# MEDICAID PHARMACY IN FOCUS

## Opportunities to Improve Texans' Health and Access to Care

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# Executive Summary

Texas has 411 primary care health professional shortage areas, and only 58% of primary care needs in those areas are being met. Lack of access to health care and primary care providers is worse in rural communities. As health workforce shortages grow, states are looking for ways to increase access to health care, especially in areas facing primary care provider shortages. Pharmacies and pharmacists have the potential to deliver additional services to improve access to care and improve Texans' health. This report provides the landscape of pharmacy in the Texas Medicaid program, including an overview of Medicaid members' access to prescription drug benefits, and explores opportunities to better utilize pharmacists in the Medicaid program.

Traditionally, pharmacies have been primarily reimbursed for dispensing prescription drugs. However, community pharmacists are often the most accessible healthcare professional for many patients and are well positioned to provide additional services if reimbursed appropriately. Many states have started to expand the types of services they will reimburse pharmacists to deliver, in an effort to increase access to needed services. And more health plans are including pharmacists in their healthcare quality improvement programs through alternative payment models.

Pharmacists are trained to test, treat, and immunize for many infectious diseases, and by practicing their full scope of practice within their training and license can alleviate pressure on the health care system. Along with dispensing prescription medications and offering expertise in the safe use of prescriptions, pharmacists play an important role in enhancing public health and increasing access to care.

Currently, enrollees in Medicaid, CHIP, and the Healthy Texas Women program have good access to pharmacy providers, with nearly 90% of the state's 5,120 community pharmacies participating. A majority (58%) of Texas pharmacies will deliver filled prescriptions to their patients' homes, 78% administer immunizations, and a few have started administering infusions in-store (0.3%). During the COVID pandemic, most immunizations were administered by pharmacies, and the public health emergency provisions also authorized pharmacists to test and treat their patients for COVID. Pharmacists demonstrated their abilities, and the public experienced the benefits of their role as advanced healthcare professionals.

Pharmaceutical care has historically been delivered and managed very distinctly from medical care. Existing policies, processes, systems, and workflows of pharmacy providers and payers are tuned for optimal delivery of medications, not for the delivery of services currently performed by other healthcare providers. Therefore, making the adjustments to add pharmacies as providers of those services will require collaboration and intentional efforts by all stakeholders, beginning with education on what is already available. Focusing those efforts on specific targets, such as increasing immunization rates and testing and treating streptococcus, Influenza, and COVID may yield relatively quicker results with long-term benefits for Medicaid enrollees.

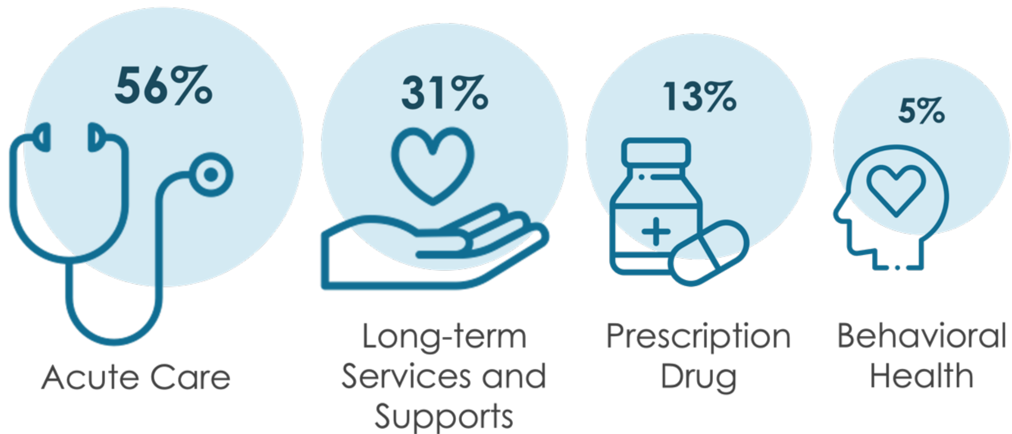
# Background

## Overview: Prescription Drug Benefits in Medicaid

The Medicaid covered outpatient prescription drug program, or pharmacy program, is an optional benefit for state Medicaid programs and Texas opted in at the inception of the Texas Medicaid program. The program provides enrollees access to prescription medications and over-the-counter medications when ordered by an authorized prescriber and delivered in an outpatient setting.

According to the Health and Human Services Commission (HHSC), prescription drug expenditures represent 13% of the Medicaid budget. For state fiscal year (SFY) 2024, the Texas Legislature appropriated $4.24 Billion (All Funds) to HHSC for Medicaid prescription drug benefits and $4.01 Billion (All Funds) for SFY 2025.

**FIGURE 1: MEDICAID SPENDING BY SERVICE TYPE**




The functions performed by the Texas Health and Human Services Commission (HHSC) and its managed care organizations (MCOs) to administer the overall Medicaid program are also required for the pharmacy program. However, the pharmacy program functions are commonly performed by separate organizational units, sub-contractors, and systems from the general Medicaid program functions because of distinct attributes of the prescription drug benefit. See a comparison in TABLE 1.

**TABLE 1: COMPARISON OF OVERALL MEDICAID AND PHARMACY PROGRAM FUNCTIONS**

| MEDICAID PROGRAM FUNCTION | PHARMACY PROGRAM FUNCTION |
| --- | --- |
| PROVIDER ENROLLMENT | Enroll and maintain a pharmacy provider network |
| COVERED BENEFITS DESIGN | Determine which drugs and related products will be covered for each program |
| RATE SETTING | Set reimbursement rates for prescription drugs, over-the-counter drugs and related products and services |
| BENEFITS POLICY DESIGN AND PRIOR AUTHORIZATION DETERMINATION | Develop prior authorization criteria and evaluate requests for prior authorization |
| CLAIMS PROCESSING | Adjudicate point-of-sale claims submitted by pharmacies |
| PROVIDER HOTLINES | Provide real-time support to pharmacy providers attempting to dispense medications to members |
| PROGRAM MANAGEMENT AND OVERSIGHT | Audit Pharmacy Benefit Managers and pharmacy providers; evaluate MCO adherence to the Preferred Drug List |

## Key Differences: Medicaid Pharmacy and Medical Benefits

Many functions performed by the state and its MCOs to administer Medicaid pharmacy benefits and medical benefits are similar, but there are important differences in the pharmacy program that affect its structure, financing, stakeholder motivation, and benefits-management decisions. TABLE 2 and the narrative below describe some of the unique features of the Medicaid prescription drug benefit.

#### TABLE 2: UNIQUE FEATURES OF THE MEDICAID PHARMACY PROGRAM

| FEATURE | DESCRIPTION |
|---|---|
| PHARMACY BENEFIT MANAGERS (PBMS) | MCOs delegate most prescription drug benefit functions to a separate entity, the pharmacy benefit manager (PBM), which is generally a third-party but may be owned by the MCO. At minimum, the PBM manages the pharmacy provider network, processes prescription drug claims, and sets the reimbursement amount per drug.<br><br>Impacts:<br>• Pharmacies have limited interaction with their members' MCO.<br>• PBMs often operate multiple, additional lines of business, including commercial, Medicare, and exchange plans. A pharmacy desiring to participate in one MCO's line of business may be required to accept similar contract terms for another line.<br>• Historically, pharmacies have expressed some distrust of PBMs. |
| DRUG MANUFACTURER REBATES | For a drug manufacturer's drug product to be covered by a state Medicaid program, the Center for Medicare and Medicaid Services (CMS) requires the drug manufacturer to enter into a National Drug Rebate Agreement with the U.S. Department of Health and Human Services for all their drugs.<br><br>"Manufacturers are then responsible for paying a rebate on those drugs for which payment was made under the state plan. These rebates are paid by drug manufacturers on a quarterly basis to states and are shared between the states and the Federal government to offset the overall cost of prescription drugs covered under the Medicaid Program."<br><br>Impacts:<br>• State Medicaid programs must cover every drug under the national rebate agreement, regardless of its price.<br>• The state Medicaid program receives rebate revenues, not the MCO or its PBM; therefore, HHSC sets MCO capitation rates based on the historical, full amounts of MCO prescription drug expenditures.<br>• Texas recovers over 50% of its capitated and fee-for-service Medicaid drug expenditures from rebates. Texas law requires all rebate revenues returned to its |

