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Community Pharmacy Credentialing for Medical Insurance to Facilitate Sustainability in COVID-19 Testing

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Abstract

Background: In April 2020, pharmacists were added as medical providers under Idaho Medicaid in response to recent scope expansion for pharmacists and to increase beneficiaries' access to coronavirus disease 2019 (COVID-19) testing and services. The COVID-19 pandemic prompted expedited Medicaid enrollment for pharmacists but did not address coverage of medical services provided to privately insured individuals for pharmacy-based testing services.

Objective: This study aimed to describe processes used by independently owned, community-based pharmacies in Idaho to credential with private insurers and report outcomes.

Methods: Relevant information and forms required to credential with the four major payers in the state of Idaho were collected. Packets were obtained via medical insurers' websites and by direct contact. Questions that arose from community pharmacists during the submission process were collected and answered on a shared spreadsheet, and insurance representatives were contacted directly to resolve questions.

Results: Eight out of 13 participating pharmacies submitted an average of three credentialing packets for their facilities. Thirty-five pharmacists also submitted an average of four credentialing packets for themselves. As of mid-May 2021, nearly 20 weeks after submission, only 67 out of 129 pharmacists had received word regarding the status of their applications. Less than half of all pharmacist applications were approved (after their first attempt).

Conclusion: Efforts to support the education of both pharmacists and medical insurers may streamline the credentialing processes in the future.

Keywords
pharmacies, credentialing, insurance, health, reimbursement, COVID-19, community pharmacy, independent pharmacy

Background

Traditionally, pharmacists bill prescription claims via a pharmacy benefit manager (PBM). PBMs serve as a middleman between the medical insurance and pharmacy, effectively blocking any option to bill the medical insurance for clinical encounters (e.g., evaluation and management or testing services, and immunization administration), as other providers would. Provider status is necessary for the pharmacists in the United States to sustainably provide clinical services unrelated to the dispensing of medication. While efforts to obtain federal provider status continue to be underway,[1] pharmacists in a number of states are currently recognized as healthcare providers, allowing them to receive

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reimbursement for medical services rendered.[2,3] In April 2020, Idaho's Medicaid program recognized pharmacists as healthcare providers, increasing access to vital health services for beneficiaries. Idaho licensed pharmacists with an established National Provider Identification (NPI) number were auto-enrolled as non-physician providers with Idaho Medicaid.[4] This allowed pharmacists to be reimbursed for non-dispensing medical services rendered. Following this enrollment, pharmacists in Idaho could bill Medicaid for services related to their expanded scope of practice under the Idaho Medicaid medical benefit (e.g., testing services for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and independent prescriptive services for certain conditions).[4]

Idaho Medicaid's actions allowed the state to increase necessary testing services for the 18% of Idahoans who are program recipients.[5] Although provider status with this state public payer represented a major advancement for the profession, the change did not include coverage of medical services provided to the approximately 57% of Idaho residents with private health insurance, a barrier to pharmacy-based testing services.[5]

Credentialing is a process whereby insurance providers assess and confirm healthcare professionals' qualifications to provide, authorize, and be reimbursed for covered healthcare services they provide. It is separate from program enrollment and is required both for the individual provider (i.e., the pharmacist) and the place of service (i.e., the community pharmacy).[6] Credentialing is mandated by the Centers for Medicare and Medicaid Services regulations to uphold patient safety and prevent provider waste, fraud, and abuse.[7] As part of the process, pharmacists must present proof of their education, licensure, training, certifications, malpractice insurance coverage, and list any infractions, sanctions, or reports of malpractice for review and evaluation by insurance providers.[7] Once credentialed and enrolled, providers can be contracted to join an insurer's panel of providers that can bill the insurer for covered medical services rendered. This represents a critical part of providing sustainable SARS-CoV-2 testing services to the general public throughout the pandemic.

In response to the COVID-19 pandemic, the Idaho State Board of Pharmacy provided a grant to Idaho State University College of Pharmacy (ISU) in July 2020 to design and administer a community-based pharmacy point-of-care testing (POCT) program in rural areas of the state.[8] To do this, ISU contracted with 13 pharmacies of Community Pharmacy Enhanced Services Network of Idaho (CPESN-ID) to deliver rapid antigen testing and perform nasal swabs for laboratory polymerase chain reaction (PCR) analysis. This collaborative work, known as the COVID-19 Rapid Antigen Testing Expansion Program (Program), was part of a multi-pronged initiative to increase POCT services offered in community pharmacies throughout Idaho.

Objective

This article describes the credentialing support provided to community pharmacists and pharmacies over the course of the Program. Participating independent pharmacies sought credentialing from major private payers in Idaho in order to sustain SARS-CoV-2 testing services beyond the life of the grant-funded program. The lessons learned during the Program may aid other pharmacists and pharmacies seeking reimbursement for providing medical services and indicate some of the challenges to overcome.

