Session # C4

Financing and Sustaining Integrated Clinical Pharmacists in the Medical Home

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Faculty Disclosure

The presenters of this session do NOT have any relevant financial relationships (in any amount) during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Describe the obstacles to sustaining clinical pharmacy services in the Medical Home.
- Analyze obstacles and financing options to develop possible solutions for sustaining clinical pharmacy services in the Medical Home.
- Identify examples or opportunities for supporting integrated clinical pharmacy services through direct revenue models.

Bibliography / Reference

1. Cobb CD. Optimizing medication use with a pharmacists-provided comprehensive medication management service for patients with psychiatric disorders. Pharmacotherapy. 2014;34:1336-1340.
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4. Freeman DS, Manson L, Howard J, & Hornberger J. Financing the primary care behavioral health model. Journal of Clinical Psychology in Medical Settings. First published online February 16, 2018.
5. Goldstone LW, DiPaula BA, Caballero J, et al. Improving medication-related outcomes for patients with psychiatric and neurologic disorders: value of psychiatric pharmacists as part of the health care team. Ment Health Clin. 2015;5: 1-28.
6. Bartell, J. Pharmacy Society of Wisconsin. (2018) Billing for Pharmacist-Provided Services: Medicare Annual Wellness Visits, Incident to, and more [Video Webinar]. Accessed on September 25, 2018. Available at: http://www.pswi.org/Education/Online-CE/PSWWEB20_30COURSE.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Patient-Centered Medical Home (PCMH)

- Primary care model of healthcare reform
- Integral component of the Patient Protection and Affordable Care Act (2010)
- Supported by both the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ)
- Aims to boost quality, accessibility, and efficiency of primary care by increasing availability of services while managing costs[1]

Pharmacy Role in Medical Homes

- Pharmacists are trained in principles of patient-centered, team-based medication management:
  - **Collect** S/O information necessary to understand medication history and clinical status of the patient
  - **Assess** information to understand clinical effects of the medication regimen in conjunction with patient's overall health goals; identify and prioritize problems
  - Develop patient-centered care **Plan** in collaboration with patient/care giver and other team members that is evidence-based and cost effective
  - **Implement** care plan in collaboration with other team members and the patient/caregiver
  - **Follow-up** on safety and effectiveness of care plan
- Pharmacists may complete post-graduation training to specialize in areas such as ambulatory care or psychiatric pharmacy (residency and/or board certification)

Pharmacist Role in Medical Homes

- Opportunity for pharmacist roles within the PCMH supporting safe, evidence-based and cost-effective medication use
  - Commonality of medication prescription in primary care
- Studies of collaborative medication management (CMM) between pharmacists and primary care providers (PCPs):
  - Co-management of chronic conditions (diabetes, dyslipidemia, and hypertension)
  - Associated with **improved clinical outcomes; reduced healthcare expenditures related to hospitalizations, physician time, and prescription costs; resulting in positive ROI (range 3:1 to 5:1)**
  - Pharmacist services within PCMH specifically
  - Associated with outcomes including **improved metrics of diabetes control, and reductions in hospital readmissions and overall healthcare costs**

Pharmacy Role in Medical Homes

- **Problem:** Few resources exist to assist healthcare leaders (managers, business and operations personnel and the C-Suite) to finance and sustain embedded clinical pharmacists in the PCMH – let alone design and implement these programs.

- **Opportunity:** Analyze obstacles and financing options including sustainment for clinical pharmacy services in the Medical Home.

- **Goal:** Develop possible solutions, identify opportunities and provide examples for sustaining clinical pharmacy services in the Medical Home.

Obstacles to Sustaining Clinical Pharmacy Services in the Medical Home

- Lack of established payment systems for pharmacists in primary care:
  - Pharmacists are not recognized as non-physician providers (NPP) and clinical pharmacist services are not included under Medicare Part B
  - Under Medicare Part D pharmacist medication management services are recognized, but this is a narrow definition
  - Most federal and private payers do not include broad pharmacist services in their payment systems; narrow coverage only under Medicare Part D
  - Reimbursement avenues for pharmacy services vary across states, practice settings, organizational structures, payers, and supervision requirements

Obstacles to Sustaining Clinical Pharmacy Services in the Medical Home

- Consequences of this include:
  - Unclear or lack of widely accepted productivity targets by which to plan and project fiscal sustainability
  - Unknown longitudinal demand for clinical pharmacy services (i.e., as health outcomes improve within a population)
  - Lack of universally understood scope of practice for pharmacists within Medical Homes and consequently, lack of recognized and consistently applied credentialing process

