

Closing the Primary Care Gap: Is Pharmacist  
Prescriptive Authority the Answer?

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I. INTRODUCTION

America's primary care workforce is waning.<sup>1</sup> In the past decade, the United States saw a fifty percent decrease in the number of medical students entering primary care, and the country faces a potential shortage of 150,000 physicians in the coming decade.<sup>2</sup> However, as access to physicians decreases, pharmacists remain one of the most accessible medical professionals in the current healthcare system.<sup>3</sup> In 2010, the United States Department of Labor (DOL) reported that there were nearly 275,000 pharmacists.<sup>4</sup> The DOL projected that the profession will grow by twenty-five percent in the coming decade, increasing at a rate nearly double that of most occupations.<sup>5</sup>

Pharmacists can play an important role in closing the primary care gap by participating in teams of qualified professionals, such as collaborative

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1. See Erin Albert, *The Case for Pharmacists as Legal Health Care Providers*, 9 IND. HEALTH L. REV. 187, 188 (2012).

2. *Id.*

3. *Id.* at 189.

4. See Bureau of Labor Statistics, *Occupational Outlook Handbook, 2012-13 Edition, Pharmacists*, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK (Mar. 29, 2012), <http://www.bls.gov/ooh/Healthcare/Pharmacists.htm> (indicating that in 2010, there were 274,900 employed pharmacists).

5. *Id.*

drug therapy management (CDTM) programs.<sup>6</sup> CDTM is a collaborative practice agreement between one or more physicians and pharmacists where pharmacists working within the context of a defined protocol are allowed to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, and adjusting drug regimens.<sup>7</sup> Nearly all states authorize some form of CDTM, but only a few states grant the broad privilege of prescriptive authority to advanced-practice pharmacists, who undergo training above and beyond that of traditional pharmacists.<sup>8</sup>

State legislatures should adopt regulations similar to those enacted in New Mexico and North Carolina, granting prescriptive authority to pharmacists in order to close the primary care gap. To make this feasible, Congress must allow these advanced-practice pharmacists to bill Medicare Part B by granting them provider status. This article will argue for the importance of prescriptive authority for advanced-practice pharmacists nation-wide, detailing the need for such authority in terms of cost-effectiveness and access to care, while addressing barriers to successful

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6. See Thomas Bodenheimer & Hoangmai H. Pham, *Primary Care: Current Problems And Proposed Solutions*, 29 HEALTH AFFS. 798, 804 (2010), available at <http://web.pdx.edu/~nwallace/AHP/StateofPC.pdf> (indicating that creating primary care teams is a possible solution to closing the primary care gap).

7. ANDREW MADDEN, JOSEPH RAMIREZ, JAMIE ROHRS & LEO VANDERPOOL, N.M. PHARMACISTS ASS'N ROTATION, PHARMACIST PRESCRIBING PRACTICES: INTERNATIONAL REGULATIONS AND IMPLICATIONS (2012), available at [http://www.nm-pharmacy.com/COP\\_/Extern\\_Articles/RPh\\_Prescribing.pdf](http://www.nm-pharmacy.com/COP_/Extern_Articles/RPh_Prescribing.pdf).

8. See *id.* (indicating that in 2012, forty-seven states had CDTM programs); See also Matthew Murawski, Kristin R. Villa, Ernest J. Dole, Timothy J. Ives, Dale Tinker, Vincent J. Colucci & Jeffery Perdiew, *Advanced-Practice Pharmacists: Practice Characteristics and Reimbursement of Pharmacists Certified for Collaborative Clinical Practice in New Mexico and North Carolina*, 68 AM. J. HEALTH-SYST. PHARM. 2341, 2342 (2011), available at <http://www.ajhp.org/content/68/24/2341.full.pdf> (indicating that in 2011, thirty-eight states had CDTM programs, and that pharmacists with advanced-practice designations have more prescriptive privileges than pharmacists without an advanced-practice designation).

implementation of prescriptive authority.

