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COMMENTARY

Pathway to pharmacist medical provider status in Washington State

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A R T I C L E I N F O

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A B S T R A C T

Objectives: To describe Washington State's successful legal and legislative efforts to gain pharmacist medical provider status and major medical compensation and to compare those efforts with similar efforts in other states to identify key lessons learned.
Summary: Washington State Engrossed Substitute Senate Bill 5557 was enacted in 2015, securing pharmacists as medical providers and requiring compensation under major medical insurance for pharmacists providing health services (Revised Code of Washington 48.43.715). Other states have passed, or attempted to pass, pharmacist provider status bills, but none have achieved both pharmacist medical provider status and mandatory major medical compensation.
Conclusion: Pharmacist medical provider status ideally should include recognition as a medical provider and compensation through major medical health insurance as a clinical decision maker rather than an "incident-to" provider. Both elements should be sought as part of a complete legislative package to ensure sustainable patient access to needed health care services.
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Pharmacist medical provider status is crucial for improved patient access to needed health care services. For purposes of the present article, we define pharmacist medical provider status for pharmacists who provide clinical services that are compensated, within the fee-for-service construct, as a contracted and credentialed network medical provider within a health plan's major medical benefit. This definition contrasts with traditional pharmacy compensation within a health plan's drug benefit and with pharmacist services compensated primarily via facility fee charges or as an "incident-to" provider. Incident-to services are those services that are furnished incidentally to physician professional services in the physician's office or in a patient's home.[1] Pharmacist billing of incident-to services implies that a different medical provider (i.e., a physician) is making the clinical decisions and directly supervising the pharmacist. Although a pharmacist may provide some incident-to services, encounters in which the pharmacist is the primary clinical decision maker, and not under direct supervision of another health care provider, are the foundation of pharmacist medical provider status.

Pharmacists have provided clinical services for many years, helping to fulfill unmet patient needs. For example, chronic disease management (diabetes and anticoagulation) and initiation of urgent preventative services (contraception) are 2 areas where pharmacists have demonstrated that they can improve patient access. Yet pharmacists have typically not been compensated for such services by health plans, even when other categories of health care providers have been. Rather, any compensation has been constrained to pharmacy benefit manager payments to pharmacies or to incident-to mechanisms that assume that pharmacists are acting only under direct orders. New laws, such as Washington State's, can correct this long-standing discrepancy.

Although many resources continue to be directed toward federal legislative efforts to amend the Social Security Act to provide coverage under Medicare for pharmacist services,[2] the enactment of such legislation is uncertain.[3] State efforts in this area, however, are increasing, and it is the potential combined efforts of individual states, such as Washington State and others, that may ultimately provide a catalyst for future federal law. As such, the present commentary examines Washington State's pathway to pharmacist medical provider status and compares Washington State's new law with recent laws enacted in other states. This new Washington State law establishes health plan obligations in Washington State. It has no authority to affect federal

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Key Points

Background:

- Washington State pharmacists' scope of practice expanded in 1979.
- Washington State's 1993 Health Services Act mandated equal reimbursement for all providers providing services within their scope of practice.
- Pharmacist reimbursement for clinical services has been limited.

Findings:

- Washington ESSB 5557 resolves reimbursement discrepancies.
- Pharmacist provider status legislation in other states have had mixed results.

programs such as the Medication Therapy Management Program provided under Medicare Part D.[4]

State efforts toward pharmacist medical provider status

Washington State's achievement of pharmacist medical provider status

Washington State pharmacists have long enjoyed an enhanced scope of practice, but recognition as medical providers with compensation for services provided has taken several decades to achieve. Progressive changes in Washington State's Pharmacy Practice Act began in 1979, authorizing pharmacists to enter into collaborative drug therapy agreements and thus to be able to provide numerous clinical services, such as drug administration and medication management services. These changes permitted pharmacy practice in Washington State to evolve to include innovative components such as the provision of contraceptives, vaccines, and therapeutic management of asthma and diabetes. In 1993, Washington State's Health Services Act permitted:

> "every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that: (a) The provision of such services or care is within the health care providers' permitted scope of practice …"[5]

However, the Health Services Act (also referred to as the Every Category of Provider law) was not considered by health plans or the Washington State Office of the Insurance Commissioner (OIC) to apply to pharmacists providing clinical services. Therefore, although Washington State pharmacists were able to provide needed services, they were denied compensation for these services. Compensation barriers caused some popular and effective pharmacist services to be withdrawn.

Although a class action lawsuit against the health plans may have been an option for resolving their refusal to compensate pharmacists, administrative and legislative relief was sought. Washington State pharmacists urged their legislators to request an informal opinion from the Washington State Office of the Attorney General (AG), seeking to determine if the 1993 Health Services Act included pharmacist services within its "every category of provider" classification. AG's informal opinion stated that pharmacists are health care providers and must be compensated for the services provided within their scope of practice.[6] Although the informal opinion changed OIC's perspective on pharmacists' provider status, Washington State health plans continued to claim that they complied with the "every category of provider" requirements of the Health Services Act because, in part, they paid professional dispensing fees when pharmacies filled prescriptions.

Combined, AG's informal opinion and the subsequent support of OIC facilitated successful enactment of Washington State's new law, Engrossed Substitute Senate Bill (ESSB) 5557. Under this law, most Washington State commercial health plans are required to compensate pharmacists under major medical health benefits for the essential health services included in the 1993 Health Services Act. Specific language in ESSB 5557 prevents health plans from using medication dispensing fees as evidence of compliance with the law.

Figure 1 depicts the timeline for pharmacist medical provider status in Washington State. Achieving pharmacist medical provider status was a multidecade process requiring persistence and dedication by pharmacist advocates. Such advocacy must continue as the law is implemented. ESSB 5557 specifies a 2-step pharmacist health plan credentialing/contracting implementation pathway. First, health care facilities which had existing "delegated credentialing"[a] contracts with health plans could begin billing for services on January 1, 2016. These health care facilities, rather than the health plans, perform pharmacist credentialing. Second, in all other cases where the health plans themselves credential pharmacists (i.e., community pharmacists, clinic pharmacists, etc.), extra time was built into this process. These pharmacists will be able to bill for their clinical services on January 1, 2017. To help prepare for implementation, the Washington State Pharmacy Association is providing comprehensive training programs on medical billing and is attracting stakeholders from around the country to participate.

Comparison of Washington State law with other state laws

Washington State's legislative efforts have resulted in pharmacist medical provider status and major medical compensation. Although much can be learned from Washington State's success, valuable information can also be gained from analyzing other states' recent laws. Table 1 provides a comparison of 4 other relevant state laws with Washington State's law.[b] The table specifies how the law recognizes

[a] Delegated credentialing occurs when a health care entity (i.e., health plan) gives another health care entity (i.e., health system) the authority to credential its health care practitioners. Delegated credentialing goes beyond credentials verification, because the delegated health care entity (e.g., the hospital) is responsible for evaluating practitioners' qualifications and making credentialing decisions on behalf of the delegating health care entity.

[b] For our analysis, Westlaw was queried for all state and federal proposed and enacted legislation containing the term pharmacist within 1 sentence of provider. The results were then filtered by means of a state filter within Westlaw. As of August 15, 2015, this query elicited 55 enacted laws. These laws were analyzed for selected inclusion based on clarification of provider status.

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