Achieving Provider Status, and What does it mean?

By
Steven Gray, PharmD, JD

Disclosure Statements

• I have no relevant conflicts of interest. I have no relevant financial relationships with any commercial interest.

• I am an attorney, but I am not YOUR attorney.

• The views expressed in this presentation are my own and do NOT necessarily reflect those of my employer or any other organization.

Objectives

By the end of the presentation the attendees will be able to:

1. Briefly describe the evolution of pharmacy practice from patient-centered to product-centered and back to patient-centered practice.
2. Describe the various meanings of "provider status" for pharmacists
3. Describe the recent experience in some states in achieving "Provider Status" for pharmacists
4. Discuss the potential impact of "provider status" on patients and the practice of pharmacy
5. Provide guidance to other pharmacists in this state to achieve "Provider Status".
1. Getting “Pharmacist Provider Status” in a state statute guarantees that pharmacists will be receive monetary compensation for providing “Patient-Centered Clinical Pharmacist Services”?
   – A. Always
   – B. Never
   – C. Depends

2. Which of the following is NOT a “red flag” word to avoid in pharmacist scope of practice acts for CDTM or APP services:
   – A. Diagnosis
   – B. Primary Care
   – C. Discontinue
   – D. Independent

3. Which if the following statements best describes the differences between “MTM” and “CDTM/CDTA” and “CMM” pharmacist practice?
   A. There is no difference.
   B. MTM pharmacists make recommendations while CDTM/CDTA pharmacist issue orders.
   C. MTM pharmacists work with Medicare Part D programs but CDTM/CDTA Pharmacists do not.
   D. Pharmacists can get compensated for MTM but not for CDTM/CDTA under Medicare.
   E. Private payers will NOT pay for MTM, CDTM/CDTA and CMM Practice.
From Product-Centered >>>>>>>>>> Patient-Centered

• The ‘60s – “Clinical”> from product to patient-centered care and patient medication profiles. Indian Health Service, et. al.
• The ‘70s - Standards for clinical pharmacy practice and ambulatory care clinical pharmacy in Family Medicine and Urgent Care. First CDTM/CDTA laws – Washington 1979
• The ‘80s - Expanded role for pharmacists in Managed Care and VA systems and diffusion of clinical services, research and education programs across U.S.
• Expansion of CDTM scopes and practices

From Product-Centered >>>>>>>>>> Patient-Centered

• The ‘90s - Recognition by DHHS and HCFA (now CMS) that CPS reduces ADEs in elderly and improves outcomes and reduce costs
• ‘Asheville Project’
• VA Project IMPACT
• Joint ASHP and APhA standards for Community Pharmacy residencies
• More CDTM expansions.

From Product-Centered >>>>>>>>>> Patient-Centered

• The 2000s - The spread of CDTM ambulatory care clinical pharmacy services spreads across practice settings – integrated delivery systems, hospitals, community pharmacies, and standalone practices
• MediCaid begins move from FFS to Capitated Managed MediCaid.
• MediCare Part “D” calls for “MTM” and leads to more “CDTM”.

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Patient-Centered

• The Affordable Care Act (ACA) establishes the ACOs and the “ACO” concept spreads in Commercial Coverage.
• Profession Responds with expansion of PGY1 Community Pharmacy and PGY2 Ambulatory Care Specialty Residencies
• BPS commissioned a practice analysis (2006)
• BPS inaugural board certification in Ambulatory Care Pharmacy Practice (2011)

What Does “Provider Status*” Mean?

• The term means many different things:
  – Access to Patient Records
    • Traditional, Electronic, and Health Information Exchanges
  – Health Professional Responsibility / Liability
    • Increased Fiduciary Duty
    • Mandatory Reporter
    • “Learned Intermediary”
  – Payment for “Cognitive Services” / “Professional Judgment” / “Clinical Pharmacy”
  – * Sometimes call “Practitioner”

What Does “Provider Status” Mean?

• Payment for Pharmacist Cognitive Services by:
  – MediCare Part B
  – MediCaid
  – Commercial Insurance and Health Plans
  – Self-insured Employers
  – Trust Funds
  – Private Citizens
  – ACO’s
• Without or in addition to a Dispensing Fee!
What Does “Provider Status” Mean?

- Payment for what types of Pharmacist Cognitive Services
  - Comprehensive Medication Management
  - “Initiating”, Adjusting or Discontinuing Therapy
  - Physical Assessment of Drug Therapy
  - Refill Synchronization
  - Drug Utilization Review Recommendations

What Impact on the Profession?

- Opportunities
  - Recognition and Respect
  - Membership on a “Patient Centered Medical Home” Team
  - Practicing at highest levels of education and ability
  - Increased career Satisfaction and comfort, or

  Or it can mean “Nothing!”

  (If the Opportunities are not seized soon.)

The California Experience – SB 493

- Already had some “Provider Status”
  - Access to confidential patient information
  - Licensed and with it “Mandatory Reporter” status

- What did we get – exactly?

  “The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.”

