Community Pharmacy Services Agreement 2012

Stage 4 Feedback

Summary of Feedback

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1. **Overview of the changes proposed for the Stage 4 funding model**

The Stage 4 proposal would continue the journey that began in July 2012 to recognise that many patients with long-term conditions need significant medicine management adherence support from their pharmacy. The proposal would result in more funding shifting into the Long Terms Conditions Service, increasing from about 24% of the funding envelope in Stage 3 to about 29%.

The introduction of Case Mix Services Fees for LTC Services and Core Services presents a solution for the funding of core pharmacy activity that addresses the variations in dispensing profiles within and between community pharmacies and incentivises a “whole of patient” medicines management view.

The Case Mix Service Fee provides funding to recognise the number of patient visits per day and the number of items dispensed to that patient on that visit.

Both audit and monitoring would be enhanced during Stage 4 to ensure that frequency of dispensing continues to be aligned to the need of the patient.

2. **Consultation Process for Stage 4**

Preliminary thinking about a proposed model for Stage 4 was shared with the sector in January and February 2014 and fed into the further development of a Stage 4 funding model.

The formal consultation process on the next iteration of the Stage 4 funding model was widely promoted to the sector, with the schedule of information meetings advertised in newsletters and on the website. The high-level concepts were signalled to the community pharmacy sector in an *Implementation Update* on Thursday 15 May. The purpose of this *Update* was to provide an ‘easy to understand’ overview of the proposal in advance of the formal consultation document and legal clauses being sent to each pharmacy owner on Monday 19 May.

As required by the Transitional Change Mechanism in the CPSA, 20 working days was allowed for feedback. Pharmacists were invited to supply feedback via their Sector agent, their DHB, or directly via the CPSAConsultation@dhbss.health.nz mailbox.

To ensure wide publicity about the proposal and the opportunity to provide feedback, the Director of the Community Pharmacy Services Programme briefed journalists from Pharmacy Today who ran an article on the magazine’s website. *Implementation Updates* during the consultation period reminded pharmacists of the availability of information meetings, webinars, and resources on the website, and the deadline for submissions.

*No 7 Sources of Feedback* lists the sources of the feedback received from sector agents, those in writing from individual pharmacy owners, pharmacists or other stakeholders, or from those who attended information meetings.

3. **Analysis of feedback**

All feedback received by email was acknowledged. The common themes in the feedback provide the basis for this report, and quotes from the submissions are used to illustrate the theme.
Feedback was also gathered from those who attended the 28 information meetings held in each DHB. Programme team members or DHB Pharmacy Portfolio Managers collated the feedback after each meeting and this was sent through to DHBSS for inclusion in this document.

The themes presented in the feedback are grouped into three areas:

- Feedback on the Stage 4 proposal
- Feedback on the CPSA in general
- Issues that the sector would wish to be addressed in the CPSA 2015.

4. Feedback on the Stage 4 funding proposal

Overall, there is support for the proposed Stage 4 model and acceptance of the concept of Case Mix Service Fees. The proposal is seen as far less complex than previous stages leading to greater confidence around transparency.

Conversely, there is feedback that the proposal is perceived “as a complex reversion to funding prescriptions on a fee for service (dispensing) basis”, and a step away from the patient-centric service model that the CPSA 2012 was moving towards. One submission from a sector agent states they do not want Stage 4 to proceed and would prefer Stage 3A to be implemented. ¹

There was a similar concern expressed with Case Mix Service Fees as was expressed when the Interim Core Service Fee was introduced in Stage 3 – that the fee change would focus pharmacists’ attention on dispensing prescriptions rather than managing patients and their medicines regimen.

Some concern has also been expressed on whether there is sufficient funding to support Core service patients.

There was frustration expressed with a “one size fits all” funding model that does not recognise that the distribution of patient types is not evenly spread across DHBs, within DHBs, or within localities.

The availability of reporting tools to allow pharmacists to validate their payments was received positively.

The following quote fairly reflects the sentiment of a majority of the submissions received:

- “This stage of the contract seems to have struck a good balance between funding for dispensing and funding for other services with the amount of money in the envelope. I am excited to see the development of clinical services, LTC, MTA etc and my only hope is that the money invested in pharmacy would be sufficient to produce true quality implementation of these services and improvements while maintaining good dispensary services in the community.”