| | |
|---|---|
| | prescription drug programs as a method of finance, not general revenue.<br>• Rebate amounts are set by CMS, are highly confidential, vary by drug, and can exceed 90% on individual drugs. |
| REAL-TIME, POINT-OF-SALE CLAIM ADJUDICATION | Before dispensing a filled prescription to a Medicaid member, pharmacies submit an electronic claim to the PBM at the point-of-sale. The PBM adjudicates the claim within seconds and informs the pharmacy if the claim will be paid, the reimbursement amount, and any cost-share amount payable by the member.<br>Note: there is no cost sharing for Medicaid prescriptions, but there is for the Children's Health Insurance Program (CHIP) and the Health Texas Women (HTW) program.<br>Impacts:<br>• If the claim is denied, the member will not receive their medication, with few exceptions. This is very different from physician services where the provider bills the MCO after providing service to the member.<br>• If payable, the pharmacy provider must dispense the medication—they may not pick and choose based on the reimbursement amount. |
| PREFERRED DRUG LIST (PDL) | In Texas, drug manufacturers compete to have their products designated as the "preferred drug" for a therapeutic class by offering additional, supplemental rebates above the rebate amount negotiated with the CMS and by providing evidence of the drug's effectiveness. A Medicaid PBM may not reimburse a pharmacy for a "non-preferred drug" unless the member's physician provides evidence, they have tried the "preferred drug", or the member cannot tolerate it.<br>Impacts:<br>• Drugs on Texas' Medicaid Preferred Drug List (PDL) are more often brand name drugs than generic drugs. After national and supplemental rebates, the net cost of these drugs is lower to the state than other drugs in the same therapeutic class, including generic drugs. However, Medicaid PBMs do not see these rebates and their costs are generally lower for generic drugs.<br>Issues related to national and state rebates have resulted in the Texas Legislature requiring HHSC to manage the formulary |

| | |
|---|---|
| | and PDL rather than its MCOs (and PBMs). The issue of formulary management has been a source of tension since 2012. |
| ANY WILLING PROVIDER | In Texas, any registered community pharmacy may participate in the Medicaid program. Pharmacies must complete all required enrollment and credentialing processes with HHSC and applicable MCOs (PBMs) prior to serving members of state assistance programs.<br><br>Impacts:<br><br>Unlike other provider types, MCOs (PBMs) may not limit their pharmacy provider networks, this is referred to as "any-willing provider". |

## Medical Benefits and Services/Medical Billing

Medical policies outline the billing codes, reimbursement requirements, provider requirements, prior authorization requirements, limitations, and exceptions for each covered Medicaid service. The Texas fee-for-service (FFS) medical policy is maintained by the Medicaid Policy Division at HHSC and is outlined in the Texas Medicaid Provider Procedures Manual and for managed care each MCO has their medical policies outlined on their websites and provider portals.

> DEFINITION
>
> **MEDICAL BENEFITS AND SERVICES**
>
> Services that have traditionally been delivered by a non-pharmacy provider such as acute care services (physician services, nursing services, inpatient services, behavioral health services) long-term care services and supports (attendant care, home modifications, etc.) and supplies and equipment.

When a healthcare provider provides a service, they bill either the state or the managed care organization using a HCPCS (Healthcare Common Procedure Coding System) or a CPT (Current Procedural Terminology) code. Each code has an established rate and billing rules associated with it and outlined in the medical policy. To bill a medical service, a provider must enroll with HHSC under their provider type (physician, nurse, home health agency, clinic, optometrist, therapist, etc.). Once enrolled as a provider in the Medicaid, CHIP, and/or HTW programs they are eligible to bill the fee-for-service medical claims system. To serve managed care members the provider must be credentialed and then enter into a contract agreement with one or more MCOs.

In 2021, HHSC adopted new rules and added "Pharmacist" as a new provider type in the medical claims system to allow pharmacists to enroll and bill for certain medical services (or non-dispensing services) in addition to prescription drugs. While there are very few pharmacists that have enrolled as medical providers, this change opens the door for pharmacists to be reimbursed for more than just filling prescriptions under the pharmacy benefit.

## Pharmacy Benefits and Services/Pharmacy Billing

The billing policies and procedures and the clinical prior authorization for the FFS program are outlined in the Pharmacy Provider Procedure Manual, which is maintained by the Vendor Drug Program (VDP) at HHSC. MCOs list their claims submission and clinical prior authorization criteria on their websites and provider portals. In addition to prescription drugs, certain home health supplies and select vitamin and mineral products are also reimbursable as a pharmacy benefit.

DEFINITION

PHARMACY BENEFITS AND SERVICES

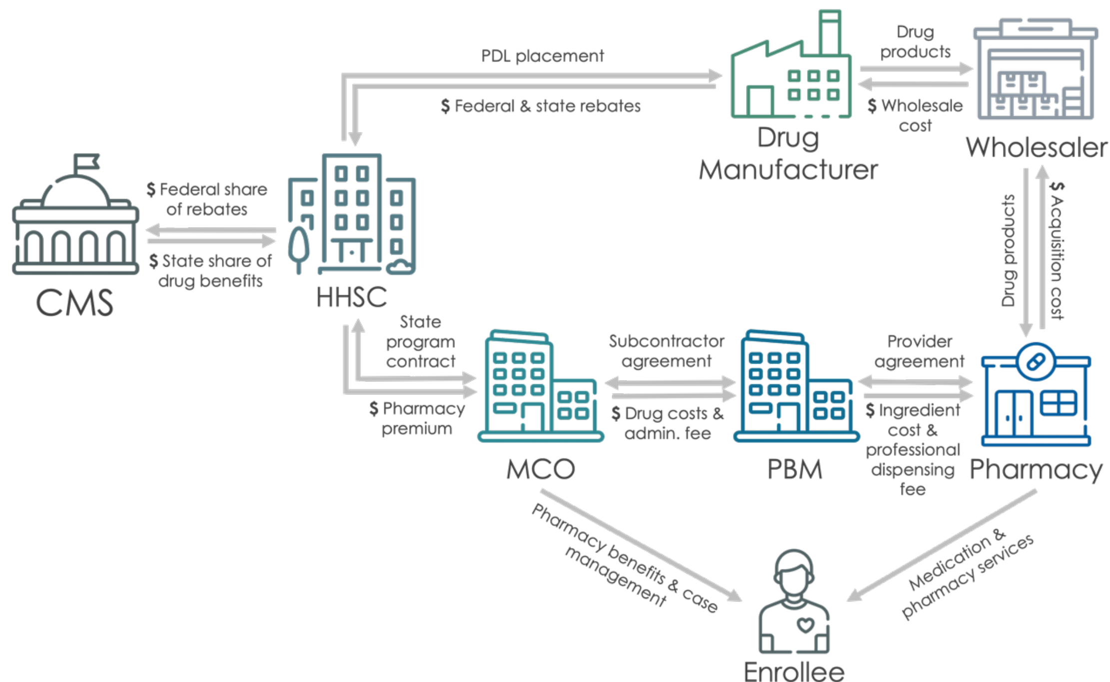
Outpatient prescription drugs and products dispensed by a pharmacy.

All traditional Medicaid outpatient prescription claims are processed through real-time, point-of-sale systems using the National Drug Code (NDC), which identifies the specific drug dispensed. The reimbursement methodology for prescription drugs can be more complicated than medical benefits and are determined by a complex set of policies, at both the federal and state levels.

Clinician-administered drugs or biologicals, also known as physician-administered drugs, are injectable medications administered in a physician's office or outpatient clinic setting when additional testing or monitoring is required or when oral medications are not appropriate. These drugs are billed and reimbursed as a medical benefit.

FIGURE 2 Figure 2 illustrates some of the unique relationships between entities involved in the provision and payment of Medicaid outpatient prescription drug benefits. The reimbursement relationships between the payer, PBM, and pharmacy are described under *Pharmacy Reimbursement*, below.

**FIGURE 2: MEDICAID PRESCRIPTION DRUG BENEFIT RELATIONSHIPS**



# Pharmacy Reimbursement

The result of the CMS requirement for states to cover all drugs from manufacturers with a rebate agreement is broad access to prescription medications for Texans enrolled in Medicaid. There are some limitations; for example, the CMS requirements apply to medications approved by the U.S. Food and Drug Administration, not experimental drugs.

When a pharmacy submits a point-of-sale claim for dispensing a drug and the payer (MCO PBM or HHSC) determines the claim is payable, the electronic response specifies the amount the pharmacy will be reimbursed for the filled prescription. The reimbursement amount is the sum of at least two components: the ingredient cost and the professional dispensing fee.

PBMs negotiate reimbursement rates with their network pharmacy providers on behalf of their MCOs. PBMs use different rate setting approaches than HHSC's FFS model but also reimburse based on the ingredient cost plus a professional dispensing fee.

## INGREDIENT COST

The ingredient cost of a drug reflects the price paid by pharmacies to acquire the drug from a manufacturer or wholesaler and is calculated based on a percentage of what pharmacies and drug wholesalers pay for the drug. Pharmacies use a variety of methods to negotiate lower acquisition costs.

CMS final rules effective in 2016 required states for FFS to set ingredient costs at pharmacies' actual acquisition cost (AAC). To assist states with setting ingredient costs at AAC, CMS regularly surveys pharmacies across the U.S. and collects their actual acquisition costs for each drug product. CMS compiles the survey data and publishes the National Average Drug Acquisition Cost (NADAC), updated weekly. For prescription drug claims paid by HHSC under its FFS model, Texas adopted NADAC as its Ingredient Cost methodology, with some exceptions.

The CMS final rule does not apply to Medicaid MCOs and MCOs are not required to pay for ingredient costs based on AAC but, per federal and state requirements, must make payments sufficient to ensure appropriate access for their members. In Texas, MCOs generally set ingredient costs for brand name drugs—those still under patent—based on a percentage of the Average Wholesale Price (AWP) and pay for generic drugs according to their Maximum Allowable Cost (MAC) list.

