Provider Status & Practice Scope for Pharmacists: Extraordinarily complex issues
So what’s the fuss?

• What is it about Provider Status that makes it the Holy Grail of Pharmacy’s comeback?
• Why is it such a fight to obtain provider status- or, to put it differently, why DON’T we have provider status?
• What would the consequences be if we DID have provider status?
• And what, ultimately, does PS mean to me (or you) as a pharmacist?
• Perhaps it is best to keep PS in perspective by considering the Holy Grail.
The Holy Grail

• Despite people’s firm convictions to the contrary, the Holy Grail doesn't appear in the bible. It is NOT the cup Jesus drank from, DESPITE what Indiana Jones may have told you.

• The HG is a literary contrivance. In the “Ur-Text” for the HG (13th century), it seems to be some sort of nice platter for holding fish for “the Fisher King” that was paraded along with his many other rare and wonderful possessions- it took later authors to associate the concept with the Messiah.

• Provider status, while not total fiction like the HG, definitely functions in some ways as a kind of a plot device, as important for its symbolic importance as what it actually is.
Provider Status- multiple meanings and uses

• Part of the problem is the multitude of possible ways in which the concept of PS functions.
• It can be considered a noun, a verb, a definition, a status, a designation, and a legal entity.
• It means different things to different people, and implies different consequences to different groups and organizations.
• And, quite frankly, almost everyone thinks it means the same thing to everyone else that it means to them.
First of all, you already have provider status

- Under Medicare Part ‘D”, pharmacists were given provider status for MTM services
- MTMS services: review patient history, medication profile (Rx & OTC), recommendations for improving health outcomes and treatment compliance.
- Billing codes are **not** to be used for product-specific information at the point of dispensing or any other routine dispensing-related activities.
Part D codes

- 99605: MTMS provided by RPh face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient
- 99606: initial 15 minutes, established patient
- 99607: each additional 15 minutes (List in addition to code for the primary service)
  
- 99607 only in conjunction with 99605, 99606
Rationale

• 99605, 99606, and 99607 and guidelines have been established to report the provision of medication therapy management services (MTMS). These services are provided by a pharmacist to optimize the response to medications or for the management of treatment-related medication problems or complications. MTM services are initiated at the request of the patient and/or caregiver, payer, pharmacist and/or other healthcare provider.
So there, right?

• But no- initiated at the request of the patient and/or caregiver, payer, pharmacist and/or other healthcare provider.
• Some HC systems only do MTMS in-house
• Some don’t pay for it
• Have to get a contract with organization that wants to pay you for it.
• Finding the payer is the problem
There are a few examples, mostly state programs

• See reading on “RPH provider status in 11 state programs”

• While slightly dated, you can see some evidence for billing under these codes and the reimbursement rates

• From $10 to a $125; a limited number of states and opportunities.
So if we can get state provider status, we’re OK, right?

- Check out the reading from the California PA-SB493- page 4-
  Provider Status – “So I Can Bill Now, Right?“

- Not quite. SB 493 does not mandate reimbursement for pharmacy services. Historically, the lack of “provider status” has curtailed reimbursement opportunities. Now that pharmacists are “healthcare providers” in CA statute, the systemic barriers which have kept pharmacists out of the “provider” club will fade, thus opening up new opportunities for reimbursement.”

- “CPhA will work diligently with other partners in the coming months and years to educate Medi Cal and other payers about this exciting change.”
Provider Status is kind of like a parking permit—which, at Purdue, is kind of like a hunting permit.

- PS recognition allows you to look for organizations that want to purchase your services.
- It does NOT guarantee many people will.
- And in an environment where, as one of the readings mentions, decision makers are avoiding “costers” and looking for “savers”, it won’t be easy.
- At best, it gives us a chance to compete with other potential providers.
What about CPT “Incident to” codes?

