Pharmacist Provider Status in 11 State Health Programs

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A major priority for the American Society of Health-System Pharmacists (ASHP) is to foster expanded patient access to the clinical services of pharmacists. One of the most important tactics for achieving this objective is to obtain, incrementally, payer-specific provider status for pharmacists. ASHP and other pharmacist associations are seeking to amend the Social Security Act to list pharmacists among the federally recognized providers who may bill Medicare Part B for patient care services. After Medicare Part B provider status is achieved for pharmacists, it is very likely that most payers, over time, would follow suit. However, it is not necessary to wait for this federal legislative breakthrough in order to make progress with other payers, such as state Medicaid programs. Pharmacists already have provider status in a growing number of programs, which eventually may lead to universal provider recognition.

For the purposes of this paper, "pharmacist provider status" means that pharmacists are compensated directly by a third-party payer for providing medication therapy management (MTM) services. (Eleven national pharmacy organizations have developed a consensus definition of MTM services.) Pharmacists have this status in a number of state programs, many of which function within Medicaid. The purpose of this paper is to analyze several of these state programs to identify lessons that may be learned as ASHP and others seek to expand pharmacist provider recognition by third-party payers. (The process that pharmacy organizations used to redefine pharmacist scope of practice to include collaborative drug therapy management may also offer lessons related to achieving provider status.)

Incremental provider status recognition for pharmacists may eventually lead to broader federal recognition. Legislation has been introduced in the past to achieve such recognition. For example, the Medicare Clinical Pharmacist Practitioner Services Act of 2008, introduced April 14, 2008, would allow pharmacists to bill under Medicare Part B for direct patient care services they are authorized by states to perform under a collaborative practice agreement. Many health professionals other than physicians have provider status under Medicare Part B (physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dieticians or nutrition professionals). The process that nurse practitioners used to achieve federal provider status has been reported in detail. Notably, private payers followed the federal lead in recognizing nurse practitioners as providers.

Pathways to Pharmacist Provider Status under State Programs

We reviewed 11 programs in nine states – Florida, Iowa, Minnesota, Mississippi, Montana, North Carolina, Ohio, Vermont, and Wyoming – and discovered that states took various paths to provide MTM services to certain patients (Clark JP, Mississippi Division of Medicaid, personal communication, 2008 April 9; Nichola, Ohio Department of Health Bureau for Children with Medical Handicaps, personal communication, 2008 May 14; Hanus P, Molina Healthcare, personal communication, 2008 May 27; Moff R, Vermont Department of Disabilities Aging and Independ-
ent Living, personal communication 2008, April 18). Montana’s program is not yet operating (Citron R, Montana Department of Public Health and Human Services, personal communication, 2008 March 12).

This paper describes the various ways that the selected state MTM programs are tapping into pharmacists’ clinical skills to improve patient outcomes. Most of the programs we reviewed are state Medicaid programs, with the exception of Ohio’s Medication Therapy Management Services (MTMS) program operated by the state Department of Health’s Bureau for Children with Medical Handicaps (BCMH) (Nichol A, 2008 May 14). MTMS is included in this paper because it is otherwise comparable to the state Medicaid MTM programs we examined.

We included in this paper programs of which we were aware and for which we were able to contact individuals responsible for managing those programs. This paper is not intended to include all pharmacist-based MTM programs nor is it necessarily representative of the full array of approaches that have been used to achieve pharmacist provider status. Instead, this evaluation of 11 programs shows how selected states are experimenting with paying pharmacists to manage patients’ drug therapy. Many studies have documented the benefits of pharmacist MTM services.14,22

**State MTM Programs**

The 11 programs reviewed (see Appendix) take various approaches to how programs are managed; how bills for services are processed; who is eligible to receive pharmacists’ services; the number of individuals served; and how much a pharmacist or pharmacy is reimbursed for clinical services provided. One state, Vermont, uses a third party to contract for pharmacists’ services under a pilot program (Moff R).

At the same time, many of the programs share key characteristics. For example, most of them are pharmacist-based (meaning the pharmacists providing the clinical services are enrolled in the programs and directly receive payment for services), rely on Current Procedural Terminology (CPT) codes or a system based on CPT codes for billing, and were created with the active involvement of a school of pharmacy’s faculty.