The AWP is a benchmark price, the list price from a wholesaler to a pharmacy. AWPs are reported by pharmaceutical manufacturers and published in commercial clearinghouses. MCOs' MAC lists are developed by their PBMs. A MAC price is the upper limit a plan will pay for equivalent generic drugs, including the off-patent brand drug, based on AWP. State statute requires MCOs to review and update their MAC lists at least once every seven days and to develop a process for network pharmacy providers to challenge a price on an MCO's MAC list.

## PROFESSIONAL DISPENSING FEE

Filling a prescription and dispensing the medication to a patient requires a pharmacist's time, supplies, and expertise. The Professional Dispensing Fee component of a paid claim is intended to cover the cost associated with the pharmacist's effort and resources needed to fill and dispense the medication.

In its 2016 final rule on prescription drugs, CMS "clarifies that states are required to evaluate the sufficiency of both the ingredient cost reimbursement and the professional dispensing fee reimbursement when proposing changes to either of these components." To comply with the 2016 final rule, states were required to amend their Medicaid state plan to specify how they would comply with the new AAC ingredient cost reimbursement requirements. In addition, states had to justify their Professional Dispensing Fee reimbursement to ensure a "reasonable dispensing fee". This required most states, including Texas, to conduct cost of dispensing studies in FFS and most states adjusted their Professional Dispensing Fees to between nine and twelve dollars per prescription claim.

In its 2014 cost of dispensing study Texas found the average cost to Texas pharmacies to dispense an outpatient prescription drug was $10.12. Accordingly, HHSC raised the fixed component of its FFS dispensing fee from $6.50 to $7.93 so that its variable-rate methodology would yield a higher average Professional Dispensing Fee. For reference, Medicaid.gov publishes every state's reimbursement information.

In an August 2018 report to the Texas legislature, HHSC presented data from an analysis of Medicaid MCO pharmacy claims. The average Ingredient Cost PBMs paid pharmacies in SFY 2017 was 6.4% higher than the NADAC-based rate used in the FFS model. However, the average Professional Dispensing Fee PBMs paid was $1.08.

## ADDITIONAL REIMBURSEMENT INFORMATION

For additional information about Medicaid pharmacy reimbursement, the Medicaid and CHIP Payment and Access Commission (MACPAC) published an issue brief in 2018 that provides a very good overview of the pharmacy program.

# Financial Drivers

## Community Pharmacies

A community pharmacy can range from a large retail grocery or drugstore chain to an independently owned small business. The main function of a community pharmacy is the dispensing of prescription medicines, but community pharmacies can provide a range of non-dispensing services including counseling patients on the proper use of their medications, monitoring for potential drug interactions or side effects, provide vaccines and health screenings such as blood pressure, glucose and cholesterol checks. Additionally, community pharmacists may work with physicians and other healthcare providers to adjust or manage a patient's medication regimen, as well as play a role in disease state management and preventive care. Most recently, community pharmacies have proven to be vital for the success of COVID-19 testing and vaccinations.

The difference between the pharmacy's acquisition costs and the amount they are reimbursed by PBMs is the gross profit. The net profit is the amount that remains after subtracting the cost of dispensing—i.e. operating costs—from the gross profit. Historically, the net profit margin for pharmacies have been narrow.

The biggest portion of a pharmacy's operating expenses is for staffing. Therefore, redirecting staff or hiring additional staff, especially pharmacists, to perform added services may quickly erode a store's narrow profit margin. Pharmacists have expressed a wariness of policy changes or adoption of payment models that add services without adequately providing an opportunity to recoup the added costs.

A related concern is workflow interruption. Busy pharmacies have well-oiled filling and dispensing workflows, and any interruption can cause prescription orders to back up. A licensed pharmacist is the only individual who may fill prescriptions, administer immunization or infusions, counsel patients, perform medication management, and other services. It can be a difficult business decision to redirect a pharmacist or other staff from filling and dispensing prescriptions. Because net profits from prescription drug services alone can be very slim, many stores augment their income by selling additional products and/or providing additional services. Permitting community pharmacists to provide non-dispensing services and receive additional Medicaid reimbursement or value-based incentive/performance payments can provide needed revenue to pharmacies and pharmacists. It may incentivize more pharmacists to innovate and invest in providing additional pharmacy-related services.

Traditionally, in the Texas Medicaid program, pharmacies have been primarily reimbursed for the dispensing of prescription drugs. However, community pharmacists are often the most accessible healthcare professional for many patients and are well positioned to provide additional services and close care gaps if reimbursed accordingly.

# Managed Care Organizations and Pharmacy Benefit Managers

Over the past twenty years, Texas has moved most Medicaid services and Medicaid recipients into the managed care model. Today, more than 97% of Medicaid recipients receive their services through managed care. MCOs must provide all medically necessary services to individuals enrolled in their health plan and in return are paid a fixed amount per member enrolled with their health plan per month. MCOs then negotiate rates for services with providers and pay them to administer services to members. MCOs take on full financial risk, so if the cost of administering the program exceeds its funding, they must use reserves to provide services and pay providers. HHSC caps MCO profits and requires MCOs to share profits with the state. HHSC develops MCO pharmacy capitation rates to cover pharmacy claims and administrative costs and to include a risk margin. The primary drivers of cost are rising drug prices and client utilization.

The Texas Uniform Medicaid Managed Care Contract (UMCC) requires Texas MCOs to contract with a PBM for the administration of prescription drugs. PBMs do not reimburse pharmacies for medical benefits they provide. Rather, a pharmacy submits medical claims directly to the MCO for reimbursement.

Payment models vary across different lines of business and settings for MCO payments to their contracted PBMs and PBM payments to their network pharmacies. For consistency and transparency in its programs and to enhance program oversight, the Texas Medicaid UMCC prohibits some fees PBMs have charged pharmacies in other models. It also prohibits "spread pricing", a model used by some PBMs whereby they charge the MCO for delivered drug benefits a rate higher than the amount they paid pharmacies. Instead, Texas Medicaid MCOs reimburse their contracted PBMs the amount they paid pharmacies for the prescription drugs dispensed to their members. MCOs pay PBMs a separate, additional administrative fee for their services.

As noted above, HHSC premium payments to MCOs include a set rate for prescription drug benefits. As with other quality improvement efforts by MCOs, initial expenditures may not be recouped through savings for years. Pharmacy-related initiatives that increase preventive care may avoid emergency department visits and hospitalization for some members in the short term, but these types of initiatives are aimed at long-term improvement in members' health. MCOs have expressed some concerns about their inability to lock-in members to their plan—if a member switches plans, the new plan may reap the benefits of the prior plans' quality improvement efforts. However, HHSC has noted that the rate of members switching plans is low.

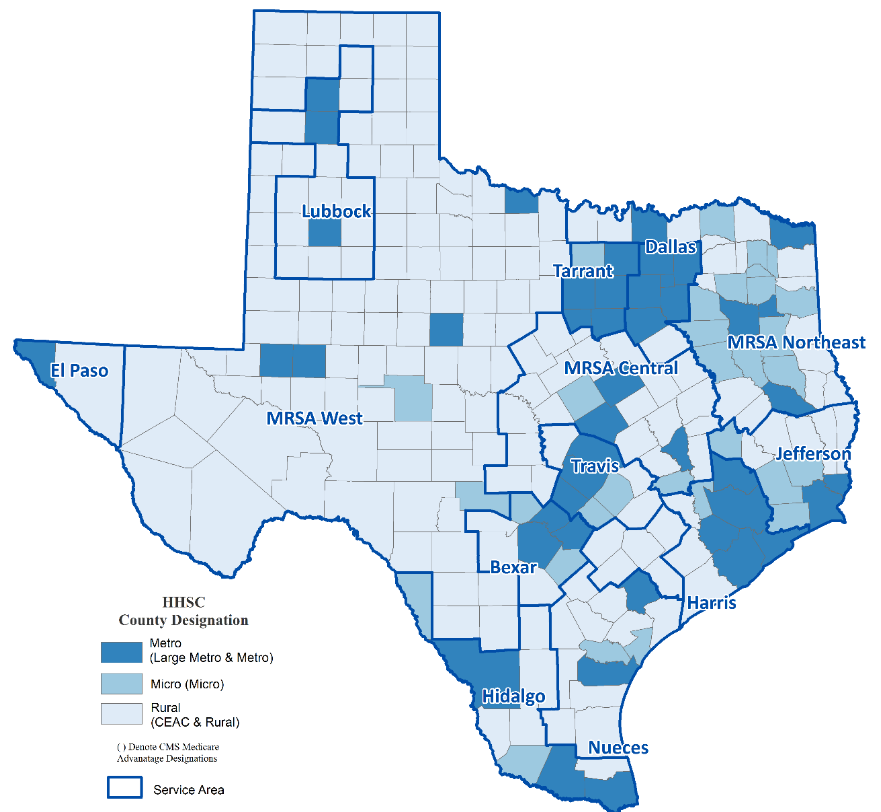
# Access to Community Pharmacies in Texas

Recent research has demonstrated that patients visit community pharmacies almost twice as often as primary care providers and that community pharmacies are particularly successful at reaching rural residents and patients who otherwise would not be reached by other health care providers.