Feedback on Funding issues

Reduction in the Transition Pool from 33% to 0%

There was general acceptance that, as signalled at the beginning of the CPSA, the Transition Pool would disappear in Stage 4, reducing from about 33% to 0%. Pharmacies understood that the

¹ Stage 3a was only to be implemented should the IT not be ready in time for Stage 4. Sector agents were aware of this potential Stage. This option was ‘taken off the table’ once it was clear that the IT would be ready in time and not consulted on.
removal of the Transition Payments was the end of funding pharmacies based on their pre-CPSA level of dispensing and reduced a perceived inequality in funding.

**Concern at financial impact of Stage 4**

Many of those who provided written feedback were going to be adversely affected by the Stage 4 proposal. These pharmacies indicated acceptance of the disappearance of the Transition Pool, but said the losses they sustained in Stage 2 and 3, with the projected loss in dispensing revenue in Stage 4 was unsustainable.

These affected pharmacies were concerned that having already changed their business model, as advised in response to Stage 2 and 3, the Stage 4 proposal left them with no other option but to decrease staff numbers or increase dispensing levels to restore the previous level of funding.

One pharmacy submitted that it has already reduced its part-time pharmacist’s hours. Time gained from dispensing efficiencies had been lost in LTC Service administration.

There was also discussion at the meetings about pharmacies that either had to reduce staffing levels, or planned to reduce staffing levels to offset reduced dispensing revenue in Stage 4.

A pharmacy within a hospital environment reiterated their concerns from Stage 3 about its financial viability, as it provides services to LTC Service patients on discharge from hospital, but does not receive the LTC Service monthly fee. The pharmacy says its financial position is compounded by the patients’ cost pressures, meaning more and more patients are “cherry-picking” items from scripts, resulting in lower script numbers.

- “This new funding model further penalises a hospital-based community pharmacy by giving a decreased subsidy for non-stat repeats which is not offset by a higher initial dispensing fee.”

The pharmacy also comments that many of the items it dispenses require special authority numbers requiring extra work for the pharmacy.

**Concern at the lowering of the LTC Service fee from $30 to $20 per month**

Even the well-received increase in the LTC Service fee to $360 per annum in Stage 3 was considered by some pharmacists to be insufficient for the administrative and clinical work required. The reduction in the LTC Service fee to $240 per annum proposed for Stage 4 has multiplied those concerns about the fee being inadequate. Many respondents say the LTC Service is not sustainable at that fee level.

This concern about the fee is coupled with concern about the lack of certainty on the level of service delivery required by a pharmacy to an LTC Service patient, and this concern is exacerbated by the prospect of clinical audit around the LTC Service.

Feedback indicates a lack of nationally consistent understanding of expectations regarding the delivery of LTC Services

There was feedback querying whether the LTC Service was contributing to better health outcomes and that without any sort of evaluation the question could not be answered.
• “We write notes about the patients in the service. It doesn’t improve or change the outcome. They are getting no more care, attention or clinical advice than before LTC was invented…”

Some pharmacists felt the lowering of the fee indicated there should be less focus on the LTC Service and more focus on dispensing activity.

Other pharmacists supported the proposed $20 monthly fee as Case Mix Service Fees meant an additional $17million of the envelope would be targeted to LTC patients.

A sector agent reported that its members were evenly split on whether the monthly LTC Service fee should remain at its current level or decrease to $20.

Some submissions noted that a pharmacist should focus on other services such as CPAMS and flu vaccinations, as they provide better reward for the time spent.

Case Mix Service Fees and Relative Value Units – feedback was wide-ranging

The proposal stated that analysis during the development of the Case Mix Fee System showed that the number of initial items dispensed is a suitable proxy for the complexity of providing professional services to patients requiring multiple items and the time involved in providing services for that patient.

A small number of submissions disputed that and believe that it is not a suitable proxy and that the model is therefore flawed.

• “… it is not a good proxy in around 50% of cases, for even other markers of complexity. Much more work is required…. CPSA Stage 4 is based upon this faulty premise…”

One pharmacist believed the model should not proceed without rigorous analysis of prescription complexity.

• “The Relative Value Unit does not bear any considered relationship to the amount of work or complexity in a prescription, it is merely a budgetary device to squeeze the remuneration into the envelope.”

One submission noted that increasing the funding for multiple items on a script would increase polypharmacy.

• “This seems to be contrary to the aim of keeping the drugs budget down, reducing dispensing events and reducing complexity of the patient’s medicines regimes.”

In general, people supported the concept of RVUs as a proxy for complexity and the RVU increasing as the number of initial items on a script increased.

However, this was coupled with concern that the new model would encourage an increase in initial items, and that based on experience, prescribers could be influenced to change prescribing patterns.

Other feedback indicated that the increase in the RVU scale for initials was not great enough.

• “To be paid just 18 cents more per item for a complex prescription with 6 or more items on it does not justify the extra work needed for this type of prescription.”