  • DUH!!!
The California Experience – SB 493
• Why the seek more explicit recognition?
  – Payment for pharmacist “Clinical/Cognitive” Services not available for most pharmacists.
  – Payers said it “may” help paying for PCS.
  – Clarify professional status on the care team
  – Broader scope of practice
  – More Respect
  – Deeper Professional Satisfaction

The California Experience – SB 493
• For All Licensed Pharmacists:
  – Order Medication Therapy Related “Tests” – Not just “Laboratory” Tests
  – Providing/ “Furnishing” “Rx Only” medications not related to “Diagnosis”
    • Immunizations for patients > 3 years old,
    • All Self-administered Hormonal Contraceptives,
    • Travel Medications per the CDS “Yellow Book”,
    • “Prescription” Nicotine Replacement Smoking Cessation Products – Note: Not Chantix or Wellbutrin
    • “Naloxone” Cognitive Services (per another “Emergency Bill”).

The California Experience – SB 493
• Officially Recognized “Advance Practice Pharmacist” Category by Board of Pharmacy
  – Scope: Initiate (Prescribe), Adjust and Discontinue Rx Only Medications – Including all Controlled Substances.
  – Order and Interpret Med Therapy Related Tests
  – Refer patients to other Health Care Providers
  – Access to and ability to enter info. in EHR
**The California Experience – SB 493**

- **Advanced Practice Pharmacist** Qualifications:
  - Licensed Pharmacist
  - Two of the following:
    - Certification from an organization recognized by ACPE
    - Accredited Residency with 50% on Interdisciplinary care team
    - One year of clinical services with CDM pharmacist, an Advanced Practice Pharmacist or a physician
  - Pay an Application Fee to the Board of Pharmacy
  - Ten hours extra of CE upon renewal
  - [Link](http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0451-0500/sb_493_bill_20131001_chaptered.pdf)

**The California Experience – SB 493**

- How was it achieved?
  - Participate in a Coalition – NPs, ODs, and mainly OTHER PHARMACIST ORGANIZATIONS
  - Capitalize on and build RELATIONSHIPS!
  - Something for everyone!
  - Being VERY cognizant of words and terms!
  - Targeted Marketing/Lobbying
  - Timing!, Timing!, Timing!

**What Has Happened Since?**

- Federal Medicare Part B Enrollment Bills
- Recognized at “Other Authorized Prescribers” (OAPs) for Part D Prescriptions
- Recognized as “Prescribers” for Medi-Cal
- Recognition for MediCaide and other Payers in other states.
- Expansion in Scope of Practice for Pharmacists and Pharmacy Technicians
- Washington, Idaho, etc.
**Guidance for Other Pharmacists**

Five Main Principles

1. Work Through Key Relationships/Coalitions
2. Something Gained for Everyone — Nothing Removed
3. Expand the Scope of Practice in the process
4. Be ready and willing to spend money and time
5. Timing!, Timing!, Timing!

**Guidance for Other Pharmacists**

- Build Relationships with key groups OUTSIDE of the pharmacist profession ASAP:
  - Physicians, Physician Groups, Legislators and Staff, Board of Pharmacy Members/Staff, Consumer Groups.
- Truly understand the needs and wants within the Pharmacists in the State.
- Be very, very careful about wording.
- Control the communications from the start and right through the process.
- Be willing to compromise and to be “ambiguous”.
- Timing!, Timing!, Timing!

**Pre-Presentation Questions**

1. Getting “Pharmacist Provider Status” in a state
   Statue guarantees that pharmacists will be receive monetary compensation for providing “Patient-Centered Clinical Pharmacist Services”?
   - A. Always
   - B. Never
   - C. Depends

Answer = “C.” It “Depends” on the jurisdiction, the “intent” of the Legislature, the policies of the payer, the type of Pharmacist Clinical Services — some yes, some no, etc.

Note the Washington State vs. the California approach.
Pre-Presentation Questions

2. Which of the following is NOT a “red flag” word to avoid in pharmacist scope of practice acts for CDTM or APP services:
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   – C. Discontinue
   – D. Independent

   “C”. The term “Discontinue” deserves a yellow “caution flag”— Certain ‘interested parties’ may try to say OK to “initiate or adjust” but cannot “discontinue”.

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3. Which if the following statements best describes the differences between “MTM” and “CDTM/CDTA” and “CMM” pharmacist practice?
   A. There is no difference.
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   E. Private payers will NOT pay for MTM, CDTM/CDTA and CMM Practice.

   “B” “MTM” as used commonly only implies making a Recommendation vs. “to order”, “to prescribe” or to “furnish”.

Post Presentation Self Evaluation

• Answers:
  – 1. C. “Depends” on the jurisdiction, the “intent” of the Legislature, the policies of the payer, the type of Pharmacist Clinical Services – some yes, some no, etc.
  – 2. C. “Discontinue” deserves a yellow “caution flag”— Certain ‘interested parties’ may try to say OK to “initiate or adjust” but cannot “discontinue”.
  – 3. B. “MTM” as used commonly only implies making a Recommendation vs. “to order” or “to prescribe”.