The series of tables below provides an overview of enrollees' access to prescription drug benefits in the Medicaid, CHIP, and Healthy Texas Women programs. Data are presented by type of pharmacy (independent or chain) and by county population category, as defined by CMS:

- Large Metropolitan
- Metropolitan
- Micropolitan
- Rural
- County with Extreme Access Considerations (CEAC)

**FIGURE 3: HHSC COUNTY DESIGNATIONS**




## MCO Pharmacy Provider Network Adequacy

TABLE 3 presents the state's pharmacy provider network adequacy standards based on a member's county and the county's population category: metro, micro, or rural. For its network adequacy standards, Texas grouped Large Metropolitan and Metropolitan counties as "Metro" counties, and Rural and CEAC counties as "Rural" counties, as shown in FIGURE 3.

**TABLE 3: HHSC MANAGED CARE PHARMACY PROVIDER NETWORK ADEQUACY STANDARDS**

| COUNTY POPULATION CATEGORY | MINIMUM STANDARD | PROGRAMS<br>STAR<br>STAR+PLUS<br>STAR HEALTH<br>STAR KIDS | STAR MRSA<br>STAR+PLUS MRSA<br>STAR KIDS MRSA<br>CHIP |
|---|---|---|---|
| METRO | Percent of Members | 80% | 75% |
| | Time Standard | 5 minutes | 5 minutes |
| | Distance Standard | 2 miles | 2 miles |
| MICRO | Percent of Members | 75% | 55% |
| | Time Standard | 10 minutes | 10 minutes |
| | Distance Standard | 5 miles | 5 miles |
| RURAL | Percent of Members | 90% | 90% |
| | Time Standard | 25 minutes | 25 minutes |
| | Distance Standard | 15 miles | 15 miles |
| ALL | 90% of members must have access to a 24-hour pharmacy within 90 minutes and 75 miles | | |

## Community Pharmacy Enrollment in Texas Programs[1]

Community pharmacies are considered chain stores if the owner has five or more stores. Therefore, a chain store may be a national retailer like Walgreens (751 Texas stores), a regional group like H-E-B (300 stores), or a multi-store pharmacy like Apple Pharmacy (9 stores in South Texas).

DEFINITION

**COMMUNITY PHARMACY**

A facility licensed (Class A license) to dispense a drug or device to the public under a prescription drug order, excluding pharmacies that engage in compounding sterile preparations.

TABLE 4 shows the percentages of community pharmacies enrolled in each program. Almost 88% of Texas pharmacies participate in Medicaid. However, there is a fairly large difference in the percentages of participating chain (94.5%) and independent (77.5%) pharmacies.

[1] Texas Medicaid only enrolls Community Pharmacies (Class A) and institutional/hospital-based pharmacies (Class C), but tables in this section only reflect Community Pharmacies.

### TABLE 4: ENROLLMENT IN STATE PROGRAMS BY TYPE OF COMMUNITY PHARMACY

| PHARMACY TYPE TSBP | NUMBER OF PHARMACIES | PERCENTAGE ENROLLED HHSC MEDICAID | CHIP | HEALTHY TEXAS WOMEN |
|---|---|---|---|---|
| INDEPENDENT | 1,968 | 77.5% | 76.4% | 74.3% |
| CHAIN | 3,081 | 94.5% | 94.3% | 93.6% |
| OTHER[2] | 71 | 0.9% | 0.8% | 0.8% |
| TOTALS | 5,120 | 87.5% | 87.0% | 85.7% |

TABLE 5 shows the distribution of chain and independent pharmacies by county population category. In Large Metro, Metro, and Micro counties, approximately 61% of community pharmacies are chain stores and 37% are independent. But, that ratio inverts in more rural counties. The percentage of independent pharmacies is nearly the same as chain stores in rural counties, but there are many more independent stores (83%) than chain (17%) in the state's CEAC. The total percentage of pharmacies enrolled in Medicaid and CHIP also increases slightly in rural counties.

### TABLE 5: PHARMACY PROVIDER ENROLLMENT BY COUNTY POPULATION CATEGORY

| COUNTY CATEGORY | TOTAL PHARM. | PHARMACY TYPE TSBP | | | PERCENTAGE ENROLLED HHSC | | |
|---|---|---|---|---|---|---|---|
| | | IND. | CHAIN | OTHER | MEDICAID | CHIP | HTW |
| LARGE METRO | 2,476 | 36% | 62% | 1% | 88% | 88% | 86% |
| METRO | 1,936 | 38% | 61% | 2% | 86% | 85% | 84% |
| METRO SUB-TOTAL | 4,412 | 37% | 62% | 1% | 87% | 87% | 85% |
| MICRO | 268 | 37% | 61% | 1% | 87% | 87% | 86% |
| RURAL | 351 | 48% | 51% | 1% | 90% | 90% | 89% |
| CEAC | 89 | 83% | 17% | 0% | 91% | 91% | 84% |
| RURAL SUB-TOTAL | 440 | 55% | 44% | 1% | 90% | 90% | 88% |
| TOTAL | 5,120 | 38% | 60% | 1% | 88% | 87% | 86% |

[2] Other: Pharmacies that checked the "Other" box on their application for TSBP licensure. The application allows these pharmacies to enter their specific type, entries included: Hospital, Public Health, and Other. Pharmacies of these types may check the Independent or Chain box and would be included in the percentages for those types.

## Access to Pharmacy-Related Services Beyond Dispensing

Community pharmacies already go beyond dispensing prescription drugs. When they submit their application for licensure, they note additional services offered, including the following non-dispensing services further detailed in TABLE 6.

### Home Delivery

Independent pharmacies (68.6%) are more likely than chains (51.4%) to offer home delivery.

### Administering Immunizations

Nearly 80% of Texas pharmacies administer immunizations. However, more than twice as many chain stores (97.8%) administer immunizations as independents (48.2%).

### Other Services

Over 67% of chain and 17% of independent pharmacies offer "Other Services". Pharmacies enter their services on their application and the Texas State Board of Pharmacy TSBP communicated they have received a variety of entries, including dialysis, long-term care, nutrition, and non-profit.

### Remote Sites

Approximately 5% of independent and 1% of chain pharmacies operate a remote site. This may indicate they use a mechanical, automated dispensing system at another site, or it may be a "satellite pharmacy" where prescriptions filled at the primary location may be dispensed to patients by a pharmacist, or a "telepharmacy".

- The telepharmacy has no on-site pharmacist but stores and dispenses prescription drugs and uses an electronic system (e.g. video) to perform drug regimen review and patient counseling. TSBP rule §291.121(c) defines two types of telepharmacies:
  - A remote dispensing site and
  - A remote healthcare site, which may include health centers, a rural clinic or FQHC, or a healthcare facility located in a medically underserved or health professional shortage area.
- A telepharmacy may not be located in a community with an existing community pharmacy.

**TABLE 6: ADDITIONAL SERVICES PROVIDED BY TYPE OF COMMUNITY PHARMACY (TSBP)**

| PHARMACY TYPE | NUMBER OF PHARM. | NON-DISPENSING SERVICES OFFERED | | | | |
|---|---|---|---|---|---|---|
| | | HOME DELIVERY | ADMINISTER IMMUNIZATIONS | ADMINISTER INFUSIONS | OTHER SERVICES | REMOTE SITES |
| IND. | 1,968 | 68.6% | 48.2% | 0.7% | 17.3% | 5.2% |
| CHAIN | 3,081 | 51.4% | 97.8% | 0.0% | 67.3% | 0.9% |
| OTHER | 71 | 0.6% | 0.5% | 0.0% | 0.7% | 0.1% |

| TOTALS | 5,120 | 57.9% | 77.9% | 0.3% | 47.8% | 2.7% |
|---|---|---|---|---|---|---|

TABLE 7 presents another view of additional services offered by community pharmacies in Texas, broken out by county population categories. The percentages of pharmacies that offer home delivery ranges from 44% (Micro) to 66% (CEAC). Inversely, the percentages of pharmacies that administer immunizations ranges from 72% (CEAC) to 89% (Micro). Interestingly, 25% of pharmacies in CEACs and 9% in rural counties have a remote site, indicating that some pharmacies in those counties are using technology to expand access to prescription services.

### TABLE 7: ADDITIONAL PHARMACY SERVICES BY COUNTY POPULATION CATEGORY (TSBP)

| COUNTY POPULATION CATEGORY | TOTAL PHARM. | NON-DISPENSING SERVICES OFFERED | | | | |
|---|---|---|---|---|---|---|
| | | HOME DELIVERY | ADMINISTER IMMUNIZATIONS | ADMINISTER INFUSIONS | OTHER SERVICES | REMOTE SITES |
| LARGE METRO | 2,476 | 60% | 75% | 0.5% | 51% | 1% |
| METRO | 1,936 | 57% | 80% | 0.2% | 47% | 2% |
| METRO SUB-TOTAL | 4,412 | 59% | 77% | 0.3% | 49% | 2% |
| MICRO | 268 | 44% | 89% | 0.0% | 44% | 4% |
| RURAL | 351 | 56% | 81% | 0.0% | 37% | 9% |
| CEAC | 89 | 66% | 72% | 0.0% | 19% | 25% |
| RURAL SUB-TOTAL | 440 | 58% | 79% | 0.0% | 33% | 12% |
| TOTAL | 5,120 | 58% | 78% | 0.3% | 48% | 3% |

# Landscape

## Current Policies

Many states have started to expand the types of services pharmacists can be reimbursed for in an effort to address provider shortages and increase access to care. Pharmacists are trained to test, treat and immunize for many infectious diseases and by practicing their full scope of practice within their training and license can alleviate pressure on the health care system. Along with dispensing prescription medications and offering expertise in the safe use of prescriptions to patients, pharmacists play an important role in enhancing public health and increasing access to care in rural and underserved areas. Below are some of the policies adopted in Texas that allow pharmacists the opportunity to provide additional services beyond solely dispensing medications.