**Program Creation and Management**

Most of the programs we reviewed are codified under state statutes. The type of legislation most of the states used to do

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**Steps to Creating a Pharmacist-led MTM State Health Program**

- Review existing programs to determine what may work in your state.
- Understand your state’s appropriations process. Many Medicaid MTM programs are authorized through appropriations bills.
- Create a team of pharmacists, pharmacy faculty, state pharmacist organization leaders, and others who will work for several years to create a program.
- Establish relationships with other healthcare provider associations to determine their level of support.

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this was an appropriations bill. Some of the bills authorizing the programs also required the submission of a report detailing the program’s effectiveness. Vermont’s Medication Assistance pilot program is an exception; it was developed after the state’s experience under a Medicaid waiver and is not codified under state statute (Moff R). Ohio’s programs were made possible by a change in the Ohio Administrative Code that recognized pharmacists as eligible providers whose services can be requested by a child’s managing physician under the Program for Medically Handicapped Children.9

In six states – Iowa, Minnesota, Mississippi, Montana, Ohio, and Wyoming – school of pharmacy faculty members played a lead role in establishing the programs34 (Kuhle J, Iowa Foundation for Medical Care, personal communication, 2008 February 11; Iseits Bj, University of Minnesota College of Pharmacy, personal communication, 2008 February 11; Nichol A, Ohio Department of Health Bureau for Children with Medical Handicaps, personal communication, 2008 May 14; Citron R; Clark JP, 2008 April 9). AARP supported the establishment of Wyoming’s and Montana’s PharmAssist programs45 (Citron R).

Three states – Florida, Montana, and Vermont – solely use third parties to manage their MTM programs (Kuhle J; Citron R; Moff R). North Carolina’s Division of Medical Assistance manages the Focused Risk Management (FORM) program and receives assistance from the state’s Medicaid fiscal agent.39 The Iowa Foundation for Medical Care administers pharmacy registration into that state’s program, but billing is handled directly by the Iowa Department of Human Services Medicaid program (Kuhle J). Minnesota’s Depart-
PAments of Human Services processes fee-for-service patients and uses third-party payers for participants in pre-paid health plans (Islets B). Ohio's RxEaze pilot program is operated by Molina Healthcare, Inc. (Hanus P). However, Ohio's MTMS program is operated by BCMH (Nichol A, 2008 May 14). Wyoming's Department of Health's Office of Pharmacy Affairs manages its program.25

Patients Served

Of the programs we reviewed, the number of patients served varies widely by program. North Carolina's FORM program serves between 7,000 and 8,000 patients monthly who move in and out of the program throughout the year (Weeks L, North Carolina Department of Health and Human Services Division of Medical Assistance, personal communication, 2008 March 25). Ohio's MTMS program has approximately 1,500 eligible participants with either asthma or diabetes, although it is unknown how many participants receive services through the program (Nichol A, 2008 May 27). Among the other three programs for which we were able to obtain information regarding the number of patients served, most programs served few individuals. Minnesota's program served 259 in its first year.26 Wyoming's program served 50 patients over a two-year period (Artery DL, Wyoming State Department of Health Office of Pharmacy Services, personal communication, 2008 Jan. 8). Mississippi's program served 24 patients in fiscal year 2007 (Clark JP). Vermont's Medication Assistance pilot program will serve senior citizens and individuals with disabilities living in five unlicensed supportive housing sites (Moff R). Montana's program, which has not begun operation, is expected to serve 50 to 100 patients per month (Citron R). Ohio's RxEaze pilot program will have 200 patients in the experimental group (Hanus P).

Most of the programs restrict which patients can participate by the number of medications they take or by the number of medications patients take together with the number of chronic conditions they have. For example, North Carolina's FORM program accepts patients taking more than 11 medications each month.24 Minnesota's Medication Therapy Management Care program accepts patients who are taking four or more medications and have two or more chronic conditions.26 Ohio's RxEaze pilot program requires participating patients to be taking five or more chronic medications and prohibits patients with behavioral health issues from participating (Hanus P).

However, not all of the programs examined restrict patient participation. Ohio's MTMS program does not restrict a pa-

tient from participating based on the number of medications a patient is taking (Nichol A, 2008 May 14). Florida's two programs are available to all Medicaid patients. All Montana citizens are expected to be able to participate in its PharmAssist program (Citron R). Vermont's pilot program is available to any resident of the targeted housing sites (Moff R).

