# F I S C A L  I M P A C T  R E P O R T

**SPONSOR** Armstrong, D. **ORIGINAL DATE** 1/24/2017 **LAST UPDATED** 2/1/2017 **HB** 84

**SHORT TITLE** Pharmacist Services Reimbursement **SB**

**ANALYST** Chenier

## ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

| | FY17 | FY18 | FY19 | 3 Year Total Cost | Recurring or Nonrecurring | Fund Affected |
|---|---|---|---|---|---|---|
| **Total** | | $3,960.0 | $3,960.0 | $7,920.0 | Recurring | General Fund/Federal |

(Parenthesis ( ) Indicate Expenditure Decreases)

## SOURCES OF INFORMATION

LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
Medical Board
Public Schools Insurance Authority (PSIA)
Human Services Department (HSD)

## SUMMARY

Synopsis of Bill

House Bill 84 would add a new section to the Group Benefits Act, the Public Assistance Act, the New Mexico Insurance Code, the Health Maintenance Organization Law, and the Nonprofit Health Care Plan Law to require reimbursement for pharmacist services when the pharmacist is acting under the scope of the pharmacist's license, at the same rate that any physician or physician assistant, or advanced practice certified nurse practitioner would be paid for the service.

## FISCAL IMPLICATIONS

HSD provided the following:

> The bill would require a new direct payment to pharmacies with little or no offset from payments to other providers.
>
> For Medication Management:

Currently, a payment is made for medication management at a rate of $30 for 15 minutes only to a physician, advanced practice nurse, or pharmacist clinician when there is not an evaluation and management service, that is "a physician office visit" that also takes place.

Thus, currently a medication management service is primarily paid to various types of behavioral health agencies, when the patient is seeing a behavioral health (BH) counselor whose scope doesn't include providing a physical exam but the patient is taking multiple BH medications. In this case, an advance practice nurse, pharmacist clinician, or other qualified individual provides the Medication Management service at $30 per 15 minutes. For state FY17, it is anticipated there will be approximately 12,000 claims for Medication Management for a total payment of $360,000.

HB 84 would expand payment for Medication Management beyond that of the pharmacist clinician (who works under the direction of a physician in a collaborative practice) to include all registered pharmacists who provide a medication management service.

The number of pharmacy claims annually approximately 6.6 million, for which each claim represents a prescription that is filled by the pharmacist. Even if the pharmacist just billed a Medication Management service on just 1 claim out of every 50 claims to result in the $30 payment to the pharmacist, the annual increased expenditure to HSD would be $3,960,000 annually.

Also, the language in the bill would lock HSD into reimbursing pharmacists for future services that the Pharmacy Board may allow pharmacists to perform, without regard to budget considerations or other costs.

**SIGNIFICANT ISSUES**

HSD provided the following:

HB 84 would require the medical assistance programs (primarily the Medicaid program) to reimburse pharmacists for services at the same rate that any physician or physician assistant, or advanced practice certified nurse practitioner would be paid for the service.

The wording in this section of the bill is not sufficiently flexible to be compatible with many federal rules regarding Medicaid reimbursement as set by the federal Centers for Medicare and Medicaid Services (CMS). Below are examples.

**Conflict with the Federal Covered Outpatient Drug Rule:**

The final federal Covered Outpatient Drug Rule (CODR) published in the federal register February 1, 2016, requires state Medicaid programs to submit new reimbursement levels and methodologies for pharmacy reimbursement to the Centers for Medicare and Medicaid Services (CMS) by June 30, 2017.

HB 84 is in direct conflict with the federal requirement regarding how pharmacies are to be paid for professional services.

The CODR continues to require that payment to the pharmacies be made in 2 separately calculated components, but changes the definition of those components.

- The rule provides for clear distinction between the ingredient cost of a drug item, and the dispensing fee currently paid to pharmacies.

- The rule eliminates the term "dispensing fee" and instead replaces it with the term "professional dispensing fee" as CMS says in the federal register "to reinforce our position that the dispensing fee should reflect the pharmacist's professional services and costs to dispense the product to a Medicaid beneficiary."

So while the federal government is supportive of assuring pharmacists are reimbursed for professional services, the CODR specifies how that payment is to be made. HB 84 attempts to establish a different means to pay for pharmacist professional services that are inconsistent and contradict the CMS requirements.

- The CODR requires the new "professional dispensing fee" to include a component for pharmacist professional services. However, it is essentially paid at an amount intended to reimburse for professional costs, but blended into the professional dispensing fee to cover all professional services and applies to all pharmacy claims, whether the pharmacist provided a specific distinct professional services on a single claim or not.