There was feedback that the RVU was too low for initials with more complex scripts.
A sector agent requested that Specific Service items on a script should be included in the count of initial items and contribute to the RVU for that script. A sector agent requested that the business rules for the IT payment system be changed to allow this.

There was a lot of feedback on the RVU levels for repeat dispensings, particularly around patients on weekly or daily dispensing.

- "The dollar value for 2nd and 3rd repeat dispensings should be higher than the proposed amount ($4) although not necessarily as high as the proposed value for the initial dispensing ($5.38)."

Some feedback suggested that legitimate frequent repeats should have the same multiplier for complexity as initial dispensing did, as the patients have the same level of complexity and need.

Some were opposed to the decreasing scale for RVUs.

- "In our pharmacy the repeats for 29+ are greater than repeats 13 to 28.... The workload simply does not change from the initial dispensing to any repeat dispensing..... the reduction in RVU is seriously flawed...."

Others had a different view.

- "The RVU for dispensings /4 onwards should be higher..... it is important to still cover the actual cost of dispensing each time, although not fund it to the same amount as initial or /2 /3 dispensings."

In general, pharmacists appeared comfortable that RVUs decreased with the increase in repeat sequence numbers, and believed this would support the CPSA’s intent to reduce unnecessary repeat dispensing.

Nevertheless, there was equal feeling that pharmacists should not be financially penalised when dispensing to patients whose prescriber had requested frequent (daily or weekly) dispensing. These pharmacists felt the RVU scale for weekly repeats needed to be increased.

- "The RVU for repeats with a suffix of 13+ are too low...... the prescriber has initiated more frequent dispensing...... pharmacy should not be penalised."

One pharmacist submitted that having an RVU of 1.0 for all items without an NHI number was unfair, as pharmacists were being penalised for prescribers’ shortcomings.

**Stage 4 proposal sees increased concern about low income patients**

Pharmacists repeated concerns they raised last year that the increase in the prescription co-payment has lead to more patients being unable to collect all the items on their script at one time, and to more pharmacists having to support low-income patients by waiving some or all of the co-payment.

One written submission asked for a formal process to be developed so pharmacists in this position could apply directly and easily to Work and Income to access funding for patients’ scripts.

- "We currently are able to access some funds via our local Medical Centre, but this is not always available."
**Splitting scripts over two or more days would penalise pharmacists**

The RVU model incentivises pharmacy to dispense all initial items to the patient on the same day, and this may disadvantage pharmacies servicing lower socio-economic communities where patients are more likely to request ‘split scripts’ i.e. collect some items today and others later.

- *All this is hidden by shame as patients are reluctant to tell their GP why their medicines are continuously out of sync and creating the impression that patients are non-adherent or mismanaging their medicines Synchronisation is not possible until they become exempt due to cost. In fact a vicious cycle develops.*

Where scripts are dispensed over separate days each day will attract its own RVU scale for that patient which may be less than would have arisen had all the LTC and Core initial items been dispensed on the same day.

This issue was raised at nearly every DHB meeting, and in many of the written submissions.

**Pharmacy under pressure from rising costs – CPI sought instead of CCP**

Many pharmacists at meetings, or in written submissions, noted that pharmacy should receive an increase in line with the Consumer Price Index (CPI), rather than the Contribution to Cost Pressure (CCP) that DHBs receive.

There was strong feedback about the continued viability of community pharmacy, with increased costs from stock-holding, labour and business investment costs.

There was also a lot of feedback that CCP should be applied more widely than the Stage 4 proposal has suggested (on the base fee for LTC and Core initial items increasing it to $4.38 per item).

CCP should apply to A3 and J3 prescriptions and all Specific Services, including special foods, Class B controlled drugs, clozapine, aseptic services, ARRC, CRC and CDOS.

**Pharmacists want to surcharge patients to compensate for fixed funding envelope**

Many submissions requested that pharmacy be given the right to surcharge patients on top of the co-payment to make up for what is perceived as a shortfall in dispensing revenue due to the fixed funding envelope, or in shortfall in drug margin revenue.

- *Clearly, the DHB have defined budgets with very little room to move on allocating funding. The simplest solution would be to allow pharmacy to surcharge to recoup our losses. This would allow us to act as professionals, the patients would decide the value of our service and it would be at no additional cost to the DHB.*

**Application of Seasonality Adjuster**

There was concern that some pharmacies with unusual patient populations (possibly due to seasonality factors, such as tourist destinations, or university towns) may find their advance payment of Case Mix Service Fees does not closely anticipate their actual payments. There was a suggestion that the seasonality adjuster needs to be customised to address the extremes of seasonality experienced in certain areas.
**Suggestion that the price for the ECP Specific Service be increased**

A sector agent has requested a review of the multiplier paid (7.95) for extemporaneously compounded products. Preparation of ECPs has changed and the multiplier no longer recognises the work required.

