary to the 2017–2018 California State Legislature, April 17, 2018

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Senate Bill (SB) 1285 analyzed by CHBRP would require coverage of services provided by advanced practice pharmacists (APhs).

1. CHBRP estimates that, in 2019, 100% of the 23.4 million Californians enrolled in state-regulated health insurance, as well as the 1.8 million Medi-Cal beneficiaries enrolled in County Operated Health System (COHS) managed care will have insurance subject to SB 1285.
2. **Benefit coverage.** SB 1285 would require coverage for services delivered by APhs,
3. **Utilization & expenditures.** Due to the limited number of APhs (less than 1% of all California pharmacists) and the varied possibilities for reimbursing covered services (reimbursement, salary, etc.), the impact of SB 1285 on utilization and expenditures is unknown.
4. **Medical effectiveness.** There is limited or inconclusive evidence of effectiveness of services provided by APhs or other pharmacists working under a collaborative practice agreement with a physician.
5. **Public health.** The short-term or long-term public health impacts are unknown.

CONTEXT

Advanced practice pharmacist (APh) licensure is relatively new in California, with the first licenses issued in 2017.[1] As of April 2018, there are 279 APh licenses in California (less than 1% of all California's pharmacists).

Working under collaborative practice agreements with physicians (CPAs), APhs may provide the following services: performance of patient assessments; ordering and interpreting all drug therapy–related tests; referring patients to other healthcare providers; participating in the evaluation and management of diseases and health conditions in collaboration with other healthcare providers; and initiating, adjusting, modifying, and discontinuing drug therapy pursuant to an order by a patient's treating prescriber and in accordance with established protocols.

Other pharmacists may also work under CPAs and may provide similar services in some settings.

Designations similar to California's APh exist in three other states: Montana, New Mexico, and North Carolina.

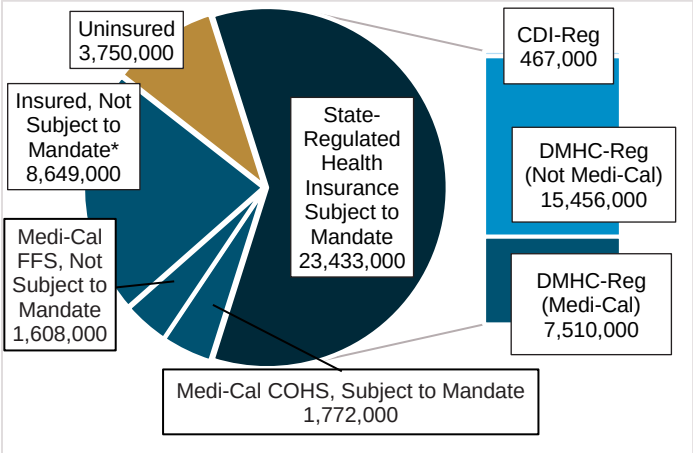
BILL SUMMARY

For plans regulated by the California Department of Managed Health Care (DMHC) or policies regulated by the California Department of Insurance (CDI), as well as for Medi-Cal managed care through either a DMHC-regulated plan or a County Operated Health System (COHS) program, SB 1285 would require coverage of services provided by an APh, including APh services related to comprehensive medication management (CMM).

Figure 1 notes how many Californians have health insurance that would be subject to SB 1285.

[1] Refer to CHBRP's full report for full citations and references.

Figure 1. Health Insurance in CA and SB 1285



Source: CHBRP 2018.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Medical Effectiveness

CHBRP found limited evidence that medication adherence does not differ between persons who receive care from APhs or pharmacists with collaborative practice agreements and persons who receive usual care. There is inconclusive evidence as to whether APhs and pharmacists with collaborative practice agreements increase use of antihypertensive medications among persons with uncontrolled hypertension. With regard to clinical outcomes, there is a preponderance of evidence that receiving care from APhs or pharmacists with collaborative practice agreements is associated with better blood pressure control than persons who receive usual care. Findings for effects on control of diabetes and cholesterol are inconclusive; some studies find no difference between persons who receive care from APhs or pharmacists with collaborative practice agreements and persons who receive usual care, whereas others find that receipt of services from APhs or pharmacists with collaborative practice agreements is associated with better control of diabetes or cholesterol. Findings regarding effects on numbers of outpatient visits are inconclusive. Findings from studies that examined rates of ED visits and hospitalizations suggest that rates of ED visits and hospitalizations among persons who receive services from an APh or a pharmacist with a collaborative practice agreement are similar to the rates of ED visits and hospitalizations among persons who received usual care. The only study that examined adverse events found no difference between persons who received services from pharmacists with collaborative practice agreements and persons who received usual care.

Benefit Coverage, Utilization, and Cost

Currently, 52% of enrollees have coverage for the services provided by an APh or a pharmacist working under a collaborative practice agreement (CPA). SB 1285 would raise the figure to 100%.

However, the means of compensation for services provided varies. CHBRP is unaware of covered APh services being discretely reimbursable, but reimbursement may be bundled with other provided services or services may be accessible through an APh's employment relationship with a licensed health facility, a physician, practice, or other employer.

Due to the limited number of APhs and the variety of possible forms of coverage compensation that would appear to be compliant with SB 1285, the impact of the mandate on utilization and expenditures is unknown.

Public Health Impacts

SB 1285 would have unknown impacts on short-term or long-term public health.

Essential Health Benefits and the Affordable Care Act

SB 1285 would not appear to interact with essential health benefits (EHBs) because it not a new benefit coverage requirement, but a requirement to cover services provided by APhs practicing in their existing professional scope. As physicians and other pharmacists with CPAs appear to already engage in these activities, SB 1285 does not appear to add to covered benefits despite adding coverage for a specific type of provider.