- CPT (Current Procedural Terminology) codes in theory allow some pharmacists to bill for cognitive services.
- See “billing for Rph’s cognitive services”
- These are the CPT codes 99211 to 99215, levels 1 through 5. All but level 1 require an MD on the premises, and the rates of payment are rather low.
Needed patients to pay for a pharmacist (billing article)

- **Table 4, 3 columns-code, # of pts needed to generate adequate charges, # of pts needed to generate adequate collections, to pay for a single pharmacist:**
  - 99212 (level 2) 12 23
  - 99213 (level 3) 7 14
  - 99214 (level 4) 5 10
- Then look at Figure 1- ACTUAL charges & collections
Provider Status

• OK, so we have provider status (sort of) and it doesn’t seem to be turning everything around.

• Why are we now excited about some higher level of provider status?

• What makes us think any further recognition will make things better?
Consider the ACO editorial by S. Barnes

• The man makes a simple, and truthful, point
• ACOs create an environment where the savings Rphs can generate can make a difference.
• But because of the way ACOs are structured legally, the RPh cannot collect any of those savings dollars directly.
• You are reduced to saving money so the real providers can receive the “bonus”
Provider or Technician?

- Provider status is important for two key reasons:
  - One- “usual and customary”
  - Two- Performance Metrics
Usual and Customary

- The Federal government’s social security Act (SSA) recognizes specific providers that it allows the federal government to reimburse
- This list becomes a sort of “default” provider list for most other payors.
- NOTE: It does NOT require or guarantee that non-federal payors will sign a contract with pharmacists to pay for services rendered.
- But the odds of that go up- considerably.
Performance Metrics

• The ACO model includes a wide range of performance metrics

• IF we are providers, then we shall have our own performance metrics in the mix as well-

• And that will encourage organizations to ensure they have the pharmacists (and the pharmacists who are skilled enough) to ensure those quality measures are met.
Accountability

- Check out the short editorial on “A tidal shift”
- One of the things that comes with provider status is accountability
- We have to do our jobs, and do them right, and be evaluated on our performance.
- This is a very different model than what we usually deal with.
- And, frankly, it scares people.
- But, if you want to see it, check out “Pursuit of PS”
The crux of the biscuit

• Moving Pharmacy forward is a herculean task.
• A key part of the problem is that practice is controlled at the state level
• While the most meaningful form of reimbursement is controlled at the federal level.
• There are players in this game that resist federal recognition of pharmacists as providers because they see this as an erosion of the state’s rights by federal decree. This is complicated political territory.
What we end up with is a bootstrap/jackknife-type procedure between state and federal law and recognition that we must maneuver through.
Federal Provider Status Update

• Provider Status Advocacy Plan
  – Provider status and reimbursement under Medicare Part B
  – Services as allowed by State Law
  – Initially targeting the medically underserved
Resources Available and Under Development

- One-pager on the value of pharmacists’ services

- Provider Status Q&A

Outside Analysis: perspective on the value of pharmacists’ services-developed by Avelere.

Sign Up to Get Involved

• If you are an APhA member, you can sign up to volunteer to help with the Federal Provider Status efforts

• Sign up here: http://aphanet.qualtrics.com/SE/?SID=SV_cYeifs4ksJLZk5D
STATE LEVEL PROVIDER STATUS
State vs. Federal Provider Status

**Federal**
- Recognition of pharmacists as providers in the Social Security Act  
  - Medicare Part B, Medicare ACO’s
- Can effect payment from federal government directly and private/state payers indirectly
- End goal: increase patient access to pharmacists’ patient care services

**State**
- Recognition of pharmacists as providers in state statute  
  - Insurance code, business/professional code, pharmacy practice act, other areas
- Can effect state payers and some private payers within that state
- End goal: increase patient access to pharmacists’ patient care services
Provider Status vs. Scope Expansion

It is important that as you look at provider status in your state you determine what the “first step” needs to be. Provider status is sometimes confused with scope expansion – both are important and can be approached separately or simultaneously, depends on the political environment in that state.