## II. THE NEED FOR PHARMACIST PRESCRIPTIVE AUTHORITY

### *A. The Primary Care Gap*

Fifty-six percent of all physician visits are for primary care purposes.<sup>9</sup> Yet, only thirty-seven percent of physicians practice primary care, and the future of the profession looks bleak.<sup>10</sup> In a 2007 survey of fourth-year medical students, only seven percent of respondents indicated that they planned to pursue a career in adult primary care.<sup>11</sup> The number of primary care practitioners is expected to grow by a mere two to seven percent by 2025.<sup>12</sup> The aging baby boomers population will double the number of American seniors by 2030, and the rapid growth of the general population adds an additional level of concern for the growing primary care gap.<sup>13</sup>

The gap is glaringly obvious in rural areas, where the ratio of primary care physicians to patient population is less than half that of urban centers, with only forty-six physicians per 100,000 patients.<sup>14</sup> Twenty-one percent of Americans reside in rural areas, overwhelming the resources of the mere ten percent of primary care practitioners working outside of city limits.<sup>15</sup> In both urban and rural areas of the country, the difficulty of access to care is

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9. Bodenheimer & Pham, *supra* note 5, at 801.

10. *Id.*

11. *Id.*

12. *See id.* (indicating that the workload of primary care practitioners is expected to increase twenty-nine percent from 2005 to 2025, while the number of practitioners is estimated to grow by a mere two to seven percent in the same time frame).

13. Albert, *supra* note 1, at 188.

14. Bodenheimer & Pham, *supra* note 5, at 802 (noting that the ratio of primary care physicians to patient population in urban areas is 100 per 100,000).

15. *Id.*

increasing faster than the number of primary care physicians.<sup>16</sup> Physician extenders like nurse practitioners (NPs) and physician assistants (PAs) offer some hope of a solution to the problem.<sup>17</sup> However, the number of NPs and PAs graduating each year, in conjunction with the number entering primary care, indicate that these physician extenders alone are insufficient to close the primary care gap.<sup>18</sup> Even considering the number of primary care physicians, NPs, and PAs together, the gap in the ratio of practitioners to patient population is expected to grow in the coming years.<sup>19</sup>

Another factor expected to exacerbate the primary care problem will stem from the implementation of the Medicaid expansion provision in the Patient Protection and Affordable Care Act (PPACA) in January 2014.<sup>20</sup> In 2012, forty-seven million nonelderly Americans were uninsured.<sup>21</sup> The implementation of the Medicaid expansion, in concert with the increased affordability and accessibility of private insurance, is sure to increase the number of adults seeking primary care services.<sup>22</sup> States can begin to remedy the primary care gap by creating CDTM teams that include pharmacists with prescriptive authority, thus increasing the number of

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16. *See id.* at 801 (indicating that population growth and aging are estimated to increase primary care workload by twenty-nine percent, leading to estimated shortages of 35,000-44,000 primary care practitioners).

17. *See id.* at 804 (indicating that the creation of primary care teams is a possible solution to the primary care gap).

18. *Id.* at 801.

19. *See id.* (indicating that the ratio of primary care practitioners to patient population is expected to fall nine percent from 2005 to 2020).

20. *See* Ann Sanner, *Newly Insured to Deepen Primary Care Doctor Gap*, SANTA MARIA TIMES, (Sept. 30, 2013, 5:55 PM), [http://santamariatimes.com/news/local/features/affordable-care-act/newly-insured-to-deepen-primary-care-doctor-gap/article\\_34f9acfa-2a34-11e3-88ff-001a4bcf887a.html](http://santamariatimes.com/news/local/features/affordable-care-act/newly-insured-to-deepen-primary-care-doctor-gap/article_34f9acfa-2a34-11e3-88ff-001a4bcf887a.html).