### Pharmacist Enrollment in Medical Billing Systems

Many of the non-dispensing services discussed in this report are considered medical benefits. For pharmacies and pharmacists to be recognized and reimbursed as billing and performing providers, respectively, of these services they must exist in the medical benefits system managed by the Texas Medicaid & Healthcare Partnership (TMHP).

Historically, pharmacies wishing to deliver prescription drug benefits to individuals enrolled in Medicaid, CHIP, or the HTW programs had to enroll through the HHSC VDP pharmacy benefits system. All other provider types enrolled through the medical benefits system. In February 2021, HHSC consolidated the enrollment processes, so all provider types enroll through the TMHP medical benefits system. Therefore, modifying or adding medical benefits to allow pharmacists as performing providers may require less effort and cost than in the past.

The inclusion of pharmacies in the medical billing system does not imply that pharmacies can immediately begin billing for providing these additional services.

- For most services, medical benefits policies and Medicaid fee schedules will need to be updated or developed to enable pharmacists and pharmacies as valid providers of those services.
- For some services, pharmacies may have to enroll as a different provider type. This is similar to current policy that requires a pharmacy that also provides durable medical equipment, like incontinence supplies, to enroll as a "Home Health Durable Medical Equipment" provider for billing purposes.
- For other services, the individual pharmacist—not just the store/pharmacy—may have to enroll so the system can validate the individual's licensure or other certification.

### Collaborative Practice Agreements

A collaborative practice agreement (CPA) creates a formal practice relationship between a pharmacist and a physician. It defines certain patient care functions delegated to the pharmacist and the circumstances when the pharmacist can provide them. Pharmacists and

providers can collaborate even without a CPA, but the agreement delegates patient care functions to a pharmacist beyond the pharmacist's typical scope of practice. In 2019, the Texas Legislature passed SB 1056, which amended the Occupations Code and clarified that a physician may delegate to any properly qualified and trained pharmacist the implementation and modification of a patient's drug therapy under protocol. Pharmacists in Texas may now enter into CPAs with physicians for their patients and establish protocols to make changes to a patient's drug therapy regimen.

There are barriers to entering into a CPA and to its use. A CPA is between a physician and a pharmacist or a practice group, with multiple physicians, and pharmacy, with multiple pharmacists—and all must be named on the CPA. It delegates limited authority, within agreed upon protocols, to a pharmacist but only for patients of the physician(s). A level of trust is required between the entities to enter into an agreement. It takes time to develop the protocols and for TSBP approval of the CPA application.

Integrated health systems are a setting in which infrastructure exists to help support a CPA. But even in these settings some MCOs have experienced reluctance by health system physicians to delegate authority to an outpatient pharmacy.

Rural areas are also good settings for a CPA where trust exists, and both the physician group and pharmacy have few staff. By contrast, a chain store in an urban setting is more likely to have higher pharmacist turnover and unknown pharmacists filling in for the regular staff.

## Medication Therapy Management

DEFINITION

**MEDICATION THERAPY MANAGEMET (MTM)**

A range of services provided to individual patients to help them get the most benefit from their medications and detect and prevent costly medication issues.

MTM provided by pharmacists results in:

- A review of all medications prescribed by all prescribers providing care to the patient, and any over-the-counter and herbal products the patient may be taking to identify and address medication problems. Problems may include medications not being used correctly, duplication of medications, unnecessary medications, and the need for medication(s) for an untreated or inappropriately managed condition;
- In-depth, medication-related education, consultation, and advice provided to patients, family and/or caregivers to help assure proper use of medications;
- Collaboration with the patient, physician, and other health care providers to develop and achieve optimal goals of medication therapy.

Because of its potential benefits, the key activity in MTM is the Comprehensive Medication Review (CMR). CMS requires all Medicare Part D plans to offer an annual CMR to their enrollees who have multiple chronic conditions, multiple medications, and total medication costs over a certain threshold.[3] The CMR is defined by CMS as:

[3] Code of Federal Regulations §423.153(d) is the guiding statute for CMS for Part D sponsors.

"… an interactive person-to-person or telehealth medication review and consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider …"

The authors of this report found support for MTM amongst interviewees but adoption in Medicaid and CHIP has been minimal. Reasons reported for low MTM completions rates in Medicare also apply in Texas Medicaid:

- Because of its comprehensive, interactive nature, a CMR is time-consuming and easily exceeds 30 minutes of a pharmacist or other healthcare practitioner's time. Providers report reimbursement rates are frequently insufficient and billing processes ill-defined by payers and policy makers.
- Health plans can review their members' health information to identify those who may benefit the most from MTM. Some MCOs have preferred to perform MTM themselves rather using community pharmacists or PCPs. With this approach, MCOs may realize MTM's benefits and avoid the need to find willing MTM providers and to develop policies, rates, and data exchanges with providers.
- CMS requires plans to offer CMR to eligible Part D enrollees, but plans report low uptake rates and providers have reported patient no shows for CMR appointments as an issue. Consideration of the patient's experience and additional education about MTM may be helpful.
- Most Medicaid and CHIP enrollees are healthy children, reducing the percentage likely to be selected for MTM.

The National Board of Medication Therapy Management provides excellent reference information on this topic, including definitions, summaries of federal and state policies, and surveys of research efforts.

## Additional Non-Dispensing Services

In its 2022 report to the Texas Legislature, the Value-Based Payment and Quality Improvement Advisory Committee recommended HHSC expand the provision of pharmacist-delivered services, including:

- Clinical Laboratory Improvement Amendments (CLIA)-waived point-of-care testing[4],
- Smoking cessation,
- Diabetes Self-Management Education and Support (DSMES),
- Transitions of Care,
- Comprehensive medication reviews,
- Medication therapy management (MTM), and
- Services performed under collaborative practice agreements.

[4] According to CMS, "as defined by CLIA, waived tests are categorized as 'simple laboratory examinations and procedures that have an insignificant risk of an erroneous result.' The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews manufacturer's applications for test system waiver."

The committee believes this could significantly increase access to care for enrollees in rural and medically underserved communities.

Increasing the number of pharmacists delivering additional, non-dispensing services will require a better understanding by payers, physicians, policy makers, and even pharmacists of the changes and requirements to incorporate these services. The concepts are relatively easy for consumers to understand but not necessarily easy to implement because of the historically narrow roles of pharmacists. The box to the right describes an example of a patient with the flu.

Without prescribing authority, a pharmacist cannot perform steps 3 through 5. They are limited to referring their patient to a physician, such as the patient's PCP or an urgent care center. This gap in a pharmacist's scope of practice increases the time to treatment for a patient and their level of effort to obtain that treatment, including travel to multiple sites.

The gap could be bridged for some patients if their PCP and pharmacy develop a collaborative practice agreement. By contrast, the National Alliance of State Pharmacy Associations found six states, as of October 2022, that allow pharmacists direct prescribing authority without a CPA for conditions that can be detected by a rapid test. Idaho allows pharmacists broad prescribing authority and others require a standing order or limit the conditions that can be treated. These policies greatly

## Influenza Test and Treat Example

If a person felt sick and feared they had the flu, it would be ideal to walk into a community pharmacy to be tested and, if the test results are positive, walk out with a filled prescription for an antiviral. According to the Centers for Disease Control and Prevention (CDC), "antiviral drugs can lessen fever and flu symptoms and shorten the time you are sick by about one day. They also may reduce the risk of complications such as ear infections in children, respiratory complications requiring antibiotics, and hospitalization in adults."

A person can walk into some pharmacies and be tested for the flu, but if the results are positive the individual will need a separate visit to a physician's office or clinic to obtain a prescription for the antiviral and must then return to the pharmacy to fill the prescription. Antiviral medications should only be taken if initiated within 48 hours of the onset of symptoms, so timing is important.

This seemingly simple encounter is comprised of multiple procedures or services:

| | | |
|---|---|---|
| 1 | INITIAL PATIENT INTERVIEW SCREENING | Gather patient information & vital signs & determine if the testing is applicable. |
| 2 | ADMINISTER THE INFLUENZA RAPID TEST | Pharmacy must have a certificate of waiver from CMS to perform CLIA-waived tests. Pharmacist must complete & document their training to administer tests. |
| 3 | REVIEW TEST RESULTS & DETERMINE COURSE OF TREATMENT | If positive, determine appropriate treatment (treat with antiviral drug/prescribed OTC or refer to physician). |
| 4 | COUNSEL PATIENT & OBTAIN CONCURRENCE ON TREATMENT | Communicate test results and treatment recommendations. |
| 5 | ORDER MEDICATION /REFER | Order antiviral drug, refer to physician, or both. |
| 6 | DISPENSE MEDICATION | Fill medication order & counsel patient. |
| 7 | DOCUMENT ENCOUNTER & TRANSMIT TO PCP | Update the patient's medical record |

expand access for their residents to point-of-care testing and treatment for Influenza and other dangerous infections. The 88th Texas Legislature filed but did not enact legislation granting pharmacists prescribing authority without a CPA–limited to patients with streptococcus, Influenza, or COVID-19—using a standing order or written protocol.