Obstacles to Sustaining Clinical Pharmacy Services in the Medical Home

- Failed initiatives and poor integration can be fiscally costly and negatively impact the patient experience and morale of the care team

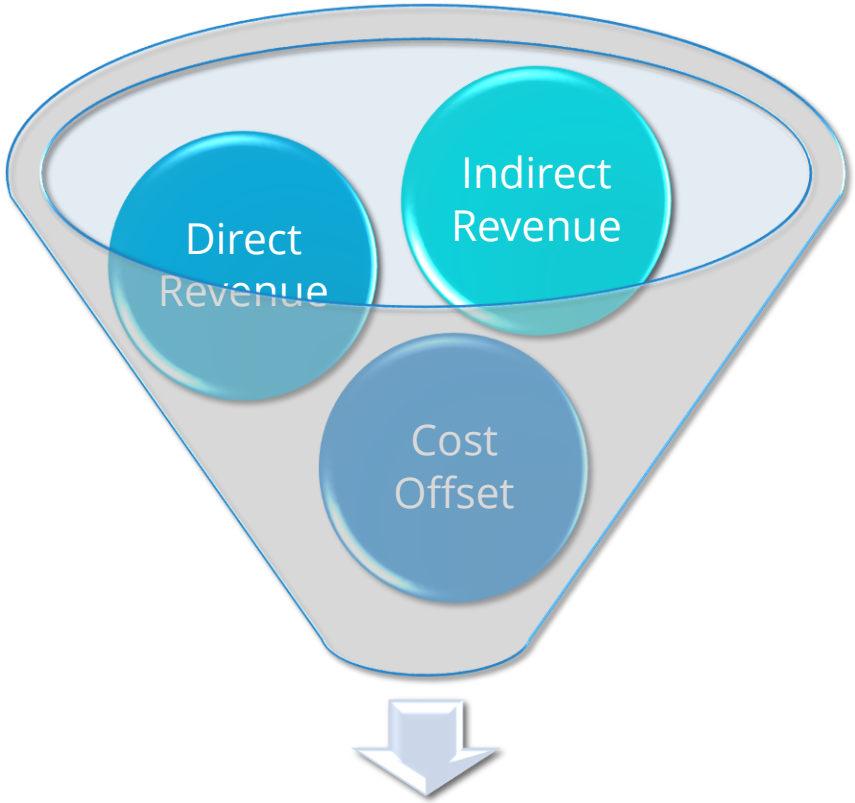
- Current funding sources limited to:
  - Grants (temporary)
  - Donations (one-time boost)
  - Practicum/Clinical Training programs (requires resources, administrative and supervisors' time)
  - Funding "out of the bottom line"
  - Cost sharing (via Schools/Colleges of Pharmacy)
  - Revenue generation (variable, often slow to begin)
  - Cost avoidance (difficult to quantify, may fall outside funding institution)
- Current healthcare climate is unstable leading to risk-aversion

Supporting the Cost of a Pharmacist

- Hire integrated clinical pharmacists and offer a salary
  - Avoid stepping in reverse to devise a fee-for-service model for them
  - Average salaries in this field range from $87 K to $159 K
    - Median $124 K or $60 per hour (U.S. Bureau of Labor and Statistics)
- Use space flexibly and don't hesitate to have the pharmacists share resources or space
- Create workflow models and business rules that ensure routine and high utilization of the clinical pharmacist's services – ensure these are driven by pro forma and the business case analyses

Bureau of Labor Statistics: https://www.bls.gov/ooh/healthcare/pharmacists.htm

Supporting the Cost of a Pharmacist



Fiscal Sustainability

Direct Revenue Generation

- Research state/local reimbursement avenues for pharmacy services and for comprehensive levels of primary care services
  - Explore direct billing opportunities for pharmacy services
  - Use pharmacists as physician extenders to maximize the level of care provided, thereby increasing PCP reimbursement rates