21. *Key Facts About the Uninsured Population*, KAISER FAMILY FOUND. (Sep. 26, 2013), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

22. *See* Sanner, *supra* note 20 (predicting that the shortage of primary care physicians will worsen when an estimated 30 million uninsured Americans gain coverage under the PPACA in 2014).

accessible primary care practitioners.<sup>23</sup>

*B. Patient Non-Adherence to Medication*

Patients who fail to properly adhere to their prescriptions present significant problems for our healthcare system.<sup>24</sup> The New England Healthcare Institute (NEHI) recently released research indicating that one-third to one-half of patients do not take their medications properly.<sup>25</sup> The reasons for non-adherence include an array of medical and social issues, including intolerance, apathy, inability to pay, and poor memory.<sup>26</sup> The NEHI also reported that patients who fail to take their medications as prescribed cost the healthcare system approximately \$290 billion annually.<sup>27</sup> Creating CDTM programs that include advanced-practice pharmacists is a possible solution to this costly problem, as it would increase the number of practitioners monitoring adherence.<sup>28</sup>

Among those most susceptible to non-adherence are patients with chronic diseases, such as diabetes and heart disease.<sup>29</sup> When patients with chronic diseases fail to adhere to their prescribed medications, the

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23. See Bodenheimer & Pham, *supra* note 5, at 804 (indicating that creating primary care teams is a possible solution to closing the primary care gap).

24. See Press Release, New Eng. Healthcare Inst., NEHI Research Shows Patient Medication Nonadherence Costs Health Care System \$290 Billion Annually (Aug. 11, 2009) [hereinafter NEHI Press Release], available at [http://www.nehi.net/news/press\\_releases/110/nehi\\_research\\_shows\\_patient\\_medication\\_nonadherence\\_costs\\_health\\_care\\_system\\_290\\_billion](http://www.nehi.net/news/press_releases/110/nehi_research_shows_patient_medication_nonadherence_costs_health_care_system_290_billion) (noting that patient non-adherence to medication costs the health care system \$290 billion in avoidable spending annually).

25. *Id.*

26. Jannet M. Carmichael & Janice A. Cichowlas, *The Changing Role of Pharmacy Practice—A Clinical Perspective*, 10 ANNALS HEALTH L. 179, 184 (2001).

27. NEHI Press Release, *supra* note 24.

28. See *id.* (suggesting that creating health care teams incorporating nurses, care managers, pharmacists, and other clinicians is a possible solution to patient medication non-adherence).

29. See *id.* (indicating that patients with chronic diseases are particularly susceptible to spotty adherence practices).

inevitable implications are unnecessary hospitalizations, medical complications, and increased mortality rates.<sup>30</sup> Treating patients with chronic diseases is not cost-effective for physicians, but CDTM programs that include pharmacists can provide an answer to this spending crisis.<sup>31</sup> In a 2008 survey of advanced-practice pharmacists in New Mexico and North Carolina, respondents indicated that they primarily managed such chronic patients.<sup>32</sup> Advanced-practice pharmacists, with training in pharmacotherapy and diagnosis, can manage chronic disease states, resulting in longer intervals between patient visits to primary care physicians.<sup>33</sup> Allowing these credentialed pharmacists to manage patients with chronic diseases enables physicians to spend their time on more complex patients who require their expertise and monitoring.<sup>34</sup>

### *C. Eliminating Unnecessary Primary Care Visits for Minor Ailments*

Just as advanced-practice pharmacists can reduce the need for chronic patients to visit a physician, they can also eliminate the need for patients to book primary care appointments for simple ailments like colds and minor infections.<sup>35</sup> Particularly in states like New Mexico, where the population is largely rural, pharmacists with prescriptive authority can eliminate

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30. *Id.*

31. C. Richard Talley, *Prescribing Authority for Pharmacists*, 68 AM. J. HEALTH-SYST. PHARM. 2313, 2333 (2011), available at <http://www.ajhp.org/site/TalleyEditorial.pdf>.

32. See Murawski, *supra* note 7, at 2344-45 (indicating that respondents primarily managed diabetes, coagulation or lipid disorders, hypertension, asthma or chronic obstructive pulmonary disease, pain, and heart failure).

33. Raymond W. Hammond & Ernest J. Dole, *The Pharmacist Clinician: Prescriptive Authority in New Mexico*, 2 J. OF MANAGED CARE PHARM. 594 (1996), available at [http://www.amcp.org/data/jmcp/Campus\\_v2\\_594-596.pdf](http://www.amcp.org/data/jmcp/Campus_v2_594-596.pdf).