An additional complexity, beyond prescribing authority, is regarding authorization by HHSC and MCOs for pharmacies to bill and be adequately reimbursed for providing all the services in this “Test and Treat” encounter. HHSC and MCOs’ policies, procedures, and billing systems would have to be modified to recognize pharmacists as the performing providers, assign procedure codes for billing, and set rates.

Finally, electronic documentation and communication systems between pharmacies and PCPs and pharmacies and MCOs should be implemented or improved. Pharmacists regularly communicate with physicians by phone to discuss a particular prescription or patient, but that method is insufficient for the type and volume of information that must be communicated to keep a PCP’s health records updated for their patients.

# Opportunities and Recommendations

## Alternative Payment Model Opportunities

Health care experts overwhelmingly agree that fee-for-service payment models incentivize volume without promoting quality. Therefore, current health care quality strategies aim at moving away from compensating providers based on volume and instead on the value of care provided.

Texas Medicaid MCOs must follow contract requirements established by HHSC that ensure a certain percentage of payments made to providers are in some form of alternative payment model (APM) or value-based contract focused on improving quality of care. By calendar year 2022, MCOs are contractually required to have at least 50% of total provider payments for medical and prescription expenses in APMs, and at least 25% of the total payments must be in risk based APMs. If an MCO fails to meet the APM targets, the MCO must submit a corrective action plan, and HHSC may impose contractual remedies, including liquidated damages. HHSC is currently in the process of amending the managed care manual to adopt a new APM framework that is aimed at encouraging MCOs to advance the type of APMs they are implementing and the types of providers and services they have in an APM contract.

APMs come in many forms and can include multiple types of providers, but the one commonality is that they provide financial incentives for high-quality, cost-efficient patient care. APMs may apply to specific clinical conditions, care episodes, or patient populations. The MCOs are required to submit annual reports to HHSC, outlining past and proposed APMs. HHSC reports that in 2018 there were 17 APMs that involved a pharmacy or lab.

Recognizing that pharmacists are underutilized and could fill care gaps, especially in rural areas of the state, the HHSC Value-Based Payment and Quality Improvement Advisory Committee made several recommendations to the Texas Legislature related to expanding the use of pharmacists including:

- HHSC should establish standards and a working definition for an Accountable Pharmacy Organization (APO) and work with stakeholders to increase engagement with APOs.
    - Define an APO provides clarity when discussing the types of pharmacy organizations involved in VBP contracting. The concept of an APO is distinct from other pharmacy contracting entities (i.e., pharmacy services administrative organization or PSAO).
    - Increasing VBP arrangements with APOs should improve patient outcomes. Pharmacists will be incentivized to longitudinally engage patients when paid to produce outcomes and lower costs.
- HHSC should develop guidance for MCOs to reimburse pharmacists for services within a pharmacist's scope of practice.
    - It would be helpful if HHSC could provide additional clarity and guidance to MCOs for paying pharmacists for services under the medical benefit like all

other providers. While MCOs could pay pharmacists today, low utilization may indicate a lack of knowledge about these payment options.

- It would be helpful for HHSC to provide a list of services that fall within a pharmacist's scope that may be reimbursable by MCOs.

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Given the fact that pharmacists can bill for certain non-dispensing services there are opportunities to increase pharmacy APMs to help improve health outcomes and fill care gaps. Other pharmacist services that may lend themselves to APM agreements include:

## Diabetes Self-Management Education and Support (DSMES)

DSMES services provide an evidence-based foundation to empower people with diabetes to navigate self-management decisions and activities. People who participate in DSMES have been shown to have better diabetes-related outcomes than those who do not. Pharmacists could be leveraged to provide more frequent testing of members' A1c levels at the pharmacy and increasing adherence to maintenance drugs and products—for example, insulin and glucose test strips and educating members on self-care. More than one of the pharmacies interviewed are already performing some or all of these services.

## Medication Adherence

MCOs may see improvement in some of the quality measures monitored by HHSC through partnership with pharmacies to monitor and increase adherence to medications. Measures related to the improvement in the health of patients with chronic diseases or conditions, especially if those conditions are controlled by medication, are good candidates. Children with poorly controlled asthma and adults with hypertension or diabetes may see improvement through better adherence.

## Immunization Administration

MCOs seeking to improve their child members' immunization rates, may find benefits from partnering with pharmacies to augment their immunization efforts. Members who are not ideologically opposed to vaccines but have resisted MCO efforts to set or honor pediatrician appointments may be more willing to visit or may have greater access to a community pharmacist.

## Health Screenings

Pharmacists are positioned to provide health screenings Members given their easy access in the community and the fact that they often have more interaction with Medicaid members than other providers. The information gathered through screenings should be shared with both the MCO and primary care provider to prompt follow-up care and interventions. Potential screenings include:

- **Post-partum maternal depression**
  The Legislature and HHSC have prioritized initiatives and funding to address maternal mortality and improve treatment for maternal depression and leveraging pharmacists may help increase screening rates.

- **Screening, Brief Intervention and Referral to Treatment** (SBIRT)
  The Texas Medicaid program currently reimburses certain providers to provide SBIRT services if they take the four-hour required training on the intervention. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders,

as well as those who are at risk of developing these disorders. SBIRT includes:

  - Screening to quickly assesses the severity of substance use and identify the appropriate level of treatment.
  - A brief intervention focused on increasing insight and awareness regarding substance use and motivation toward behavioral change.
  - Referral to treatment for those identified as needing more extensive treatment with access to specialty care.

- **BH (PHQ9)**
  This screening is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
- **Screening for non-medical drivers of health needs** (employment, food, housing, transportation)
  One pharmacist interviewed indicated their pharmacy trains pharmacists and pharmacy techs to be community health workers and provides referrals to community resources.

### Transitions Of Care And Discharge Planning

The Texas Medicaid program emphasizes the need for MCOs and providers to ensure members have a personalized plan before discharging from hospitals or other institutional settings, with the goal of reducing preventable readmissions. Involving pharmacists in discharge planning or reimbursing community pharmacists to assist and monitor members and provide transition of care MTM—which includes: medication reconciliation, medication reviews and communication with members following discharge—may help reduce preventable readmissions, according to a 2020 HHSC report to the legislature.

# APM Considerations

While APMs provide opportunities to improve the quality of health care and increase a pharmacist's revenue through financial incentives, these arrangements do require a considerable amount of administrative work, data collection and negotiation to implement. Outlined below are some of the considerations for developing and implementing a pharmacy related APM.

## Financial Considerations

If members with chronic conditions increase their medication adherence rate, more prescriptions will be filled and billed. The increase in the plan's prescription drug costs will be immediate but the savings attributable to the improvement will not be realized until much later. Health plans have cited this as a potential disincentive and a consideration when developing APMs and by HHSC in the premium rate-setting process.

Pharmacists influence but do not completely control how much they pay for drugs nor how much they are reimbursed by PBMs. Pharmacists expressed a willingness to participate in total cost-of-care and other risk-based APMs but are hesitant if the models do not adequately consider the drug costs.

Low net profit margins in pharmacies and the lack of billable non-dispensing services mean that pharmacies may have limited bandwidth, i.e. staff, to add services for an APM, so agreements may need to be structured differently than APM agreements with physicians, perhaps offsetting some costs that are not billable.

## Information Exchange

Successful APMs require regular data sharing between the MCO and provider. Pharmacy-related APMs will also require regular information exchange between the MCO and pharmacy and, most likely, physicians. This may be challenging due to existing pharmacy platforms being focused on the dispensing of prescription drugs, but similar challenges existed when health plans and physicians first began developing APMs.

## Alignment of Quality Measures

Physicians have raised the issue about the difficulties of complying with differences in quality measures between health plans and lines of business (Medicare, commercial, and Medicaid). Pharmacies are similarly concerned, and opportunities exist now for consistency between plans. Medicare is further advanced in implementation of pharmacy related APMs than Medicaid. At minimum, if an MCO has existing pharmacy related APMs for their Medicare business, similar models should be considered for their Medicaid business.

## HHSC Pharmacy APM Requirements

The UMCC requires MCOs to obtain approval from HHSC before entering into any APM agreements with pharmacies, while arrangements with other providers do not require prior approval. HHSC is concerned about the potential for APMs that incentivize use of non-preferred drugs, which could reduce drug manufacturer rebate revenue. The

## Clinically Integrated Networks

As care delivery models evolve, providers are coming together to leverage clinically integrated networks (CINs) to meet the triple aim and achieve additional reimbursement from payors. A CIN is a group of providers that partner together to make a collective commitment to performance improvement with a focus on improving the quality and efficiency of care. To support these population health goals, they can contract together to help achieve goals without the risk of violating antitrust laws. CINs also allow providers to combine their patient panels to increase the volume of members in an APM, collect and share data, and provide financial stability and reduce risk for providers interested in entering an APM.