Service	Billing Codes	Summarized Requirements	Reimbursement Level
Incident To	99211 – 99215	Hospital- & Physician-Based clinics, direct supervision required, unclear if pharmacists can bill beyond 99211	$
Facility Fee	G0433	Hospital-Based clinics only, direct supervision required, one code regardless of time and complexity level	$$
Medicare Annual Wellness Visit (AWV)	G0438, G0439	Direct supervision required, initial, “Welcome to Medicare” visit must be completed by referring provider first, once yearly	$$
Chronic Care Management (CCM)	99490, 99487, 99489	General supervision, non-face-to-face management (bundled payment), ≥2 chronic conditions for duration of 12 mo, patient consent	CCM- $ Complex CCM- $$
Translational Care Management (TCM)	99495, 99496	General supervision, set timelines, pharmacist can perform non-face-to-face activities only (bundled payment), not payable if patient re-hospitalized within 30 days	Moderate- $$ Complex- $$$
Medication Therapy Management (MTM)	99605 – 99607	Time-based, face-to-face visits, plans offering MTM benefit	$ - $$$

Indirect Revenue Generation

- Increased efficiencies can result in:
  - PCPs can conduct more visits
  - PCPs can care for complex patients
  - May lead to cost-offset

- Value-based payment system
  - Assist care team in achieving quality metrics surrounding patient-centeredness, patient engagement, quality care, access to care, and cost-effective care
  - High priority items: diabetes, hypertension and asthma control; adherence to antipsychotics; appropriate antibiotic use; medication documentation; high-risk medication use in the elderly

Cost Offset


Hospitalizations / readmissions
Clinic visits
ED visits / admissions
Medication errors
Use of unnecessary / inappropriate medications

Additional Financing Options and Possible Solutions

- Start with accessible current funding sources:
  - Research and apply for grant money for pilot programs or demonstration projects
  - Collaborate with academic centers (pharmacist faculty, pharmacy residents/students)
  - Seek private donations, particularly from relevant sources (e.g., opioid crisis has sparked increased awareness, resources, funding and initiatives)
  - Practicum/Clinical Training programs
  - Funding “out of the bottom line” – investing up front will pay-off with **sound business practices** that are proactive, well-planned and continuously monitored

Sound Business Practices

- Develop specific business cases and pro forma that result in cost-effective integrated pharmacy services

- When determining ROI for clinical pharmacists consider alternative measures in addition to direct revenue:

  - Meet with payors: present the data and benefits to paying for these services, share your pro forma and business plan

  - Quality improvements as a result of clinical pharmacists' care delivery
  - Improvements in patient safety and risk management
  - Primary care provider satisfaction and burn-out
  - Cost offset and cost savings

