## 2015 Annual Convention

<table>
<thead>
<tr>
<th>Date:</th>
<th>Tuesday, October 13, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>8:00 am – 9:30 am</td>
</tr>
<tr>
<td>Location:</td>
<td>Gaylord National Harbor Resort and Convention Center, National Harbor 10</td>
</tr>
<tr>
<td>Title:</td>
<td>Opportunities and Reimbursement Models for the Community Pharmacist in Primary Care Partnerships</td>
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<tr>
<td></td>
<td>ACPE # 207-000-15-126-L04-P · 0.2 CEUs</td>
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<td>ACPE # 207-000-15-126-L04-T</td>
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<tr>
<td>Activity Type:</td>
<td>Application-based</td>
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<tr>
<td>Speaker:</td>
<td>Bryan Ziegler, PharmD, Executive Director, Kennedy Pharmacy Innovation Center</td>
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### Pharmacist and Pharmacy Technician Learning Objectives:

Upon completion of this activity, participants will be able to:

1. Describe the changing landscape of primary care medical practice and reimbursement models for primary care providers.
2. Identify the healthcare quality metrics that are driving primary care value-based reimbursement and identify those that can be influenced by pharmacist services.
3. Discuss various pharmacist service opportunities that a community pharmacist could provide in collaboration with a primary care provider.
4. Identify resources for a community pharmacist to utilize when implementing new collaborative services with primary care providers.
5. Discuss strategies for identifying primary care medical practice targets that present good opportunities for community pharmacist collaboration.

### Disclosures:

Bryan Ziegler declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

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Opportunities and Reimbursement Models for the Community Pharmacist in Primary Care Partnerships

Bryan Ziegler, PharmD, MBA
Executive Director, Kennedy Pharmacy Innovation Center
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Disclosure

The speaker has no disclosures to report.

Learning Objectives

• Describe the changing landscape of primary care medical practice and reimbursement models for primary care providers.
• Identify the healthcare quality metrics that are driving primary care value-based reimbursement and identify those that can be influenced by pharmacist services.
• Discuss various pharmacist service opportunities that a community pharmacist could provide in collaboration with a primary care provider.
• Identify resources for a community pharmacist to utilize when implementing new collaborative services with primary care providers.
• Discuss strategies for identifying primary care medical practice targets that present good opportunities for community pharmacist collaboration.
Fee for Service

• Provides payment for professional services in which the practitioner is paid for the specific service rendered, rather than receiving a salary.
  – Payment is dependent on the quantity of care, rather than quality of care.
  – Payment is established based on Evaluation and Management (E&M) codes
  – Adverse incentive to drive volume, more services-more money.

Fee For Service Model

Quantity Driven Model

Adverse Incentive to Drive Volume, More Services-More Money.
Fee For Service Model

Quantity Driven Model

Pay for Performance

• Provides financial incentives to clinicians for achieving patient-focused high value health outcomes based upon evidenced-based defined measures such as:
  - Clinical outcomes
    • A1c to control
    • Lowering blood pressure
    • Smoking cessation
  - Select care processes
    • Testing A1c
    • Measuring blood pressure
    • Mammograms

Shared Savings

• Payment strategy providing incentives for clinicians to reduce health care spending for a defined patient population by offering them a percentage of net savings resulting from their efforts.
  - Based on comparison with a control group.
  - For reducing potentially avoidable complications (PAC) associated with treating a chronic condition.
    • Hospital Admissions
    • ED Visits
Bundled Payments

- Bundled payment is a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given 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.
    - Coronary Bypass
    - Joint Replacement
    - Care Coordination
    - Chronic Care Management
  - Ambulatory Care Pilots

Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future


Payment Models Examples

- Patient Centered Medical Home
  - Care coordination payment (Bundled)
  - Patient visits (FFS)
  - Care gap quality reports (P4P & SS)
Active Learning

Which of the following best describes payment models for primary care providers TODAY?

A. 100% fee for service
B. Fee for service with a growing amount of value or bundled payments mixed in
C. Predominantly fee for value payment with some fee for service mixed in
D. Bundle payments for all care provided

Active Learning

Which of the following best describes payment models for primary care providers in the next 1-3 years?