34. Talley, *supra* note 28, at 2333.

35. See Hammond & Dole, *supra* note 30, at 594 (indicating that pharmacist clinicians in communities with no primary care physician may eliminate the need for patients to travel to see physicians for minor ailments).

unnecessary patient travel for minor illnesses.<sup>36</sup> Allowing qualified pharmacists to prescribe low-risk medications like antibiotics increases access to care and decreases the ever-present demand on the resources of primary care practitioners.<sup>37</sup>

### III. CURRENT ADVANCED-PRACTICE PHARMACY MODELS

#### A. *The New Mexico Pharmacist Prescriptive Authority Act*

Enacted to resolve the failing quality of care provided to the rural population of New Mexico, the Pharmacist Prescriptive Authority Act (PPAA) of 1993 provides that pharmacists who obtain extensive training in diagnosis and physical assessment may become licensed as pharmacist clinicians.<sup>38</sup> Under the PPAA, pharmacist clinicians undergo pharmacotherapy and physical assessment training equivalent to that of physician assistants, enabling them to register for a Drug Enforcement Administration (DEA) number and apply for prescriptive authority under a physician's supervision.<sup>39</sup> Pharmacists can qualify as clinicians by way of four methods: (1) national certification as a physician assistant, (2) satisfactory completion of sixty hours of physical assessment training, followed by a nine-month clinical residency, (3) satisfactory completion of the sixty-hour physical assessment curriculum, a 150-hour, 300-patient contact supervised preceptorship, and a passing examination score, or (4)

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36. *Id.*

37. *See id.* (indicating that pharmacist clinicians may alleviate excessive physician workload and address the concern of providing quality health care to under-served populations).

38. *See id.* (indicating that the PPAA was originally designed to address the concern of providing quality care to the under-served rural population); *See also* Murawski, *supra* note 7, at 2342 (indicating that pharmacist clinicians must complete training in diagnosis and physical assessment equivalent to that of physician assistants).

39. Murawski, *supra* note 7, at 2342.

certification through the Indian Health Service's Pharmacist Practitioner Program, verification of contact with six hundred patients within two years, and a supporting affidavit from a supervising physician.<sup>40</sup> New Mexico's CDTM program is a model of what other state legislatures should adopt, as it allows qualified, experienced pharmacists prescriptive authority under supervision of a physician.

*B. The North Carolina Clinical Pharmacist Practitioner Act*

North Carolina's Clinical Pharmacist Practitioner Act (CPPA) provides another example of collaborative advanced-practice pharmacy that state legislatures should emulate. Similar to New Mexico, North Carolina extended prescriptive authority to certified pharmacists in 2000 with the CPPA.<sup>41</sup> To earn the Clinical Pharmacist Practitioner (CPP) title, a licensed North Carolina pharmacist must sign a collaboration agreement with a supervising physician, and must obtain one of the following: (1) Board Certified Pharmacotherapy Specialist or Certified Geriatric Pharmacist certification, or American Society of Health-System Pharmacists residency, including two years clinical experience, (2) Doctor of Pharmacy degree with three years experience, plus completion of one North Carolina Center for Pharmaceutical Care or Accreditation Council for Pharmacy Education Certificate Program, or (3) Bachelor of Science degree with five years experience, plus completion of two certificate programs.<sup>42</sup> As in New Mexico, CPPs are granted prescriptive authority and may register for a

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40. Hammond & Dole, *supra* note 30, at 594, 596.

41. Betty H. Dennis, *An Overview of the Clinical Pharmacist Practitioner in N.C.*, N.C. ASS'N OF PHARMACISTS, <http://www.ncpharmacists.org/displaycommon.cfm?an=13> (last visited Oct. 4, 2013).

42. *Id.*

DEA number.<sup>43</sup> By allowing qualified pharmacists to prescribe and collaborate with physicians, the CPPA provides an example of a successful CDTM program that other states should adopt.