Methods

As part of the Program, independent pharmacies were contacted and encouraged in mid-December 2020 to submit credentialing paperwork (for both pharmacists and pharmacies) with major private insurance payers in the state of Idaho. Pharmacies that successfully submitted credentialing packets by December 30, 2020, were provided with a financial incentive to reimburse pharmacists for their time to complete paperwork. Pharmacies were provided with approximately 2.5 weeks to complete submissions.

The Program's credentialing efforts targeted Blue Cross of Idaho, Regence Blue Shield, Pacific Source, and Select Health. These payers were selected because of their market share statewide: Blue Cross of Idaho Health Services, Inc. (29.6%); Select Health (11.5%); Regence Blue Shield of ID, Inc. (9.1%); and Pacific Source Community Health Plans (3.5%).[9]

To assist pharmacies in their credentialing efforts, Program administrative team members gathered instructions, key contacts, credentialing packets, and other required paperwork from the four payers of interest. This information was obtained via provider resources on the insurers' websites and by contacting provider support services. When questions from participating pharmacies arose during the paperwork process, Program staff assisted by reaching out to payers to resolve questions and guide pharmacists. All questions and answers were gathered on a shared spreadsheet accessible to all pharmacists involved in the Program.

To assess results of credentialing efforts, Program staff distributed a web-based questionnaire on December 30, 2020. The questionnaire collected data on the number of credentialing packets submitted by pharmacists and pharmacies and to what payers. Pharmacists had to attest to their submitted packets through electronic signature.

Additional data were collected in April–May 2021 to assess success of the initial submission of credentialing packets. Data were collected using an online spreadsheet–based form that collected what type of response was received from payers, and an open-ended prompt for any pertinent feedback or comments. Pharmacies were given ten days to respond to the request to complete the online form; reminders were issued via email, phone call, or in-person.

Results

Credentialing Packet Application Status

By December 30, 2020, a total of 35 pharmacists submitted an average of four credentialing packets. Of note, 2 pharmacists

left employment after beginning the credentialing process. Eight out of the 13 participating pharmacies submitted an average of three credentialing packets for their facilities (i.e., pharmacies). Details of submitted packets are presented in Table 1.

As of mid-May 2021, nearly 20 weeks after submission, only 67 out of 129 (51.9%) pharmacists had received notification regarding the status of their applications. Of the 33 pharmacists who submitted credentialing packets to Blue Cross of Idaho, the largest private payer in the state, 19 were rejected, while 14 had not received a response—zero were accepted or had requests for changes. Pacific Source credentialed 19 of the 32 pharmacists who applied. Similarly, Regence Blue Shield of Idaho accepted 17 of 32 submitted applications, requested changes from one, denied one, and had not responded to 13 applicants. Select Health accepted 2 out of 32 applications, requested eight submit revisions, and did not respond to 22 applications.

Pharmacist Feedback on Process

Pharmacists surveyed reported via open-ended comments that private payers were confused by their applications and unsure if pharmacists/pharmacies were asking for credentialing related to drug or durable medical equipment (DME) dispensing. One of the most common reported problems by pharmacists was insurers' inability to answer questions designed for other medical providers, who practice under a different reimbursement model. For example, under "provider," there was no option to select "pharmacist," and so they had to use a generic "physician extender" to proceed with the application. However, this selection led to more difficulties later, as menus did not include pharmacy titles or certifications. Pharmacists were advised by insurer credentialing representatives to leave non-applicable fields blank; however, this also led to further issues where omissions were considered paperwork errors, resulting in processing delays, packet resubmissions, and packet expiration necessitating resubmission.

Discussion

While pharmacists increasingly administer immunizations and are reimbursed via PBMs for the supplies and vaccine itself (and partially for the time taken to administer), it is still uncommon for pharmacists to receive compensation for any clinical services.[10] Furthermore, while some pharmacies are licensed DME providers for Medicare patients, this is not the provider status needed to bill for clinical services.[11]

This effort toward credentialing represents one step toward securing reimbursement of COVID-19 testing for privately insured residents and achieving service sustainability. This targeted effort resulted in 129 pharmacists and 31 pharmacy packets being submitted. During follow-up in May 2021, approximately one-third of packets had been accepted. However, nearly half of all submitted packets were still awaiting a response by the payer.

In our feedback from pharmacists as well as personal conversations with payer-credentialing representatives, there was confusion surrounding pharmacist provider credentialing. There is a need to educate pharmacists on the billing vernacular used by all other healthcare providers in the industry, as well as the processes involved in payer credentialing and enrollment. There was also confusion from insurance companies and payer-credentialing representatives, potentially reflecting a general lack of understanding of the training pharmacists receive, their scope of practice, and under which benefit (pharmacy and/or medical) provided clinical services should be charged. Moving forward, there is an opportunity to better understand structural flaws as well as facilitators in the credentialing process. Identification of this information may help stakeholders such as professional pharmacy organizations enable process changes to increase the success of credentialing efforts.