A. 100% fee for service
B. Fee for service with a growing amount of value or bundled payments mixed in
C. Predominantly fee for value payment with some fee for service mixed in
D. Bundle payments for all care provided

Transforming Community Pharmacy Practice

Mostly Product Driven Model
Transforming Community Pharmacy Practice

Mostly Product Driven Model

Transforming Community Pharmacy Practice

Product + Service Driven Model

Pharmacist Revenue Services

- Fee for Service
  - Medicare Annual Wellness Visit (AWV)
  - Chronic Care Management (CCM)
  - Transitional Care Management (TCM)
  - Comprehensive Medication Management (Incident to)
- Performance Based
  - Population-based Medication Management (PMM)
  - Transitional Care Management (TCM)
  - Quality Goal Achievement
Immunizations

- Immunization rates are being evaluated by some payers as a quality measure
- Influenza, Pneumococcal current focus
- PCPs need to have documentation of immunization in their data records uploaded to payers
Medicare – Annual Wellness Visits

- Free, preventative service for Medicare beneficiaries
- Eligible for one AWV per year
  - Not during 1st year of Part B coverage
  - Not in same year as IPPE (Welcome to Medicare Physical Exam)
- Two types:
  - Initial Wellness Visit
  - Subsequent Wellness Visit

Obamacare’s Medicare Wellness Benefit ‘Nobody Knows’ About

In a 2012 John A. Hartford Foundation survey, 68% of patients age 65 years and older had not heard of the AWV, and only 17% had received an AWV. That percentage may be high, as the Centers for Medicare and Medicaid Services 2012 Medicare Current Beneficiary Survey (MCBS) indicates that only 8.8% of Medicare patients had received an AWV.

http://pubs.royle.com/article/Medicare+Annual+Wellness+Visits/1941403/0/article.html

AWV Components

<table>
<thead>
<tr>
<th>Acquire Beneficiary Info</th>
<th>Initial AWV</th>
<th>Subsequent AWV</th>
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</thead>
<tbody>
<tr>
<td>Health Risk Assessment</td>
<td>Administer</td>
<td>Update</td>
</tr>
<tr>
<td>List of Providers</td>
<td>Included</td>
<td>Update</td>
</tr>
<tr>
<td>Medical/Family History</td>
<td>Included</td>
<td>Update</td>
</tr>
<tr>
<td>Depression Risk Assess</td>
<td>Included</td>
<td>--</td>
</tr>
<tr>
<td>Functional Ability Assess</td>
<td>Included</td>
<td>--</td>
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</table>
**AWV Components**

<table>
<thead>
<tr>
<th></th>
<th>Initial AWV</th>
<th>Subsequent AWV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Signs</td>
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<td>Included</td>
</tr>
<tr>
<td>Cognitive Assessment</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Counsel Beneficiary</td>
<td>Initial AWV</td>
<td>Subsequent AWV</td>
</tr>
<tr>
<td>Written screening schedule for next 5-10 years</td>
<td>Included</td>
<td>Update</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Included</td>
<td>Update</td>
</tr>
<tr>
<td>Personalized health advice &amp; possible referrals to preventative services</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

*Medicare Learning Network: The ABCs of the Annual Wellness Visit*

**AWV – Time/Payment**

- Time = ~30-45 minutes
- Initial AWV (G0438) - one per lifetime
  - Avg payment = $166
- Subsequent AWV (G0439) – one per year
  - Avg payment = $111

**Smoking Cessation**

- Medicare Part B covers up to 8 visits in a 12 month period
- Medicare - Visits must be provided by a qualified doctor or other non-physician qualified provider
- PCMH and other Quality initiatives have focus on smoking cessation
Smoking Cessation - Medicare

<table>
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<tr>
<th>CPT Codes</th>
<th>Symptomatic Patient</th>
<th>Asymptomatic Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406:</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes, up to 10 minutes</td>
<td>G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes</td>
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<tr>
<td>99407:</td>
<td>Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes</td>
<td>G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes</td>
</tr>
<tr>
<td>Frequency</td>
<td>2 cessation attempts per 12-month period; maximum of 4 intermediate or intensive sessions per attempt (i.e., up to 8 sessions per 12-month period)</td>
<td>2 cessation attempts per 12-month period; maximum of 4 intermediate or intensive sessions per attempt (i.e., up to 8 sessions per 12-month period)</td>
</tr>
</tbody>
</table>


Obesity Screening & Counseling

• Medicare Part B covers up to 20 visits in a 12 month period
• Medicare - Visits must be provided in a primary care setting (Group or Individual)
• Elements:
  • Screening for Obesity (BMI)
  • Dietary Assessment
  • Behavioral Counseling and Therapy (diet, exercise, +/- drugs)

MLN Matters – Intensive Behavioral Therapy (IBT) for Obesity 2014 Obesity Counseling Reimbursement Fact Sheet. Ethicon

Obesity Screening & Counseling

• Billing: G0447 (CPT Code) – ‘Incident to’
• $26 avg payment

Note: In addition, Medicare may cover behavioral counseling for obesity services when billed by the one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified under our regulation of 42 CFR Section 410.26(b) (conditions for services) and 42 CFR Section 410.27 (conditions for outpatient hospital services and supplies incident to a physician's professional services) or 42 CFR Section 410.27 (conditions for outpatient hospital services and supplies incident to a physician's professional services).
Chronic Care Management (CCM)

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/compensation, or functional decline.
- Comprehensive care plan established, implemented, revised, or monitored.