Reimbursement

Reimbursement in eight of the nine states (see Table) is either solely pharmacist based (Iowa, Mississippi, Montana, Ohio, Vermont, and Wyoming) or is pharmacist based and also involved the pharmacies in which those pharmacists practice (Florida and Minnesota).25,27 (Islets B; Citron R; Nichol A; Hanus P; Moff R; Kuhle J). Only North Carolina's FORM program is solely pharmacy based, with pharmacy providers receiving a professional service fee per patient per quarter.21

Payment for clinical services ranges widely among the programs reviewed. Three state programs—Indiana, Montana, and Wyoming—offer flat fees for a pharmacist's initial consultation with a patient and for follow-up assessments (Kuhle J; Citron R; Artery DL). Fees paid for an initial assessment range from $350 in Indiana to $150 in Wisconsin and Montana (Citron R; Artery DL). Follow-up assessments can range from $25 to $75 for an annual consultation in Indiana (Citron R).

Other states' programs establish the pharmacist's fee according to the types of services provided or according to a more complex combination of the number of medications being taken, the number of drug therapy problems, the complexity of a patient's care, and the amount of time a pharmacist spends with the patient.

For example, under Minnesota's program, a pharmacist is paid $52 for providing MTM services for a new patient who is taking one medication and has one medical condition for which the pharmacist does not identify any drug therapy problems.28 In another example for a more medically complicated patient, a pharmacist under this program is paid $148 for providing MTM services for a new patient taking nine or more medications who has four or more medical conditions for whom the pharmacist identifies at least four drug therapy problems.

Florida's programs reimburse pharmacies according to the types of services provided, such as a comprehensive medication review and prescriber consultation (Kuhle J). North Carolina meanwhile pays up to $30 per quarter per patient to one pharmacy.21 Mississippi allows pharmacists to bill for pre-
ventive medicine counseling, for which they are paid $20 for a 30-minute session.\(^\text{27}\) Ohio’s two programs pay $52.57 for the first 15 minutes of an initial patient encounter, $34.35 for each subsequent encounter, and $24.74 for each additional 15 minutes with a patient (Nichola A, 2008 May 14; Hanus P).

Under Vermont’s pilot program, two pharmacists are under contract to conduct brown bag checkups of the medications and over-the-counter products individuals living in the targeted sites are taking (Moffit R). The pharmacists also will educate individuals on how to safely and effectively use their medications.

How pharmacists and pharmacies bill for clinical services varies as well, although most use CPT codes or codes based on CPT codes, with the exception of Iowa, North Carolina and Vermont\(^\text{24}\) (Kuhle J; Citron R; Artery DL; Moffit R; Hanus P; Nichola A, 2008 May 14).

Results of Programs

We obtained information on the results of Minnesota’s Medication Therapy Management Care program and Iowa’s Pharmaceutical Case Management (PCM) program. A North

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<th>State MTM Program Billing, Payment Systems</th>
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<tr>
<td><strong>Pharmaceutical Case Management (IA)</strong></td>
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<td><strong>Quality Related Events Program (FL)</strong></td>
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<tr>
<td><strong>Medicaid Drug Therapy Management Program for Behavioral Health (FL)</strong></td>
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<tr>
<td><strong>Medication Therapy Management Care (MN)</strong></td>
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<td><strong>Pharmacy Disease Management (MS)</strong></td>
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<td><strong>Montana PharmAssist</strong></td>
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<td><strong>Focused Risk Management (NC)</strong></td>
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<td><strong>Medication Therapy Management Services (OH)</strong></td>
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<td><strong>RxEaze (OH)</strong></td>
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<td><strong>Medication Assistance (VT)</strong></td>
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<td><strong>Wyoming Pharm Assist</strong></td>
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Carolina official advised that a study of FORM’s results is underway. We were not able to obtain information on the results of the remaining six states’ programs.

In the first year of Minnesota’s program (April 1, 2006 to March 31, 2007) 34 pharmacists provided MTM services to 259 patients and resolved 789 drug therapy problems, 3.1 per patient. Collectively, pharmacists were paid $39,866 to provide these MTM services.

An evaluation of Iowa’s PCM published in December 2002 reported that pharmacists met with 943 patients, sending recommendations to physicians for 500 of these patients and detecting an average of 2.6 medication-related problems per patient. For 52% of patients, pharmacists recommended to physicians that the patient start a new medication. One-third of the time, pharmacists recommended a patient discontinue taking a medication.

