# Pharmacist Providers

Expanding access to healthcare in Nevada utilizing an existing resource

## Introduction

The passage of SB260 in the 2017 Legislature opened the door to potentially expand access to healthcare in Nevada by utilizing pharmacists working under collaborative practice agreements. SB260 provides the framework to allow collaborative pharmacy practice to occur in any setting in our State including community pharmacies, Federally Qualified Health Centers (FQHCs), or any other ambulatory practice setting.

Pharmacists co-managing patient's chronic disease states through collaborative drug therapy management (CDTM) have demonstrated improved outcomes in a variety of disease states including high blood pressure[1], high cholesterol[2], and diabetes[3]. Pharmacists also have a unique knowledge base among healthcare providers to identify and resolve issues with polypharmacy (i.e. use of > 5 medications)[4].

States that have implemented payment for pharmacist professional services have demonstrated a positive return on investment (ROI). CareSource, a Medicaid managed care plan in Ohio reported a **$4.40 to $1 ROI** for total healthcare expenditures after beginning to pay for pharmacist MTM services.[5]

Currently pharmacists are not a provider type under Nevada Medicaid. As such, billing for clinical services like CDTM is limited to "incident to" utilizing the CPT code 99211. Reimbursement utilizing this code does not cover the salary costs of a pharmacist. Given the current reimbursement structure, organizations employing pharmacists in Nevada are hesitant to implement new CDTM programs. In order to effectively expand care utilizing pharmacists for CDTM a new provider type would need to be created to allow pharmacists access to bill Medicaid an expanded list of CPT codes.

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[1] Victor RG, Lynch K, Li, N, et al. A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops. NEJM 2018. http://www.nejm.org/doi/full/10.1056/NEJMoa1717250

[2] Lowrie R, Lloyd SM, McConnachie A, et al. A cluster randomised controlled trial of a pharmacist-led collaborative intervention to improve statin prescribing and attainment of cholesterol targets in primary care. PLoS One. 2014 Nov 18;9(11):e113370.

[3] Wassell K, Sullivan J, Jett BP, et al. Comparison of clinical pharmacy specialists and primary care physicians in treatment of type 2 diabetes mellitus in rural Veterans Affairs facilities. Am J Health Syst Pharm. 2018 Mar 1;75(5 Supplement 1):S6-S12.

[4] Schwartz EJ, Turgeon J, Patel J, et al. Implementation of a Standardized Medication Therapy Management Plus Approach Within Primary Care. J Am Board Fam Med. 2017;30(6):701-714.

[5] https://www.nga.org/files/live/sites/NGA/files/pdf/2015/1501TheExpandingRoleOfPharmacists.pdf

**What CPT/HCPCS Codes do pharmacists anticipate billing?[6]**

The following types of codes are likely to be used when billing for medical services.

Note: this is not an exhaustive list, other codes may be billed.

| **CPT / HCPCS Code Types** |
|---|
| E&M Codes |
| MTM Codes |
| Medication/Vaccination Codes |
| Lab Test Codes |
| Diabetes Mellitus Self Management Code |
| Potential Harm Reduction |

• *E&M Codes:* Evaluation and Management Services describe provider-patient encounters that vary based on complexity of care, level of service etc., regardless of whether these services are provided in the provider's office, hospital, or in the patient's home. These codes can cover a variety of services including Complex Chronic Care Coordination, Alcohol and Substance Abuse, Preventive Medicine Counseling, etc. Code assignment should be based on documentation present in the medical record.

• *MTM Codes:* Medication Therapy Management Services describe face-to-face patient assessment and intervention by a provider. These services, initiated by request of a physician, are designed to optimize response to medication or to manage treatment related medication interactions or complications. Uses of these codes are NOT intended for services associated with routine dispensing.

• *Medication/Vaccination Codes*: Vaccines and other drugs administered by a pharmacist. **Note:** Use of these codes and medical billing is not appropriate for administration/dispensing that is covered under a patient's pharmacy-drug benefit

• *Lab Test Codes:* Lab testing pursuant to drug therapy management or assessment of adverse effects.

• *Diabetes Mellitus (DM) Self-management education*: This may include Blood Glucose (BG) meter training, use of meter in overall DM management, counseling, etc. It would not take the place of the typical counseling/set-up requirement for BG meters and would likely require fairly significant documentation.