Non-face-to-face service provided to Medicare beneficiaries.

CCM

Supervision

CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioners) under the general supervision (rather than direct supervision) of a physician (or other appropriate practitioner).

“general supervision” means the definition specified at 42 CFR 410.32(b)(3)(i), that is, the procedure or service is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.
CCM

Structured Data Recording – Demographics, Problems, Medications, Allergies, etc

Comprehensive Care Plan

Access to Care/Continuity to Care

Manage Care – (ongoing assessment, med reconciliation, etc)

Payment - CCM

• Per Member Per Month (PMPM) bundled payment
• ~$42

Let’s take a look at providers that are embarking on new health care reform models.

Accountable Care Organization (ACO)

- Health care organization that is accountable for 100% of expenditures and care for a defined population of patients.
- Sponsoring organizations may include Hospitals, Physicians, Pharmacies
- Provide evidence-based care in a collaborative and coordinated model.
- ACOs are typically not insurance companies but held to a fixed pre-payment amount and bonus eligible.

Accountable Care Organization (ACO)

- Focus:
  - Measurement of quality and cost
  - Chronic conditions
- Payment methods:
  - Bundled payments with performance payments
  - Shared savings
  - Capitation PMPM
  - FFS with withhold and physician performance bonus
- Aligned with Patient Centered Medical Home (PCMH)
PCMH - Attributes

• Patient-centered
  - primary health care, relationship-based with orientation toward the whole person

• Comprehensive care
  - accountable for meeting patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care

• Coordinated care
  — coordinates care across the broader health care system, including specialty care, hospitals, home health care, and community services

PCMH - Attributes

• Superb access to care
  — Shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team.
  — Provides methods of communication and care such as email and telephone.

• Systems-based approach to quality and safety
  - Committed to evidence-based medicine quality, performance improvement, and patient satisfaction

Integrated Care in the PCMH

• Comprehensive, team-based care
• Team needed to address all challenges to providing quality care
• Practices have added staff such as health coaches, dieticians, psychologists, care coordinators, chronic care managers, pharmacists, & community health workers
• “Share the care” & Practice at the top of license

So...How do we measure Quality?

Pharmacy Quality Reporting
Physician Quality Reporting

<table>
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<tr>
<th></th>
<th>Basixx, MD</th>
<th>Target</th>
<th>Current</th>
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<tbody>
<tr>
<td>Diabetes Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% poor control (&lt;9.0%)</td>
<td>30%</td>
<td></td>
<td>32%</td>
</tr>
<tr>
<td>% control (≥7.0%)</td>
<td>80%</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>% control for select populations (&lt;7.0%)</td>
<td>60%</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td>Hypertension</td>
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<tr>
<td>BP ≥ 140/90 mmHg</td>
<td>30%</td>
<td></td>
<td>23%</td>
</tr>
<tr>
<td>Cholesterol Mgt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TC ≥ 300 mg/dL</td>
<td>100%</td>
<td></td>
<td>98%</td>
</tr>
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Challenges/Opportunities

- Today, the average primary care visit with a physician lasts 11 minutes.
- Appointments are typically scheduled in 15 minute increments, with double appointments sometime scheduled to allow for no-shows.

Value of Pharmacist in PCMH

- Quality of patient care
- Patient satisfaction
- PCMH revenue
- Physician productivity
- Cost Avoidance

Medication Management

Pharmacist Key Activities

- Obtain and evaluate patient history as it impacts medication management and patient care outcomes.
- Assess and manage medication therapeutic regimens of chronic conditions within written treatment guidelines.
- Provide patient counseling on medications, nutrition, lifestyle, and medication self-management.
- Conduct limited physical assessments per guidelines for managing medication therapeutic regimens.
- Order diagnostic tests and medical devices to support medication management of chronic conditions.
Other Key Community Pharmacist Activities: Team-Based Care

- Immunizations
- Smoking cessation
- Obesity/Weight loss
- Adherence
- Chronic disease targeted services

Active Learning

- Which of the following is NOT an example of a healthcare quality metric that is driving primary care value-based reimbursement?