#### IV. THE REIMBURSEMENT PROBLEM

A major barrier to the success of advanced-practice pharmacy models lies in reimbursement.<sup>44</sup> Under current models, advanced-practice pharmacists are not recognized as midlevel providers for reimbursement purposes, including by federal programs such as Medicare.<sup>45</sup> The root of the problem stems from the language of the Social Security Act.<sup>46</sup> Professionals that are typically considered physician extenders, such as NPs and PAs, are eligible for billing to Part B as midlevel providers.<sup>47</sup> However, advanced-practice pharmacists are not on that exclusive list.<sup>48</sup> In 2004, Congress introduced a bill that proposed the Medicare Clinical Pharmacist Practitioner Services Coverage Act (MCPSCA) to address the inability of advanced-practice pharmacists to bill to Part B.<sup>49</sup> Unfortunately, the bill later died in the House Ways and Means Subcommittee on Health.<sup>50</sup> Congress reintroduced the bill in 2008 and 2010, but the MCPSCA suffered the same fate each time.<sup>51</sup> If enacted, the MCPSCA would recognize advanced practice-pharmacists as midlevel

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43. Murawski, *supra* note 7, at 2342.

44. *Id.* at 2349-50.

45. *Id.* at 2342.

46. Talley, *supra* note 28, at 2333.

47. *See id.* (indicating that nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, qualified psychologists, clinical social workers, and certified registered nurse anesthetists are eligible for Medicare Part B payment).

48. *Id.*

49. H.R. 4727, 108th Cong. (2003).

50. Murawski, *supra* note 7, at 2342.

51. *Id.*; *See also* H.R. 5780, 110th Cong. (2007); *See also* H.R. 5389, 111th Cong. (2009).

providers, allowing them to bill Part B at 85% of the physician reimbursement rate.<sup>52</sup> This failure to recognize credentialed pharmacists as midlevel providers impedes the successful implementation of collaborative treatment programs throughout the nation.<sup>53</sup>

In a 2008 survey of advanced-practice pharmacists in New Mexico and North Carolina, 82.8% of respondents indicated that their services saved their patients money, and an overwhelming 92.2% reported that their services were decreasing costs for the United States healthcare system.<sup>54</sup> The responding pharmacists estimated that their services would cost approximately sixty-nine percent more if physicians provided them.<sup>55</sup> Notwithstanding the cost-effectiveness of their services, only sixty-four percent of the respondents were able to bill for their services through their employers.<sup>56</sup> Those respondents indicated that they were primarily using Evaluation & Management codes or billing incident-to fees to generate revenue for their employers, billing an average of \$6,500 per month.<sup>57</sup> These billable fees amount to less than the average monthly salary of an advanced-practice pharmacist.<sup>58</sup> The undeniable implication is that advanced-practice pharmacists are operating at a loss.<sup>59</sup>

The survey indicated that the respondents primarily managed chronic disease states associated with limited billing opportunities, such as diabetes,

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52. Murawski, *supra* note 7, at 2342.

53. *See id.* at 2349-50.

54. *Id.* at 2346.

55. *Id.*

56. *Id.* at 2344.

57. *Id.* at 2345 (indicating that thirty-seven respondents billed through use of Evaluation & Management codes 99211, 99212, 99213, and 99213, and thirteen respondents billed for “incident-to” fees).

58. *Id.* at 2348.

59. *Id.*

coagulation or lipid disorders, hypertension, asthma, and heart failure.<sup>60</sup> With such limited opportunity to bill for their non-dispensing services, each potential chance for reimbursement is vital to the success and continuation of advanced-practice pharmacy. Despite the growing primary care gap and the effectiveness and accessibility of advanced-practice pharmacists there is still resistance to granting them provider status.