Twenty Texas pharmacists came together in Austin on March 1, 2017. to form the CPESN® Texas. The Texas Network is open to any individual pharmacy, whose services meet all the Network's minimum required services. The goal of CPESN® Texas is to improve the overall health of the citizens of the state of Texas by focusing on quality performance in all aspects of pharmacy practice to include implementation of enhanced pharmacy services, provision of high-quality patient care, collaboration with other health care providers and key stakeholders, and working closely with payors to improve overall health care resources, utilization, and costs. The formation of CPESN® Texas provides a great opportunity for providers and payors to work together to develop and implement pharmacy related APMs.

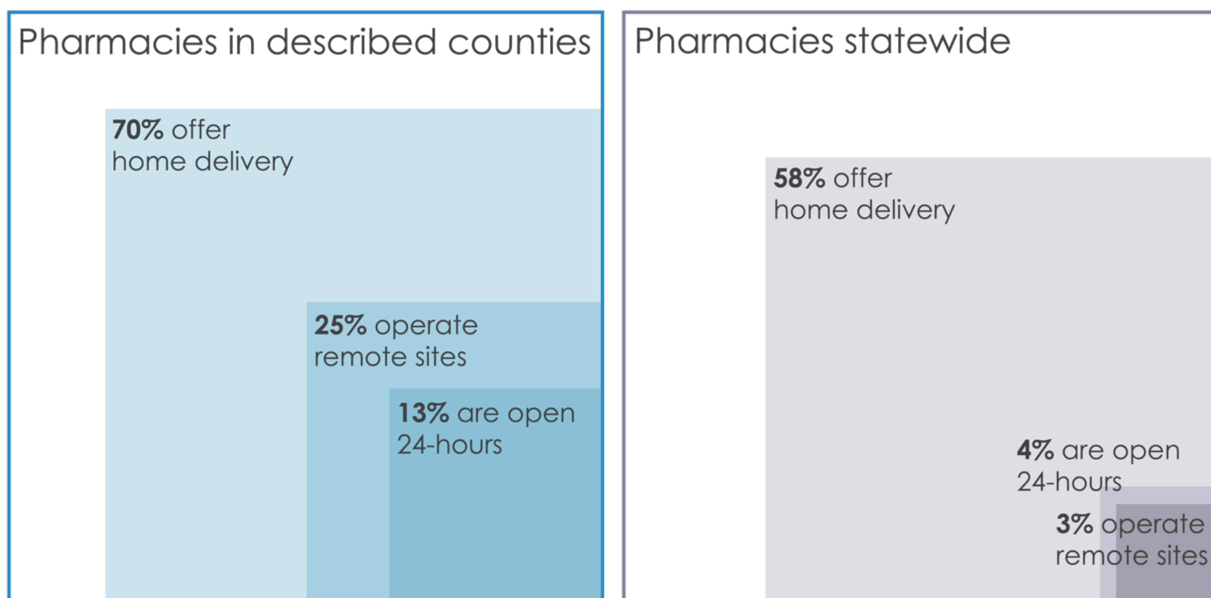
concern is valid but inserts an administrative hurdle that can deter pharmacy related APMs and could perhaps be eliminated by modifying the UMCC requirement.

## Rural Health Opportunities

Texas has 411 primary care health professional shortage areas, and only 58% of primary care needs in those areas are being met. Lack of access to health care and primary care providers is worse in rural communities. With nearly 9 in 10 Americans living within five miles of a community pharmacy, pharmacists are some of the most accessible healthcare professionals and often time the first line of contact for patients in rural communities. As health workforce shortages continue to grow, states will look for ways to increase access to health care, especially in areas facing primary care provider shortages like rural communities. Using pharmacists to help patients manage medications and address chronic illness is one strategy states may examine and the recommendations in this report can have an even bigger impact if implemented in rural communities, especially expanding telepharmacy.

Seventy-three small and CAEC counties are served by only one or two pharmacies. 76% of those pharmacies are independently owned (compared to 38% statewide). These pharmacies provide services at higher-than-statewide rates in response to their communities' needs, as pictured in FIGURE 4 However, the rate of pharmacies that administer immunizations, 73%, is slightly lower than statewide (78%). Note: there are 29 counties without a pharmacy.

#### FIGURE 4: RATES OF PHARMACY SERVICES



## Innovation in Rural Communities

Pharmacies in rural communities, especially independent pharmacies, are finding ways to better serve their communities. For example, two innovative pharmacists approached for this report are in rural communities. Benjamin McNabb, PharmD, is owner of Love Oak pharmacy in Eastland and Lee Ann Hampton, PharmD, is owner of Paris Apothecary in Paris, Texas.

Dr. McNabb has been successful in his team's partnership with an MCO to improve A1c levels for his patients through more frequent and regular testing, Diabetes education, and addressing their non-medical drivers of health (NMDOH). His pharmacy operates a telepharmacy in a nearby community without a community pharmacy. He is active in increasing the number of Texas pharmacies participating in CPESN to help them contract with MCOs on APMs. He has pharmacy technicians and delivery drivers trained as Community Health Workers to better serve his patients. Dr. McNabb is also a member of the HHSC Value-Based Payment and Quality Improvement Advisory Committee.

Dr. Hampton and her colleagues hold weekly classes for their Medicare Part B patients on Diabetes self-management. And, she has leveraged the use of automated dispensing machines to free up her time for patient care, including starting a related company, Be Well Services, to focus on chronic care management. She says the excellent response she is receiving from patients is because "People trust their pharmacist."

Both pharmacists believe more independent pharmacies can add non-dispensing services, as they have. They recommend additional support and education for pharmacists, including:

- Developing, documenting, and sharing repeatable processes with peers;
- Continuing education courses on the medical benefit and how to bill medical systems or on making workflow and process changes;
- Coursework in pharmacy schools on value-based care and APMs; and
- Coursework in pharmacy schools and pharmacy technician training programs on NMDOH.

# Recommendations

## Educate Providers on Available Opportunities

Interviews with pharmacists, Medicaid health plans, HHSC staff, and other stakeholders reveal that there is interest in using pharmacists to address care gaps and there are opportunities to increase the rate of pharmacists providing non-dispensing services, but there is a need for more education on what services are reimbursable and how to bill medical benefits.

## Assist Pharmacies with Enrolling as Medical Benefit Providers

Very few individual pharmacists have enrolled in Medicaid. Medicaid has a robust network of enrolled pharmacies, but pharmacists must enroll as individuals to bill as the performing provider for most non-dispensing services. HHSC and health plans should work with pharmacists to identify the major barriers keeping pharmacists from enrolling as a Medicaid provider and billing non-physician services.

## Develop Reimbursement Models for Additional Services

HHSC should encourage health plans and pharmacists to work together to develop reimbursement for non-dispensing services either as a medical benefit, a pilot, or an alternative payment model. MCO pharmacists have indicated that there are few Medicaid APMs focused on pharmacy today and that there has been low uptake from pharmacists when they have approached them to discuss APM opportunities. MCOs do acknowledge however that there are opportunities to leverage pharmacists to increase access to care because they tend to have strong relationships with the health plan's members, especially in rural areas.

Community pharmacists have indicated interest in engaging in APMs or contracting for additional services, but the incentive must be large enough to support infrastructure needs such as the administrative burden associated with billing and necessary staffing to successfully implement and manage an APM. It would be beneficial to leverage the work of the Texas Pharmacy Association and CPESN Texas to convene pharmacists and payors to develop a simple program to begin testing payment models and explore APMs that include some of the non-dispensing services outlined in this report.

## Identify Pharmacy-Related Quality Measures

It will be important to identify quality measures that can be impacted by interventions conducted by pharmacists in order to initiate an APM. It would be beneficial to conduct a review of the quality measures used by HHSC in its quality improvement programs to identify

viable measures that may be further improved by community pharmacists providing non-dispensing services. Similar to other providers, pharmacists would like to see consistency in the use of these measures between plans and, if feasible, lines of business (Medicare and commercial).

## Develop an Action Plan to Improve Immunization Rates that Includes Pharmacist Administration

During the COVID-19 public health emergency (PHE), the majority of vaccines administered to the general public were administered by pharmacists, demonstrating people's comfort with this provider type and pharmacies' ability to meet the demand. Yet, post-PHE pharmacists provide no vaccines to children or adults in Medicaid, with the exception of pregnant women receiving flu shots.

Texas has lagged behind the national average of childhood immunization rates with 67.8% of children receiving the full series, according to the National Immunization Survey, 2017. According to a recent study Childhood Immunization During the COVID-19 Pandemic In Texas, those rates were significantly impacted by the PHE:

- Among children 5 months of age, there was a 44–47% reduction in receipt of each of the major recommended vaccines between 2019 and 2020.
- In 2019, 64.7% of children 5 months of age were recorded as fully immunized as compared to 34.6% in 2020.
- 43.0% of children 16 months of age were fully immunized in 2019 compared to 18.1% in 2020.
- Declines were larger in rural counties compared to urban.

The time is right to eliminate historic roadblocks and empower pharmacists to help the state improve its immunization rates. There is reason to believe that lessons learned during the PHE can serve to break down past concerns expressed by the state, primary care physicians, and pharmacies.