This concerted effort sought to capitalize on Idaho's recognition of pharmacists' ability to offer quick, reliable, and accessible COVID-19 testing services during the pandemic. Within a short timeframe, multiple pharmacists and pharmacies submitted credentialing packets to the largest private insurers in the state. It resulted in a marked spike in credentialing packet submission/review, potentially increasing internal conversations within health insurance credentialing groups. One lesson learned from the Program is that a coordinated approach may be more effective than individual submissions, where credentialing packets may be more easily set aside because of payer confusion. Professional groups might consider supporting similar focused efforts to complete and submit credentialing packets at the same time, perhaps hosting sessions during statewide professional meetings. Advocacy and education efforts targeted directly at medical insurance providers may also help to ease the credentialing efforts made by pharmacists. The fact that close to half of all applications had not been responded to nearly five months after the packets were submitted, however, may reflect the gaps in medical insurance processes to respond to pharmacist credentialing requests. Outreach to medical insurance groups by pharmacy organizations may be warranted to clarify pharmacist training and scope of practice.

Although this project focused specifically on expansion of COVID-19 POCT, there will be a continued need for expanding patient access to medical services, especially in rural areas. In order for community pharmacies to sustainably provide both COVID-19–related and general patient care services, they must receive reimbursement for resources used for service provision (e.g., personnel and supplies). With the rollout of COVID-19 vaccination efforts, the demand for testing has mostly been replaced with demand for immunization services. While Idaho Medicaid still allows pharmacists to bill the medical benefit for medical services provided (i.e., POCT and immunization administration), most private

Table 1. Status of Pharmacist Practitioner and Pharmacy Facility–Credentialing Applications Submitted by Payer.

Payer	Applications submitted, n	Application status (as of May 11, 2021), n (%)			
		Accepted	Changes needed	Denied	No response
Pharmacist practitioner applications[a]					
Blue Cross of Idaho	33	0 (0)	0 (0)	19 (57.6)	14 (42.4)
Regence Blue Shield of Idaho	32	17 (53.1)	1 (3.1)	1 (3.1)	13 (40.6)
Pacific Source	32	19 (59.4)	0 (0)	0 (0)	13 (40.6)
Select Health[b]	32	2 (6.3)	8 (25.0)	0 (0)	22 (68.8)
Total	129	38 (29.5)	9 (7.0)	20 (15.5)	62 (48.1)
Pharmacy facility applications					
Blue Cross of Idaho	8	0	0	5 (62.5)	3 (37.5)
Regence Blue Shield of Idaho	8	6 (75.0)	0	0	2 (25.0)
Pacific Source	8	4 (50.0)	0	0	4 (50.0)
Select Health[c]	7	1 (14.3)	1 (14.3)	0	5 (71.4)
Total	31	11 (35.5)	1 (3.2)	5 (16.1)	14 (45.2)

[a]Two pharmacists left their employment after beginning the credentialing process; their data are omitted.
[b]Select Health pharmacist practitioner applications were submitted through St. Luke's Health Partners and Bright Path.
[c]Select Health did not have pharmacy facility applications available for completion. Instead, project team members collected relevant information directly from pharmacies and submitted to St. Luke's Health Partner to assist in the credentialing process; information was submitted from seven pharmacies.

insurers in the state do not. However, pharmacist provider recognition may change this, allowing for expanded services not limited to COVID-19 to be provided.

With support for credentialing services anticipated in future, the pharmacy community will need to prepare to adjust its approach to billing due to the timeliness of provider reimbursement and its effect on independent community-based pharmacies. Traditionally, community pharmacies depend on up-front payments and have sought to maximize their point-of-sale transactions. The medical insurance model, however, defers full payment 30 or more days from point-of-care. If pharmacies increasingly seek payment for clinical services, they will need to modify their finances in order to absorb the inherent delays in the current US medical reimbursement system.

This project has limitations that influence interpretation of findings. Because responses went to individual pharmacists, the capture of data related to acceptance or rejection of packets may have gaps. There may be additional correspondence from medical insurance companies related to individual pharmacist or pharmacy-credentialing packets that were not captured. Consequently, opportunities for clarification of language in the submitted materials, completion of forms, and response to queries from insurance representatives cannot be collated for broader dissemination. Related, clear data on what facilitated acceptances does not exist. Also, the pressure from the COVID-19 pandemic may have influenced the responsiveness of medical insurance companies, both positively and negatively, or altered their willingness to offer credentialing opportunities to pharmacists and pharmacies. Lastly, this work outlines the approach in one state, and pharmacists in other states may need to make adaptations in their approach to different considerations.

Conclusion

This project serves to highlight the feasibility of community-based pharmacists completing and submitting credentialing applications with medical insurers to be reimbursed for clinical services not related to dispensing of a medication. Efforts to support the education of pharmacists, pharmacies, and private medical insurers may help to streamline similar efforts in the future.

Declaration of Conflicting Interests

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Author's Note

Data from this project were presented at Idaho Society of Health-Systems Pharmacists' Spring 2021 Meeting via a podium presentation.

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