During Iowa’s state fiscal years 2002-2005, $254,797 was paid for PCM services, 94.9% of which ($241,784) was paid to pharmacists. The remaining $13,013 was paid to physicians.

Results of Vermont’s 12-week pilot program are expected to lead to the development of a training model and plan for long-term implementation of the program (Moffit R).

**Conclusion**

Pharmacists in the 11 programs we analyzed in nine states are recognized officially as MTM providers and are demonstrating their ability to deliver MTM services. In return, these pharmacists are being reimbursed for the clinical services they provide. Receiving payment for their MTM services is not only important for pharmacists financially; it is also important recognition by state officials that the work pharmacists do in helping patients manage their medications is a critical contribution to patients’ health.

Individual health-system pharmacists or state pharmacists’ organization interested in pursuing provider status recognition within a state health program can look to these models for guidance. An important first step in the process of pursuing pharmacist provider status in a state health program is to understand the state’s appropriations process, as most of these programs were authorized through appropriations bills. Another key step would be to establish a team comprised of practitioners from the state’s college of pharmacy, leaders of pharmacist state organizations, and other dedicated individuals who are willing to persistently advocate for the development of such a program for several years. In addition, establishing relationships with the associations of other healthcare providers will be important for MTM program advocates to gauge the level of support that could be garnered from these groups.

Paying pharmacists for clinical services is not only very important to pharmacists; doing so also could encourage hospitals and health systems to expand ambulatory clinical services, thereby helping more patients and continuing to demonstrate pharmacists’ skills in improving patient outcomes.

An important tactic for the expansion of patient access to the clinical services of pharmacists is to incrementally add to the growing list of health programs and third-party payers that compensate pharmacists for such services. The experience in creating and administering the 11 state programs reported in this paper should be useful to pharmacists who seek to establish similar programs in other states.

Information regarding pharmacist-led MTM programs may be submitted to Lisa Daigle, policy analyst, at ldaigle@ashp.org.

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Appendix

Iowa

Pharmaceutical Case Management

DESCRIPTION: Medicaid patients with multiple disease states receive a drug regimen review by pharmacists and physicians to determine appropriate drug therapy.

YEAR STARTED: 2000

PATIENT MEDICAL REQUIREMENTS: More than four medications; at least one chronic condition.

PHARMACIST CREDENTIAL REQUIREMENTS: Pharm.D, complete the Iowa Center for Pharmaceutical Care training program, or complete another similar program.

NUMBER OF PATIENTS SERVED: 943 patients in its first year.

LONGEVITY OF PROGRAM: This a permanent program codified under state statute.

ADMINISTERING ENTITY: The Iowa Foundation for Medical Care administers pharmacy registration. Medicaid is directly billed for services.

Minnesota

Medication Therapy Management Care

DESCRIPTION: Medication therapy management services are provided to residents receiving Medicaid, low-income residents receiving General Assistance Medical Care, and residents receiving publicly subsidized health care coverage through MinnesotaCare.

YEAR STARTED: 2006

PATIENT MEDICAL REQUIREMENTS: Four or more medications; two or more chronic conditions.

PHARMACIST CREDENTIAL REQUIREMENTS: Pharm.D. awarded after May 1996 or pass an approved Accreditation Council of Pharmacy Education program.

NUMBER OF PATIENTS SERVED: 259 patients in its first year.

LONGEVITY OF PROGRAM: This a permanent program codified under state statute.

ADMINISTERING ENTITY: MN Department of Human Services administers the program and is billed for fee-for-service patients. All other third-party payers for pre-paid health plans are billed directly.

Florida

Quality Related Events Program

DESCRIPTION: Fee-for-service, ambulatory Medicaid patients receive medication therapy management services from pharmacists. Services include an annual medication check-up, patient education, compliance monitoring, and assistance with non-prescription medications.

YEAR STARTED: 2007 re-launched.

PATIENT MEDICAL REQUIREMENTS: None.

PHARMACIST CREDENTIAL REQUIREMENTS: Completion of Outcomes Personal Pharmacist Training program is required.

NUMBER OF PATIENTS SERVED: Not available.

LONGEVITY OF PROGRAM: This is a permanent program codified under state statute.

ADMINISTERING ENTITY: Outcomes Pharmaceutical Health Care.