- The CODR method for paying for professional services to the pharmacist avoids the problems that would be created by HB 84 which have to do with what circumstances the pharmacist can bill for Medication Management such as:

    - How long must the consultation be?
    - Must the recipient actually request the service?

    These issues are avoided under the required CODR methodology by having the amounts bundled into the calculation of the dispensing fee at an amount that recognizes the professional services over all, even though some prescriptions will require more professional services from the pharmacist than others.

**Duplicative Payments:**

Since the CODR requires the professional services to be included in the calculation of the dispensing fee, any payment made under HB 84 would be duplicative and therefore would violate federal rules.

- The CODR requirement to pay a "professional dispensing fee" requires every state to submit a new state plan amendment to CMS. The understanding of HSD is that CMS is primarily approving "professional dispensing fees" for states in ranges that are several dollars greater per claim than the current dispensing fee paid by Medicaid.

- It is difficult for Medical Assistance programs to comply with the federal requirement for paying pharmacist professional fees and also comply with a state

requirement that is different from, and conflicts with, the federal requirement.

**Issues on Application of HB the Rule:**

Under Medicaid state and federal rules, a provider cannot charge the Medicaid program for a service provided to the general public at no charge. A pharmacy must charge non-Medicaid recipients for these same professional charges if the pharmacist bills the Medicaid program for a service. Therefore, it is possible that in order to be paid for these professional services by Medicaid, the pharmacy would have to increase their charge to the general public. By following the federal CODR, this situation would be avoided, and audits of pharmacies for complying with the provision of when a provider can charge Medicaid for services would be less of an issue.

**Pharmacy Prescribing and Providing Injections:**

Other pharmacist services such as providing flu shots and other injections, tobacco cessation counseling, naloxone kit distribution, and some other services are also currently reimbursed to pharmacies under specific federal rules established by CMS. They often require a different method of reimbursement from that of an advance practice nurse, for example:

- When a practitioner is providing an injection, the payment of the administration is included in the reimbursement for the injectable drug item. There is not a separate payment amount for the administration of the drug item. But the amount that is included in the advance practice nurse payment is based on a different set of costs and often is established after considering Medicare reimbursement.

  For a pharmacist, however, the payment for the administration of the drug item must be calculated separately from the payment for the drug item. When applicable, Medicare part D payment to a pharmacy serves as a base for the calculation which is based on different cost factors. The Medicare payment levels to pharmacies under part D and to practitioners under part B are not the same. In general, to include requirements in legislation that do not fit the reimbursement models that CMS requires the state to follow would lead to confusion and conflict.

OSI provided the following:

Research suggests that the demand for primary care physicians will grow 14 percent between in the next few years, while the supply of these providers will only grow approximately 8 percent, which creates a greater demand for interdisciplinary, team-based approaches to delivery of primary care services.

Pharmacists are increasingly providing direct patient care based on state scope of practice regulations in a variety of settings spanning inpatient, outpatient, and community pharmacies. Community pharmacists are among the most accessible healthcare practitioners, with 93 percent of Americans living within five miles of a community pharmacy, and they are delivering care beyond the traditional prescription medication dispensing function, offering direct patient care services such as immunizations, medication management, chronic condition management, patient education and counseling, and wellness and prevention screening.

Pharmacists are licensed by the states and state-by-state regulations outline the provision of the scope and types of healthcare services that can be delivered by pharmacists. While opportunities for pharmacists to provide direct patient care services emerge, options for obtaining reimbursement for these services continue to be limited for community pharmacists. This legislation would provide an additional avenue for reimbursement of community pharmacists for the provision of primary care services. Accordingly, this legislation may expand the availability of primary care services to insured individuals, especially in rural areas.

While expanding access to primary care services, there may be administrative obstacles to the implementation of this legislation. Insurance companies may have to change billing practices and contracts with pharmacists to provide reimbursement for these services. For example, reimbursement for many pharmacies functions are not directly handled by the insurer, but are handled by third-party pharmacy benefit managers who pay claims based on a bundled cost for prescription drugs. This legislation may result in a one-time cost to insurers to develop billing processes to reimburse pharmacists for these services. Additionally, insurance companies and pharmacists may need to engage in a thorough review of standardized CPT codes applicable to their services. Current standardized coding procedures may limit the services for which pharmacists may be eligible to bill.

Additionally, as currently written, it is unclear whether the legislation would allow insurance companies to reimburse for services only provided by pharmacists with whom it was contracted. The legislation, as written, may require insurance companies to reimburse all pharmacists, whether contracted as in-network or not, for any and all services for which they are licensed.

## TECHNICAL ISSUES

As drafted, the bill does not include the article numbers for the non-profit and HMO sections of the Insurance Code.

EC/al/jle