A. % of diabetic patients with HbA1c < 9
B. % of adult patients receiving influenza vaccine per ACIP recommendations
C. % of office visits completed in 11 minutes or less
D. Patient satisfaction scores

Active Learning

- Which of the following healthcare quality metrics can be positively influenced by pharmacist involvement?

A. % of diabetic patients with HbA1c < 9
B. % of adult patients receiving influenza vaccine per ACIP recommendations
C. Patient satisfaction scores
D. All the above
Payment Options – Incident to/Contract

- If providing care to patients under Collaborative Practice Agreement and within Scope of Practice:
  - “Incident to”
  - Team-based care billing (99211-99215)
  - Contract model (FFS) with PCP

Where’s the Money?
PCMH/ACO Models

- Increase Access to Care
- Improve Outcomes
- Reduce Costs
- Pending

Transitional Care Management

- TCM services are furnished following the beneficiary’s discharge from one of the following inpatient hospital settings:
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Inpatient Rehabilitation Facility
  - Hospital Inpatient Observation orPartial Hospitalization, and
  - Partial Hospitalization at a Community Health Center.

- Following discharge from one of the above settings, the beneficiary may be referred to a
  - Community Setting
  - Skilled Nursing Facility
  - Home Health Agency
  - Inpatient Hospice
  - Assisted Living Facility
Hospital Discharges

20-40% of PCPs receive D/C Summaries <2 weeks late

17-20% of PCPs receive notice at time of D/C

TCM - Medicare

• Multiple Components
  • Interactive Contact
  • Certain non-face-to-face services, and
  • A face-to-face visit with medicare qualified provider (MD, DO, NP, PA)

If patient successfully transitions for 30 days post D/C and receives components above, then provider can bill Medicare for TCM

TCM – Medicare Billing/Payment

• TCM Moderate Complexity (99495)
  • $135-164
  • Interactive comm w/in 2 business days
  • Face-to-face visit w/in 14 days

TCM High Complexity (99496)
• $198-231
• Interactive comm w/in 2 business days
• Face-to-face visit w/in 7 days
Transitional Care Management

72% of post-discharge adverse events are medication-related.

“Many patients are discharged without understanding their illness or treatment plans, or inadvertently discontinue important medicines needed to stay well.”

TCM – Pharmacist Roles

• Medication reconciliation
• Medication education
• Medication management
• Communication with PCP

Where’s the Money?
Transitions of Care
Active Learning

• “What are some of the current services offered at my pharmacy that could be of value to a primary care provider?”

• Brief Discussion
Finding a Collaborative Partner

- Shared patients with the pharmacy
- Providers shifting into new payment models
  - Search insurance list of providers
- Proximity to pharmacy
- Payer mix
- Interest in Collaborative relationship/Team-based care

Active Learning

- "What information about target physicians do you likely have available at your pharmacy today?"

  - Brief Discussion

https://data.cms.gov/utilization-and-payment-explorer
<table>
<thead>
<tr>
<th>Service Type</th>
<th>HCPCS Code</th>
<th>Average Revenue</th>
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<tr>
<td>Established patient office or other outpatient visit, typically 5 minutes</td>
<td>99</td>
<td>$22.46</td>
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<td>Average Medicare Allowed Amount</td>
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<tr>
<td></td>
<td></td>
<td>Average Medicaid Allowed Amount</td>
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<td>41</td>
<td>Number of Beneficiaries</td>
</tr>
<tr>
<td></td>
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<td>Number of Beneficiaries</td>
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<td>Established patient office or other outpatient visit, typically 15 minutes</td>
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<td>$105.02</td>
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<td>Average Medicare Allowed Amount</td>
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<td></td>
<td>Average Medicaid Allowed Amount</td>
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<td></td>
<td></td>
<td>Average Medicaid Allowed Amount</td>
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<td>454</td>
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<td>Number of Beneficiaries</td>
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<td>Established patient office or other outpatient visit, typically 45 minutes</td>
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<td>$220.03</td>
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<td>Average Medicare Allowed Amount</td>
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<tr>
<td></td>
<td>267</td>
<td>Number of Beneficiaries</td>
</tr>
</tbody>
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**Educational Resources**
**Developing Collaborative Working Relationships Between Pharmacists and Physicians**

For pharmacists, the first step toward establishing collaborative practice agreements is to build strong working relationships with physicians.

JPhA Sept/Oct 2001

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**Reviews**

Patient-centered medical homes: Primer for pharmacists

J. Brian McKee, PharmD, BCPS, CACP


PCMH 2014 Standards and Guidelines

NCQA Patient-Centered Medical Home (PCMH) 2014

July 22, 2015

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**Questions?**