## Conduct a Cost of Administration Study

One issue that has been raised by pharmacists as a disincentive to administering more vaccines to people enrolled in Medicaid and CHIP is the reimbursement rate for vaccine administration. The Medicaid fee schedule has one rate for vaccine administration whether administered by a physician or pharmacist. Pharmacists contend the rate is insufficient.

This issue is not likely to be addressed by the recommendation above, it requires actionable data. Similar to the process used by states to establish a professional dispensing fee for medications, conducting a "Cost of Administration" study, with HHSC involvement, would provide actionable data and it could compare pharmacy costs to the cost of administration by a physician.

## Support Legislation to Allow Pharmacists Limited Prescribing Authority

During the 88th regular session of the Texas Legislature, Senator Perry authored Senate Bill 160, which would extend pharmacists' scope of practice. It would allow them to test and treat patients for streptococcus, Influenza, and COVID-19 under a broad protocol, not a CPA, and other states have adopted similar legislation. Passage of legislation like this would provide Texans access to these services as easily as they obtain immunizations.

## Improve Communication and Telecommunication Between Pharmacies, MCOs and PBMs, and Physicians

Stakeholders appear hesitant to take bigger steps towards including pharmacists in quality-improvement APMs and policy initiatives for reasons provided in this report. Holding targeted, periodic discussions with stakeholders on these topics may erode the inertia that currently exists and lead to consensus on meaningful changes and coordination on actions.

For community pharmacists to evolve into more involved participants on care teams and quality improvement initiatives, they will need to establish interfaces with MCOs/PBMs and primary care physicians to exchange timely, actionable data. In their 2022 report to the Texas Legislature the Value-Based Payment and Quality Improvement Advisory Committee asserts, "Over the past six years, the Committee has focused on the importance of timely, actionable data to enable value-based care and movement toward more advanced care models along the value-based care continuum. MCOs and providers cannot succeed in APMs to better manage population health without necessary data".

## Encourage the Adoption of Telepharmacy

Approximately one dozen pharmacies in Texas operate a remote telepharmacy. A pharmacist is not physically present at the remote site; instead, most of the work is done by pharmacist technicians under the supervision of the pharmacist at the primary location. Telecommunication systems, including video, are used by the pharmacist to supervise pharmacy technicians and to counsel patients. A telepharmacy may be in a rural hospital or clinic. Encouraging and supporting more pharmacies to operate a telepharmacy may provide rural patients with nearer access to pharmaceutical care.

# Trends to Watch: Pharmacist Workforce Issues and Store Closures

In the mid-2000's there was a shortage of pharmacists in Texas. New graduates could expect recruiters and signing bonuses. By the mid-2010's Texas had added more pharmacy schools, campuses, and graduates, and eliminated the shortage. Today enrollment in pharmacy schools is declining and there are several other factors impacting the future availability of pharmacists.

## Pharmacist Workforce Issues

Education requirements for pharmacies also increased during this period. Pharmacist degree programs increased from a five-year bachelor to a six-year doctoral program—including two years of undergraduate work. Since 2004 all U.S. pharmacy school graduates have at least a Doctor of Pharmacy (PharmD) degree. The goal of these curriculum changes was to shape the future of the pharmacy profession away from dispensing to a more clinical orientation and focused on patient care. Pharmacists are well-prepared, but the shift in the role of community pharmacy has been slow except for the increase of pharmacists as immunizers.

Transitions can be painful and the transition in the role of community pharmacies is no exception. In 2023 there were several well-publicized strikes of pharmacists and other pharmacy staff from Walgreens and CVS drug stores. Pharmacists cited unreasonable demands on their time and insufficient staff behind the pharmacy counter. In many stores there is only one pharmacist on duty who has to perform both the dispensing and non-dispensing functions, (like immunizations). In response, Walgreens shifted more of its prescription filling to off-site central-fill pharmacies, freeing up the on-site pharmacist for more non-dispensing activities, and both chains increased pharmacist technician's pay.

In a February 2022 interview with PBS, some pharmacists said they chose to leave their community pharmacies because the unreasonable workloads and expectations caused them to fear they may harm a patient. Some of these issues are considered fallout from the surge in the use of pharmacies during the pandemic. However, it will be important to monitor whether increasing non-dispensing services, as recommended in this report, will push more community pharmacies beyond their capacity to deliver those services.

There are changes pharmacies can implement to reduce the prescription filling workload of pharmacies.

- One progressive, independent pharmacist interviewed for this report uses automated dispensing machines in her pharmacy to free up her time and for greater customer satisfaction because of the customized blister packs it dispenses.
- Pharmacists may be able to reallocate more of their work to pharmacy technicians. Results of an 18-month study in Iowa showed that the percentage of pharmacists' time spent filling prescriptions dropped from 67% to 49% and time on patient care services increased from 16% to 35% when technicians had an expanded role.
- Chain stores can shift more prescriptions to a central-fill facility.

Some pharmacists may find the use of automated dispensing machines and delegation of pharmacist duties worrisome, an infringement on their scope of practice. However, other pharmacists are eager to take a more active role in patient care.

## Store Closures

Another disconcerting trend is the number of pharmacy closures in recent years, including where the stores were located. CVS, Walgreens, and Rite-Aid have closed hundreds of stores and expect to close more. A 2019 study on the impact of store closures revealed an immediate reduction of almost 6% in cardiovascular medication adherence for older patients of closed stores, and the decreased rate persisted 12 months later. The drop in adherence was nearly 8% for patients of closed independent pharmacies and in communities with few pharmacies.

Another 2019 study noted that the total number of pharmacies increased between 2009 and 2015—there were more store openings than closures. But, given the negative impact on patients when stores close, they attempted to learn the likelihood of closures in different communities. Independent stores were more likely to close than chains. And in urban areas, pharmacies serving disproportionately low-income, uninsured, and publicly insured populations were at greatest risk of closure. The researchers attributed this to pharmacies in those communities having a higher percentage of patients in lower-paying Medicaid and Medicare programs coupled with fewer opportunities to augment store revenue with sales of higher-profit items outside the pharmacy counter.

Pharmacies, especially independent pharmacies, are very concerned about a CMS rule that will go into effect January 1, 2024, related to Direct and Indirect Renumeration (DIR) for Medicare Part D plans. CMS has observed Part D PBMs paying concessions to Part D plans after the point-of-sale transaction with the pharmacy, causing the net spend to be lower. CMS found the differences in net amounts over time problematic and have directed Part D PBMs to pay pharmacies the net amount up front. Pharmacies are expecting much lower reimbursement and other issues. A recent survey of independent Iowa pharmacies revealed that over 40% expect to close within 12 months. This is a concern for independent Texas pharmacies, too, though the potential impact has not been quantified.

# Trends to Watch: Co-located Pharmacies and Health Clinics

"Walmart May Soon Become the Largest Primary Care Provider In the Country" predicts a February 2022 article in Forbes magazine. The retail giant has been quickly growing its healthcare business by placing Care Clinics in more stores. Walmart is just one business in the accelerating trend of co-locating a healthcare provider and a pharmacy.

Definitive Healthcare, a healthcare data and analytics company reported a 200% increase in the last five years in the use of retail clinics. The types of retailers and models vary greatly. Some examples follow:

- CVS Health has the biggest percentage of this market (over 63%), primarily in Minute Clinics in CVS pharmacies. They also operate "enhanced clinics", called HealthHUB, that focus on chronic disease management.
- Kroger, the grocery chain, operates The Little Clinic in over 220 stores. Their vision is "keeping customers healthy through 'food as medicine' offerings, like tele-nutrition, food prescriptions, and nutritional scoring with the goal of preventing disease."
- Walgreens bought VillageMD and operates Village Medical clinics in their pharmacies, with a goal of 1,000 clinics by 2027.

The clinics are not intended to be a patient's medical home or PCP. The typical model uses advanced practitioners as the primary provider, but others use physicians. The level of integration between the co-located pharmacy and clinic varies, from separate entities to fully integrated. In the case of CVS Health, they own the health plan, PBM, pharmacy, and clinics. This vertical alignment may create unique opportunities for APMs.

Retailers with co-located pharmacies and health clinics could provide access to care for communities with limited access. Unfortunately, that is not currently the case. The majority are located in geographic areas with higher median incomes and only about 2% are in rural areas, according to the Definitive Healthcare analysis.

We met with Adam Chesler, PharmD., Senior Vice President for Strategic Initiatives at Village MD, to better understand their model. He explained that the Walgreens pharmacy and the co-located Village Medical clinic are integrated. An important feature is their shared electronic medical records and communications platform between the clinic and pharmacy. The pharmacy can serve as a point-of-care triage for patients, with services provided by pharmacists or the clinic's physicians. A CPA between the clinic and pharmacists provides needed flexibility and efficiency.

As reported here, non-dispensing pharmacy services are not always billable. Therefore, Walgreens does not bill for these services. Instead, Walgreens and Village Medical participate in total cost of care APM agreements with MCOs, with pharmacy payments linked to outcomes.

Approximately half the Village Medical-Walgreens are located in lower-income communities and Walgreens expects to keep that target as it adds stores. There are only a few clinics in rural settings. The model currently requires a physician in the clinic, which may not be feasible in places with provider shortages. However, a new clinic they are building will not have an on-site physician but will allow a tele-visit with a remote VillageMD physician.

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