Mississippi

Pharmacy Disease Management

DESCRIPTION: Medicaid patients receive drug therapy reviews, with a physician consult, and counseling by pharmacists.

YEAR STARTED: 1998

PATIENT MEDICAL REQUIREMENTS: Hypertension, asthma, diabetes, or hyperlipidemia.

PHARMACIST CREDENTIAL REQUIREMENTS: Certification by the National Institute for Standards in Pharmacist Credentialing is required in the disease management areas for which reimbursement is sought.

NUMBER OF PATIENTS SERVED: 22 patients in state fiscal year 2007.

LONGEVITY OF PROGRAM: This is a permanent program.

ADMINISTERING ENTITY: State Division of Medicaid administers the program and is billed for services.

Montana

Montana PharmAssist

DESCRIPTION: Residents will be advised on prescription drug use and how to access government and private prescription drug programs and discounts. Pharmacists will consult with patients on drug safety and substituting cost-effective drugs.

YEAR STARTED: Not implemented.

PATIENT MEDICAL REQUIREMENTS: Four or more medications; a chronic disease; or the opportunity to benefit from the program.

PHARMACIST CREDENTIAL REQUIREMENTS: Completion of a six-hour Montana PharmAssist Training Program by the University of Montana Skaggs School of Pharmacy is required.
ASHP Policy Analysis

NUMBER OF PATIENTS SERVED: An estimated 50 to 100 patients to be served each month.

LONGEVITY OF PROGRAM: This is a permanent program codified under state statute.

ADMINISTERING ENTITY: Mountain-Pacific Quality Health Foundation will review patient applications and coordinate pharmacist-patient counseling sessions.

North Carolina

Focused Risk Management (FORM)
DESCRIPTION: Pharmacy providers review patients' medications, review the appropriateness of the medications, identify potential adverse drug events, and improve the patients' compliance to an individual treatment plan. FORM replaces the Medication Therapy Management Program.

YEAR STARTED: FORM was established in 2007.

PATIENT MEDICAL REQUIREMENTS: More than 11 medications per month.

PHARMACIST CREDENTIAL REQUIREMENTS: None.

NUMBER OF PATIENTS SERVED: Between 7,000 and 8,000 patients are served each month. The majority of patients move in and out of the program throughout the year.

LONGEVITY OF PROGRAM: This is a permanent program with the authority to pay for enhanced pharmacy services codified under state statute.

ADMINISTERING ENTITY: North Carolina's Division of Medical Assistance manages the FORM program and receives assistance from the state's Medicaid fiscal agent.

Medication Assistance
DESCRIPTION: Pharmacists provide medication therapy management services to targeted individuals to help them to continue living independently and delay them from entering managed care.

YEAR STARTED: 2008

PATIENT MEDICAL REQUIREMENTS: Senior citizens and individuals with disabilities living in five unlicensed supportive housing sites.

PHARMACIST CREDENTIAL REQUIREMENTS: None.

NUMBER OF PATIENTS SERVED: Undetermined.

LONGEVITY OF PROGRAM: Pilot program with the potential to become permanent; outcome of the Real Choices Supportive Housing Grant (CMS Medicaid waiver).

ADMINISTERING ENTITY: JSI Research and Training Institute

Wyoming

Wyoming Pharm Assist
DESCRIPTION: Pharmacists provide medication consultation with any state citizen, making recommendations to avoid drug interactions and cost-effective drug substitutions.

YEAR STARTED: 2003

PATIENT MEDICAL REQUIREMENTS: None.

PHARMACIST CREDENTIAL REQUIREMENTS: None.

NUMBER OF PATIENTS SERVED: 50 in two years as of January 2008.

LONGEVITY OF PROGRAM: Permanent program codified in state statute.

ADMINISTERING ENTITY: Wyoming Department of Health Office of Pharmacy Affairs

RxEaze
DESCRIPTION: Pharmacists provide polypharmacy medication therapy management services to Medicaid patients. Pain management also is provided.

YEAR STARTED: 2008

PATIENT MEDICAL REQUIREMENTS: Five or more medications to treat chronic diseases such as asthma, cardiovascular disease, and diabetes. Patients taking medications for behavioral health issues are excluded.
References

5. 42 U.S.C. 1842b.
11. Mt. 2005 Chapter 85.
13. Wy. 2003 W.S. 9-12-123.