Objectives

Upon completion of this session, participants should be able to:

✓ Describe implementation strategies for expanded pharmacy services that may support value-based health care models

✓ Discuss best practices for implementation of pharmacy services as quality improvement efforts that will impact value-based health care

✓ Describe how implementing expanded pharmacy services in primary care is linked to value based payment structures
Self-Assessment Questions

What services can a pharmacist bill Medicare?

a) Chronic Care Management (CCM)
b) Durable Medical Equipment
c) Transitional Care Management (TCM)
d) “Incident to” Evaluation/Management
e) All the above

Self-Assessment Questions

Requirements of “incident to” billing include all of the following EXCEPT:

a) Commonly furnished in a physician’s office.
b) Furnished by supervised auxiliary personnel employed by physician or practice.
c) Physician must be present in room when services are provided by auxiliary personnel.
d) Conducted within the Scope of Practice of the auxiliary personnel.
Payment Models

Fee for Service: FFS
Pay for Performance: FFV
Shared Savings: FFV
Bundled Payments: FFV

Bundled Payments

Bundled payment is a market-driven single comprehensive payment to providers and/or health care facilities to treat a condition or provide a treatment.

- Providers to assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications.

- Ambulatory Care Pilots

Example: Chronic Care Management
Always Remember the Value Game

![Image showing the increase in PCP utilization and pharmaceutical utilization leading to decreases in inpatient admissions, preventable admissions, preventable readmissions, and emergency department visits.]


From Volume to Value

Medicare FFS Payments

- Traditional FFS
- Value Oriented Payment

*Absolute percentage difference between actual and expected rates for CCNC enrolled vs. unenrolled.
Pharmacist Billing for Services

Pharmacists have limited options as a PROVIDER

Consider Pharmacists as AUXILIARY PERSONNEL or CLINICAL STAFF

“What has changed???

Federally Qualified Health Centers (FQHC) and Rural Health Care Initiatives (RHI) have a Prospective Payment System (PPS) that includes a bundled payment for Auxiliary Personnel and Clinical Staff that may prohibit pharmacist billing.

What has changed?

Transitional Care Management

➢ Beginning on January 1, 2017, services furnished by auxiliary personnel incident to a TCM visit may be furnished under general supervision.

Chronic Care Management (CCM) Services

➢ Beginning on January 1, 2017, services furnished by auxiliary personnel incident to a CCM visit may be furnished under general supervision.

The key to pharmacist participation is the interpretation of “Auxiliary Personnel”. CMS Medicare Billing Policy Manual Chapter 15 Section 60.1(B), and 42 CFR 410.26 states “Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.”
Auxiliary personnel…

...means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

Clinical staff…

...is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report (bill) that professional service.


CMS Policy: “Incident to” and Pharmacists

In March 2014 responding to an inquiry from the AAFP regarding physicians billing for “incident to” services provided by pharmacists, Marilyn Tavenner, CMS Administrator, stated:

“…we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services…”
SC Law and Scope of Practice

Delegation of Medical Acts:
SC Medical Practice Act provides for the delegation (…to a physician assistant, …or other practitioner authorized by law under approved written scope of practice guidelines or approved written protocols as provided by law in accordance with the applicable scope of professional practice) of certain medical acts.
Source: http://www.lir.sc.gov/pol/medical/PDF/Laws/MPAChapt47.pdf

Pharmacist Scope of Practice:
The South Carolina Board of Pharmacy confirms that the scope of pharmacy practice… permits a SC licensed pharmacist, in collaboration with a SC licensed physician, to obtain a patient medical history, evaluate laboratory results, conduct limited examinations, and make medical decisions pursuant to a medical order.
Source: http://www.lir.state.sc.us/POL/Pharmacy/Minutes/March_18_2015_motions.pdf

Supervision

General Supervision - procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required.

Direct Supervision - the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal Supervision – a physician must be in attendance in the room during the performance of the procedure.