**Concern that rising volumes would breach the funding envelope**

Some pharmacists queried whether the risk clauses in the CPSA would still apply, and whether it would be breached as the Stage 4 proposal may lead to increased volumes of repeat dispensing, or increased levels of initial items.

**Mistaken belief that free scripts for under-13 year-olds would affect envelope**

Pharmacists who had been mistakenly informed that the Government’s announcement of free prescriptions for under-13-year-olds began this year expressed concern at the meetings that this would put pressure on the CPSA funding envelope. These concerns were alleviated once pharmacists were aware of the 1 July 2015 start date.

**A3 J3 under co-payment prescriptions**

For the majority of community pharmacists there is minimal impact with A3J3 – however for a few it is significant, with $5.30 set as the cut off for professional fees. A sector agent has requested that the total base fee is $5.38.

**Oncharging**

There was a range of feedback on general aspects for oncharging including: incorrectly written prescriptions eg: missing special authority number; to address the shortfall in drug margins and to pass on costs to patients where pharmacists feel the need to dispense medication more frequently who do not meet LTC criteria.

**Call for stronger audit and more timely monitoring**

There is support for increased audit, especially on LTC Service registrations. Conversely, there is feedback that increased audit in combination with the change in the monthly LTC Service fee may be a disincentive for pharmacists delivering the LTC Service under Stage 4.

There was a strong desire for monitoring and a request for reassurance that there will be robust auditing of rates of repeat dispensing.

- “AUDIT AUDIT AUDIT those abusing the system .... We need some people to be made an example of .... we need a group with some “guts and teeth” to sort these people out once and for all.”

A sector agent requested the Dispensing Ratio Review sub-group be given a role in auditing in Stage 4.

There was concern that audit of the LTC Service should not commence until there is a clear and concise understanding of the essential requirements of the LTC Service.
Feedback on IT support/reporting/timing of payments

There was less feedback this time about system support issues than in earlier consultations.

The availability of reporting tools is felt as being a positive step forward with the ability of community pharmacy to validate themselves payments through their respective dispensary software systems.

There is a wish for the systems and processes work group to co-ordinate an overall IT strategy for end dating LTC.

Pharmacy is seeking a consolidated payment overview (one page) detailing all payments received throughout the month, individually itemized. Feedback on this issue mirrored the Stage 3 feedback.

- “Currently we extrapolate information from 8 different sources to determine the amount we are being paid for a calendar month.”

Proposed payment process accepted

There wasn’t a lot of comment about the proposed process, although some pharmacists commented that the time lag between dispensing and actual payment is too long.

- “I would really like to see a real time payment system where we are paid in full at the time, rather than a forecast payment and an adjustment months later. I realise this will take time but I would be strongly in favour of this initiative being put in place.”

One pharmacist didn’t want an estimate used to pay Case Mix Service Fees in advance.

- “I would rather see a standard amount paid every month with the adjustor having a bigger influence in the wash up after the 3 months.”

Timings and numbers of payments

The sector wants to understand why different payments happen on different days of the month.

One submission asked for payments dates to be aligned with GST reporting. Other pharmacists expressed the desire to have fewer payments per month by aligning different payment types.

Feedback on other Service delivery issues

Patient groups who require more frequent dispensing

As mentioned above in the Funding discussion, there was concern about dispensing to mental health patients whose prescriber wanted weekly dispensing for that patient.

Some patients who require frequent dispensing (e.g. patients on Diazepam weekly) do not qualify for the LTC Service but are also not on the opioid service. This group has been raised as one population that doesn’t appear to be adequately funded.

There was feedback, suggesting changes on how to manage high needs patients e.g. patients currently covered under the PHAMs service, or those receiving specific services.
Concern about dementia patients not qualifying for the LTC Service
This issue was raised in a few submissions, and at several meetings.

CRC registration process, cumbersome and difficult

- “Make the way to enrol someone in CRC (or ... CDOS...) easier. It is quite clunky the way you have to do it through the EAR.”

Co-dispensing for Opioid Service

One pharmacist requested that where a mental health patient has a dual diagnosis that includes methadone then all scripts should be paid at the methadone rate.

5. Other CPSA issues raised in feedback

The following issues are not part of the Stage 4 proposal, but were raised again during this consultation. Many of them were previously raised during the Stage 3 consultation and are addressed in the Summary and Response to Feedback on Stage 3.