[6] http://c.ymcdn.com/sites/www.wsparx.org/resource/resmgr/Providers/5557_FAQ.pdf

• *Potential Harm Reduction:* This includes individual and group class billing (such as Tobacco cessation)

**Should all Nevada Pharmacists be eligible to bill as individual providers?**

Nevada Medicaid will need to establish credentialing criteria for pharmacist providers. An example of credentialing criteria could be:

| |
|---|
| Have a Nevada State Board of Pharmacy approved collaborative practice agreement AND |
| Complete an American Society of Health System Pharmacists (ASHP) Post-Graduate Year 1 residency<br>AND/OR<br>Earn certification in a relevant area of practice, including, but not limited to, ambulatory care, cardiology, critical care, geriatrics, nuclear pharmacy, nutrition support, oncology pharmacy, pediatrics, pharmacotherapy, or psychiatric pharmacy, from the Board of Pharmacy Specialties (BPS) |

**Are other states paying for pharmacists as providers?[7]**

Payment for pharmacy services within state Medicaid or employee programs varies state to state. Within the 16 states that provide Medicaid compensation for direct patient care by pharmacists (see tables on next page), the most commonly reimbursed services include smoking cessation, counseling, and other types of preventative services. As of March 2018, ten states provide Medicaid compensation for MTM services: **California, Colorado, Iowa, Minnesota, Mississippi, Missouri, New Mexico, Oregon, Texas, and Wisconsin**. Although the Ohio Medicaid program does not directly reimburse MTM services, Ohio's largest Medicaid managed care organization, CareSource, covers MTM for all of its members. Similarly, some managed care organizations in Louisiana provide reimbursement for MTM services.[8] In addition, **Kentucky**, **Maryland**, **Minnesota**, **North Dakota**, and **Virginia** provide compensation for MTM services under their state employee health programs.

[7] https://www.nga.org/files/live/sites/NGA/files/pdf/2015/1501TheExpandingRoleOfPharmacists.pdf

[8] L Parker. Pharmacist Provider Status Questionnaire. Department of Vermont Health Access.

| Summary of Pharmacist State Payment Variation | |
|---|---|
| **Compensation** | **Total States with Language in Statute** |
| Medicaid payment for professional services | 16 |
| Medicaid MTM benefit | 10 |
| State employee MTM benefit | 5 |

Summary of State by State Medicaid Compensation[9]

| State | Professional Services | MTM or Another Comprehensive Service |
|---|---|---|
| Alabama | | |
| Alaska | X | |
| Arizona | | |
| California[10] | X | X |
| Colorado | X | X |
| Connecticut | | |
| Delaware | | |
| Florida | | |
| Georgia | | |
| Hawaii | | |
| Idaho | | |
| Illinois | | |
| Indiana | X | |
| Iowa | X | X |
| Kansas | | |
| Kentucky | | |
| Louisiana[11] | | * |
| Maine | | |

[9] https://www.nga.org/files/live/sites/NGA/files/pdf/2015/1501TheExpandingRoleOfPharmacists.pdf
[10] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1114
[11] L Parker. Pharmacist Provider Status Questionnaire. Department of Vermont Health Access.

| | | |
|---|---|---|
| Maryland | | |
| Massachusetts | | |
| Michigan | | |
| Minnesota | X | X |
| Mississippi | X | X |
| Missouri | X | X |
| Montana | X | |
| Nebraska | X | |
| Nevada | | |
| New Hampshire | | |
| New Jersey | | |
| New Mexico | X | X |
| New York | | |
| North Carolina | | |
| North Dakota | X | |
| Ohio | | * |
| Oklahoma | | |
| Oregon | X | X |
| Pennsylvania | | |
| Rhode Island | | |
| South Carolina | | |
| South Dakota | | |
| Tennessee[12] | + | + |
| Texas | X | X |
| Utah | X | |
| Vermont | | |
| Virginia | | |
| Washington[13] | + | + |
| West Virginia | | |
| Wisconsin | X | X |
| Wyoming | | |

*Reimbursement indirectly through managed care organizations

+ State laws mandating commercial insurance coverage of pharmacist professional services but does not require coverage by FFS Medicaid

•Professional services provided by a pharmacist, although not exhaustive, includes CDTM, MTM, smoking cessation, and administration of immunizations and other injectable medications.

[12] http://publications.tnsosfiles.com/acts/110/pub/pc0082.pdf

[13] http://www.wsparx.org/?page=ProviderStatus

**What would be an adequate rate of reimbursement to cover the costs of a pharmacist?**

The average hourly wage of a pharmacist in Nevada in 2016 was $60.90.[14] Adjusting for benefits the average hourly cost of a pharmacist is (60.90 x 1.18) = $71.86.

Reimbursement for pharmacist services at 85% of the fee schedule for physician services would be adequate to cover the cost of a pharmacist.

[14] U.S. Bureau of Labor Statistics, 2016. https://www.bls.gov/