Source: 42 CFR 410.32(b)(3)(i)-(iii)
Expanding Role for Pharmacists

Traditional role
- Medication distribution
- Contraindications and drug–drug interactions
- Physician’s resource for medication information
- Patient education about medications

Emerging Role
- Comprehensive Medication Management – “Incident to”
- Chronic Care Management
- Annual Wellness Visits
- Transitional Care Management
- Diabetes Self-Management Training

Outpatient Revenue Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Procedural</td>
<td>$18</td>
</tr>
<tr>
<td>99212</td>
<td>Problem Focused</td>
<td>$42</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded Problem Focused</td>
<td>$72</td>
</tr>
<tr>
<td>99214</td>
<td>Comprehensive Problem Focused</td>
<td>$104</td>
</tr>
<tr>
<td>99490</td>
<td>Chronic Care Management</td>
<td>$42/mo</td>
</tr>
<tr>
<td>99495</td>
<td>TCM Moderate Complexity</td>
<td>$135 – $164</td>
</tr>
<tr>
<td>99496</td>
<td>TCM High Complexity</td>
<td>$198 – $231</td>
</tr>
<tr>
<td>G0438</td>
<td>AWV – Initial</td>
<td>$166 – one lifetime</td>
</tr>
<tr>
<td>G0439</td>
<td>AWV – Subsequent</td>
<td>$111 – each year</td>
</tr>
</tbody>
</table>
PCMH Research Pilot Study

**Collaborators**

**Palmetto Primary Care Physicians**
- Group practice comprised of over 75 clinical providers through 20 locations in 3 counties.
- Pilot 1 Collaborative with Trident-North Charleston office
- Pilot 3 Collaborative with Summerville office
- *Transitioning from Traditional FFS to “Value-based” payments*
  - Pay for Performance
  - Shared Savings
  - Capitation with reinsurance (ACO)

**Mackey Family Practice**
- Group practice comprised of over 5 clinical providers serving 2 locations.
- Pilot 2 Collaborative with Lancaster office
- Designated rural practice

---

**Quality-A1c Improvement**

- **Patients with A1c >10.0**
  - Mean A1c Improvement: **12.1** to **9.6** (20.8%)
  - **84.0% Patients Improved**

- **Patients with A1c >7.0**
  - Mean A1c Improvement: **9.3** to **8.2** (11.2%)
  - **77.2% Patients Improved**

202 Patient retrospective chart reviews
Evaluation period November 2013–October 2014
Minimum 2 pharmacist visits and pre/post A1c
Quality-LDL Improvement

 Patients with LDL-C >130

 Mean LDL Improvement

 Patients with LDL-C >80

 Mean LDL Improvement

- 186 patients – retrospective chart reviews
- Evaluation period November 2013-October 2014
- Minimum 2 pharmacist visits and pre/post LDL-C

86.2% Patients Improved

22.5% 225%

Patients with LDL-C >130

86.2% Patients Improved

79.1% Patients Improved

16.2% 101%

Satisfaction (5-point Likert scale)

Willingness to Recommend/Refer

Provider
Patient
Staff

4.7
4.9
5.0

15% of patients volunteered they would change behavior based on pharmacist’s coaching.
Cost Avoidance

<table>
<thead>
<tr>
<th>Month</th>
<th>Encounters</th>
<th>Interventions</th>
<th>$ Avoidance</th>
<th>Avoid/Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>205</td>
<td>909</td>
<td>$139,260</td>
<td>$679.32</td>
</tr>
<tr>
<td>May</td>
<td>197</td>
<td>969</td>
<td>$148,379</td>
<td>$753.19</td>
</tr>
<tr>
<td>June</td>
<td>200</td>
<td>990</td>
<td>$151,531</td>
<td>$757.66</td>
</tr>
</tbody>
</table>

Typical Interventions

- Medication reconciliation
- Allergy identified, clarified or prevented
- Lab/test evaluation, patient consultation or recommendation
- Medication change of dose adjustment
- Patient counseling
  - self care: diet, exercise, checking blood sugars,
  - OTC recommendation, smoking cessation
- Adverse effect identified/remedied