**Scope Expansion**

- Broader immunization administration/ordering authority
- Expansion of collaborative practice agreements
- Advanced practice pharmacist or pharmacist clinician designation
SCOPE VS STATUS

SCOPE
• What you can legally do in practice - determined by the Pharmacy Act
• A state-level decision, determined locally, by the state legislature

STATUS
• What defines what you can bill for
• May be federal, may be state level, may be both
• Status only means you are legally permitted to offer your services and to bill for their delivery
• It does NOT mandate anyone has to purchase those services
Provider vs. Practitioner

**Provider**
- Definition: a person or thing that provides
- Can include a person or establishment that provides a product such as a prescription. *Pharmacies* and hospitals can be considered providers.
- Some statutory definitions may include a qualifier: *healthcare provider*

**Practitioner**
- Definition: a person who practices a profession or art
- Can only be a specially trained person. This term may more specifically identify the professional who provides a cognitive service rather than physical product.
Insurance Code vs. Other Areas of State Laws

Insurance Code

• There is sometimes a list of professionals who are defined as health care providers for the purposes of the provisions in the insurance code

• Challenge: Only about 20% of patients are covered by insurers who are held to these provisions (non-ERISA exempt plans)

Other Areas of State Laws

• Pharmacy Practice Act
• Business/Professional Code
• Being “on the list” as a provider here may not have much of an impact on payment for services unless areas of the insurance code, Medicaid provisions, or state employee benefit provisions refer back to this language

• Pharmacists can also be separately recognized as providers within Medicaid laws
State approaches to Advance Practice Pharmacist (scope)

**New Mexico Pharmacist Clinician**

**Qualifications**
- 60 hour physical assessment course
- 150 hours direct patient contact with log – must be completed in 2 years

**Privileges**
- Defined by protocol and within the scope of practice of the supervising physician or within the policies of the institution

**North Carolina Clinical Pharmacist Practitioner**

**Qualifications**
- BPS, CGP, or PGY2 Residency; or
- PharmD + 3yr clinical experience + CTP; or
- BS + 5yr clinical experience + CTP

**Privileges**
- Adjust therapy
- Order tests
- Pursuant to agreement – MD, RPh, pt, and dx specific

**California Advanced Practice Pharmacist**

**Qualifications**
- Two of the following:
  - CTP; or
  - PGY1; or
  - Actively managed patients for 1 yr under CPA with MD

**Privileges**
- Perform physical assessments
- Order/interpret labs
- Make referrals
- Initiate, adjust or stop Rx therapy (must notify PCP)
State Provided Medical Benefits

- State Employees and/or State Medicaid programs
- Some states have found success in implementing an MTM or other pharmacy service benefit into one of these state funded programs
- Could be done with or without recognition as a provider in that state
Summary

Legislative options states could pursue:

• **Statutory provider status** (insurance code, business/professional code, pharmacy practice act, Medicaid provisions)

• **Expanded scope of practice** (broaden immunization authority, optimize collaborative practice provisions, advanced practice pharmacist designation)

• **Establishment of a state funded pharmacist service benefit** (MTM or another service; Medicaid or state employees)

• Others???
It is NOT going to be easy

• Look at the papers on Advanced Practice Pharmacists.
• A consistent theme for US APM RPhs is that reimbursement and revenue generation is a severe issue
• In NC, NM, less than 5% of the eligible pharmacists have elected to pursue this training-
• And in the UK, where “federal” recognition is already in place, 4.4% in 2011 were independent prescribers, and 2.1% were supplementary prescribers.
• So far, only Alberta shows robust numbers
http://www.payscale.com  median salaries

- RPh = 98K, Hospital = 103K, PIC = 117K, Clinical Pharmacist = 110K, Pharmacist = 107K
- Physician Assistant = 86K
- Nurse Practitioner = 86K
IT REALLY IS UP TO YOU

- I think the circumstances will exist that will allow you to make pharmacy into whatever you want it to be
- But you WILL have to take risks
- You WILL have to accept responsibility
- And you WILL have to realize there will be differences in pharmacists and how much they make based on skill, not credentials.
- One last reading—"Transformative Force"—couldn’t have said it better myself.
• Questions?