#### V. RESISTANCE TO PHARMACIST PRESCRIPTIVE AUTHORITY

In a 2011 position paper, the American Academy of Family Physicians (AAFP) took a stance against extending prescriptive authority to pharmacists.<sup>61</sup> The statement indicated that the AAFP believes that only licensed doctors should have the authority to prescribe drugs.<sup>62</sup> In a 2012 press release, AAFP Board Chair Roland Goertz expounded upon the organization's fear, explaining that allowing pharmacist prescriptive authority without physician consultation could compromise the physician's ability to coordinate the care of patients with multiple medical issues.<sup>63</sup> Certainly, practitioners must carefully monitor patients who are prescribed multiple medications to manage compound medical issues.<sup>64</sup> But pharmacists, as the direct link between the prescription and the patient, are

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60. *Id.* at 2345.

61. See *Pharmacists (Position Paper)*, AM. ACAD. OF FAM. PHYSICIANS, [hereinafter *AAFP Position Paper*], <http://www.aafp.org/about/policies/all/pharmacists.html> (last visited Sep. 29, 2013).

62. *AAFP Position Paper*, *supra* note 57.

63. Press Release, Am. Acad. of Fam. Physicians, FDA Proposal to Allow Pharmacists to Prescribe Some Drugs Sparks Swift Rebuke From AAFP (May 2, 2012) [hereinafter *AAFP Press Release*], available at <http://www.aafp.org/news-now/government-medicine/20120502pharmprescribing.html>.

64. See Mary E. Tinetti, Sidney T. Bogardus, Jr. & Joseph V. Agostini, *Potential Pitfalls of Disease-Specific Guidelines for Patients with Multiple Conditions*, 351 *NEW ENG. J. MED.* 2870, 2873 (2004), available at [http://www.drmed.org/javne\\_datoteke/novice/datoteke/444-NEJM-guidelines.pdf](http://www.drmed.org/javne_datoteke/novice/datoteke/444-NEJM-guidelines.pdf).

trained experts in drugs, and their expertise extends to the implications of interactions between multiple drugs.<sup>65</sup> Pharmacists should not work entirely independently of the patient's physician. However, with proper supervision, credentialed pharmacists, as experts in medication, should be allowed prescriptive authority.

Similar to the AAFP, the American Medical Association House of Delegates Reference Committee is concerned that allowing pharmacists to independently prescribe will fragment the management of patient care.<sup>66</sup> The Reference Committee further indicated that it believed pharmacists' education and training are not equal to that of physicians.<sup>67</sup> Certainly, it would be ill advised to suggest that advanced-practice pharmacists receive training equivalent to that of physicians. However, major patient organizations, government agencies, and pharmacy organizations all recognize the value of pharmacists playing a role in the provision of health care.<sup>68</sup> Even AAFP indicated that pharmacist-managed clinics have been successful in managing patients with chronic diseases.<sup>69</sup> It is clear that even organizations that are adverse to pharmacist prescriptive authority see the value in CDTM programs.<sup>70</sup> But until the true value of advanced-practice pharmacy is acknowledged by our national legislature, denial of provider status will continue to impede the successful implementation of

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65. See Albert, *supra* note 1, at 190; See also Carmichael & Cichowlas, *supra* note 25, at 180,186.

66. AM. MED. ASS'N. H. OF DEL., REP. OF REFERENCE COMM. B 18 (2012), available at <http://www.ama-assn.org/assets/meeting/2012a/a12-refcomm-b-report.pdf>.

67. *Id.*

68. Albert, *supra* note 1, at 212 (noting that AARP, HRSA, Walgreens, and APhA see the value in pharmacists playing a role in providing health care to patients).

69. See *id.* at 209-10.

70. See *id.* at 212.

collaborative programs.<sup>71</sup>

#### VI. CONCLUSION

Advanced-practice pharmacists should not serve as physician replacements. Rather, these professionals can enhance patient care and provide the kind of quality access to care that is declining as the primary care gap grows. As the cost-effectiveness and accessibility of advanced-practice pharmacists becomes more evident, Congress must move toward a solution to the reimbursement barrier. Recognizing advanced-practice pharmacists as midlevel providers may encourage states with CDTM programs to grant broader privileges to qualified pharmacists. Such prescriptive privileges may be the solution to the growing primary care problem.

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71. See Murawski, *supra* note 7, at 2349-50.