Average savings per intervention was $153

$1.8M Annually Projected

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Physician Productivity

<table>
<thead>
<tr>
<th>Provider</th>
<th>2013 Payment/Work Day</th>
<th>2014 Payment/Work Day</th>
<th>% Increase Payment/Work Day</th>
<th>2013 Q2 Visits/Day</th>
<th>2014 Q2 Visits/Day</th>
<th>% Total Referrals to PharmD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDA</td>
<td>$2,741</td>
<td>$3,499</td>
<td>27.7%</td>
<td>24.2</td>
<td>25.0</td>
<td>46%</td>
</tr>
<tr>
<td>MDB</td>
<td>$3,100</td>
<td>$3,701</td>
<td>19.4%</td>
<td>31.1</td>
<td>31.2</td>
<td>9%</td>
</tr>
<tr>
<td>MDD</td>
<td>$2,602</td>
<td>$3,385</td>
<td>30.1%</td>
<td>23.5</td>
<td>23.7</td>
<td>27%</td>
</tr>
<tr>
<td>MDT</td>
<td>$2,582</td>
<td>$3,000</td>
<td>16.2%</td>
<td>23.5</td>
<td>24.8</td>
<td>11%</td>
</tr>
<tr>
<td>MDV</td>
<td>$2,878</td>
<td>$3,177</td>
<td>10.4%</td>
<td>24.0</td>
<td>22.7</td>
<td>7%</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>$2,781</td>
<td>$3,352</td>
<td>20.6%</td>
<td>25.3</td>
<td>25.5</td>
<td>100%</td>
</tr>
</tbody>
</table>

Contributing Factors:
1. Fee Increase November 2013
2. More New Patient Visits
3. More Complex Visits

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### Pharmacist Capacity and Revenue

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Encounters</strong></td>
<td>115</td>
<td>219</td>
<td>197</td>
<td>231</td>
<td>218</td>
</tr>
<tr>
<td><strong>Encounters/Day</strong></td>
<td>6.4</td>
<td>11.5</td>
<td>9.9</td>
<td>11.0</td>
<td>11.2</td>
</tr>
<tr>
<td><strong>Capacity Used</strong></td>
<td>34%</td>
<td>46%</td>
<td>59%</td>
<td>83%</td>
<td>72%</td>
</tr>
<tr>
<td><strong>Encounters Billed</strong></td>
<td>17%</td>
<td>15%</td>
<td>63%</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td><strong>Revenue Collected</strong></td>
<td>$1,025</td>
<td>$1,830</td>
<td>$3,641</td>
<td>$7,490</td>
<td>$7,398</td>
</tr>
</tbody>
</table>

### Building the Business Case

1. **Assess**
   - Leadership
   - Demographics
   - Needs
   - Resources
   - Revenue
   - Outcomes
   - Compensation

2. **Develop**
   - Customer Value Proposition
   - Key Activities
   - Cost Structure
   - Key Resources
   - Revenue Streams
   - Key Partners
   - Financial Model

3. **Present**
   - Assessment
   - Value Message
   - Proposal
How Can Expanded Pharmacist Services Become and Remain Viable?

1. Increased revenue
   ✓ Bill for CCM and TCM services as auxiliary personnel under general supervision?

2. Increased efficiency
   ✓ Shift some services from physician to pharmacist leaving physician to manage high complexity cases

3. Improved quality
   ✓ Patient satisfaction
   ✓ Clinical outcomes

Summary

• Pharmacists can be an integral part of the care team in FQHCs and RHCs
• Some of the care services provided by pharmacists may
  > generate new revenues or
  > improve quality and efficiency.
• Challenge is for organization to view pharmacists differently than dispensers and take some risk by reorganizing the care delivery system (administrator’s prerogative).

Thanks to Drs. Bob Davis and Bryan Zeigler for their immense contributions to this presentation and the KPIC in general.
Questions and Discussion