Drug margins and supply chain issues raised at every meeting

The largest and most disruptive issue for pharmacy is around drug margins.

There are requests for DHB funding of the shortfall in lost margins for 2013/14 and 2014/15, or for pharmacy to have the ability to pass costs on to patients.

Despite the road-show presentation outlining the activity currently underway to address the drug margin issue, pharmacists’ feedback indicates that this issue is not being addressed quickly enough.

The level of the co-payment

- If the focus is truly on the patient, rather than the medicines item as the new PSA purports, then the issues around patient co-payments and its effect on medicines access becomes integral to the effectiveness of the PSA and our financial viability.

18 months review has not been done

There was concern that the 18-month review has not been completed and a call for this to be done immediately so it can inform the development of CPSA 2015.

Quality payment

There was concern that the there is still no description of what “quality” services would look like or a mechanism for rewarding those who deliver these.

IT connectivity fee

Some DHBs pay pharmacy a fee to facilitate electronic claiming. There was a call for this payment to be applied nationally.
Dispensing efficiencies

There was a call for a concerted effort to create efficiency within the sector. Examples given were modernising the recording of controlled drugs, and flexibility around packaging in PHARMAC’s tendering process.

Request for a shared care platform

- The other essential service ... is... a robust and user-friendly e-Shared Care platform. Without this level of technology the desired outcomes will not be achieved.

Stock issues, pack size and wastage

- “I believe there is a need to move towards standardisation of dispensing packs, which will allow for freeing up of pharmacy time. Packs of 28, 30, 50, 84, 90, 100 is very inconsistent. The period of supply needs to be defined in weeks not months with 28 and 84 as the default monthly supply.”

Some pharmacists submitted that stock losses have to be addressed with a longer time allowed to use up stock.

- “I am often left with broken packs of medicine that expire on the shelf and is a huge cost to me.”

CPAMS – INR fee

The Community Pharmacy Anti-Coagulation Management Service (CPAMS) continues to be supported strongly as a service that builds good inter-disciplinary relationships and delivers good patients outcomes, however there is a request for increased funding to address increases in online supply costs.

National consistency wanted in level of Part P funding across all DHBs

A sector agent requested that a register be kept of all Part P arrangements between all DHBs and pharmacy, with a view to ensuring consistency of funding.

Consistency and alignment of PHARMAC decisions

Feedback on the impact of PHARMAC decisions on pharmacy featured strongly in some of the consultation responses, including the impact of PHARMAC on drug margins.

Better IT systems and support

Feedback indicated that the lack of IT infrastructure is not supportive of implementing the CPSA and adds time and cost to pharmacy in delivering services under the current IT capability.

6. The development of the next CPSA

It was noted that the implementation of Stage 4 would set the base for CPSA2015 and requires investment by DHBs for Stage 4 and community pharmacy to be successful.

There was robust discussion at the meetings, and some written feedback on issues that should be looked at or addressed in the next CPSA. This included:

- Confirmation from DHBs regarding their ongoing commitment to the patient-centric care model, in a cleaner and clearer way that is sustainable for both DHBs and pharmacy.
- Agreement on a funding model, e.g. envelope, bulk funding, fee for service.
- Ensure learnings are captured from the current CPSA and fed into the development of the next CPSA.
- Alignment of the CPSA with other wider health sector strategies and targets.
- Wider terms of reference for the Governance Group so it has a mandate to integrate pharmacy into primary and secondary health care.
- IT infrastructure needs to be in place to support pharmacy-moving forwards, particularly in terms of payment systems and tools to support the delivery of patient-centric services. The management of A3J3 needs to be addressed for the future CPSA.
- Significant improvements in dispensing efficiencies.
- A solution to the drug margin issue.
- Agree the scope for enhanced services, e.g. CPAMs.
- Consideration of taking a service based approach allocating an annual budget, with a transition period enabling capacity building and change management.

7. **Sources of feedback**

Feedback was received from the following sector agents:

- Pharmacy Guild of New Zealand
- Green Cross Health (formerly Pharmacy Brands)
- PharmacyPartners

**Individual feedback** was emailed in from about 40 pharmacy owners or pharmacists

Some 450 pharmacists and pharmacy owners attended the 28 information meetings held between 19 May and 12 June 2014. Viewpoints expressed at the meetings were collated by the DHBs and DHBSS and is included in this summary of feedback.

Feedback was also received from one vendor and one wholesaler.

Two interactive webinars were held to explain the proposal. Some 26 people participated or viewed the first webinar on 22 May and another 31 participated on 16 June.