Successful Direct Revenue Example for Funding and Sustaining Services

Practice Setting: Red Lake Hospital

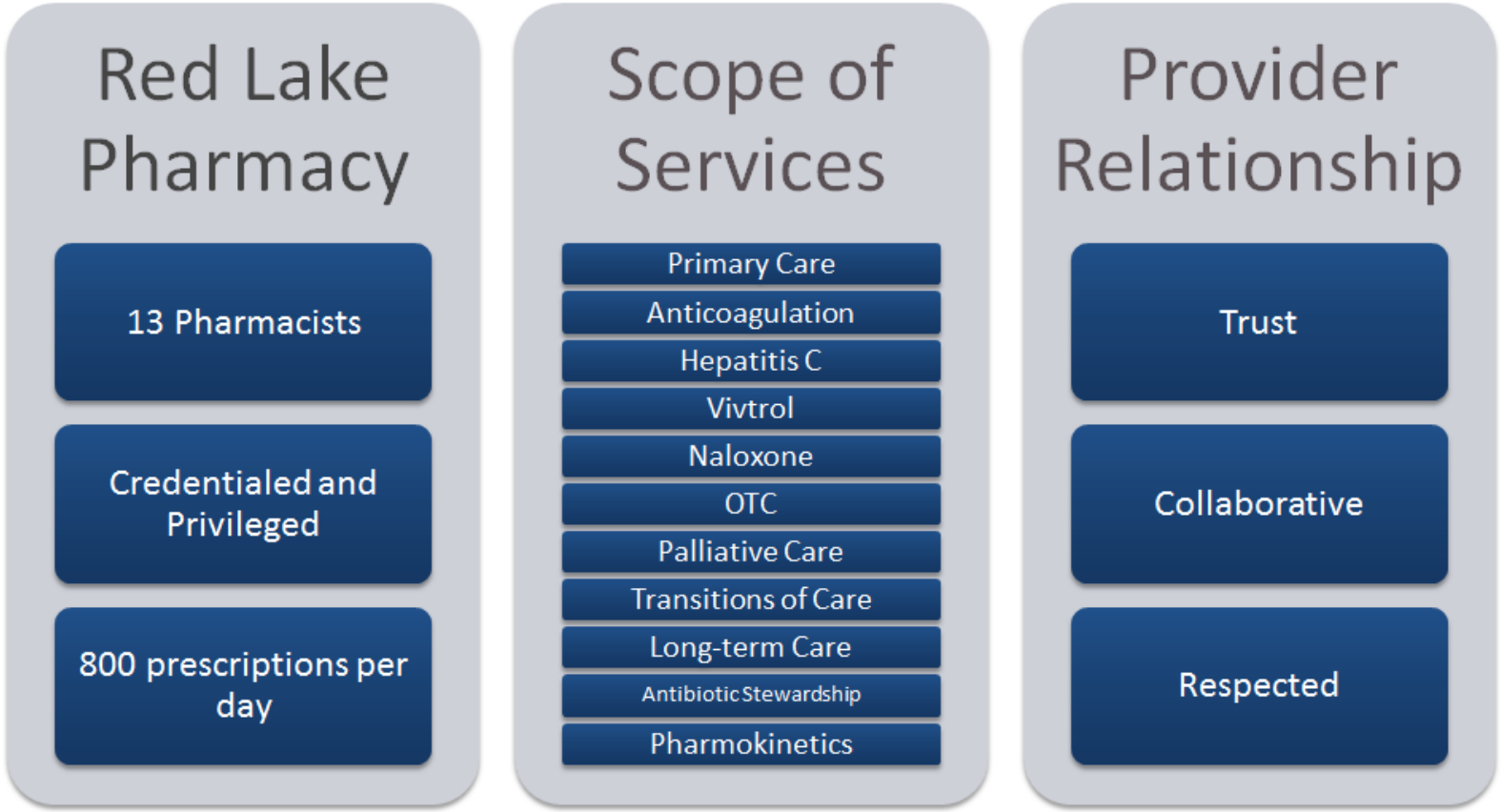
- Federal Indian Health Service facility
- Located in Northwestern Minnesota
- Patient population served: ~9,000
- Ambulatory care, community, inpatient, emergency department and long-term care consulting services

Successful Direct Revenue Example for Funding and Sustaining Services

Pharmacy Clinical Services Model:

- Pharmacists are credentialed and privileged members of the medical staff
- Chronic disease state management under collaborative practice agreement (CPA) with primary care providers (for more on CPAs, see https://www.aphafoundation.org/collaborative-practice-agreements)
- Billable outpatient services offered: anticoagulation, primary care (diabetes, hypertension, dyslipidemia, hypothyroidism, asthma, COPD, tobacco cessation), behavioral health, medication assisted treatment

Successful Direct Revenue Example for Funding and Sustaining Services



Successful Direct Revenue Example for Funding and Sustaining Services

Services:

- Comprehensive medication review
- Limited physical assessment (diabetic foot exam, vitals, etc.)
- Point of care lab testing (glucose, INR)
- Administer immunizations
- Psychiatric screenings if indicated (PHQ-9, suicide risk assessment, etc.)
- Order / interpret medication or disease state-relevant labs
- Initiate, modify, discontinue medications related to referral diagnosis
- Document comprehensive patient care plans in the electronic health record
- Communicate care plan with the patient/caregiver and healthcare team

Successful Direct Revenue Example for Funding and Sustaining Services

Workflow:

- Providers place consult to pharmacy clinic
- Pharmacist contact patients to schedule 30-60 minute appointment
- Patient appointment occurs in private pharmacy counseling rooms
- Pharmacist schedules follow up as needed
- Pharmacist completes documentation
- Patient care plan communicated to consulting provider
  - E&M billing requires direct personal supervision of non-physician provider (pharmacist)

Successful Direct Revenue Example for Funding and Sustaining Services

Standardized Documentation:

- Templates built for each clinic to meet MTM and E&M documentation standards
- Behavioral health specific: includes suicide risk assessment, past psychiatric history

Billing Codes:

- Medication therapy management codes: 99605, 99606, 99607
- Evaluation and management codes: 99212
  - “Established patient with a problem-focused history & examination with straightforward medical decision making”

Successful Direct Revenue Example for Funding and Sustaining Services

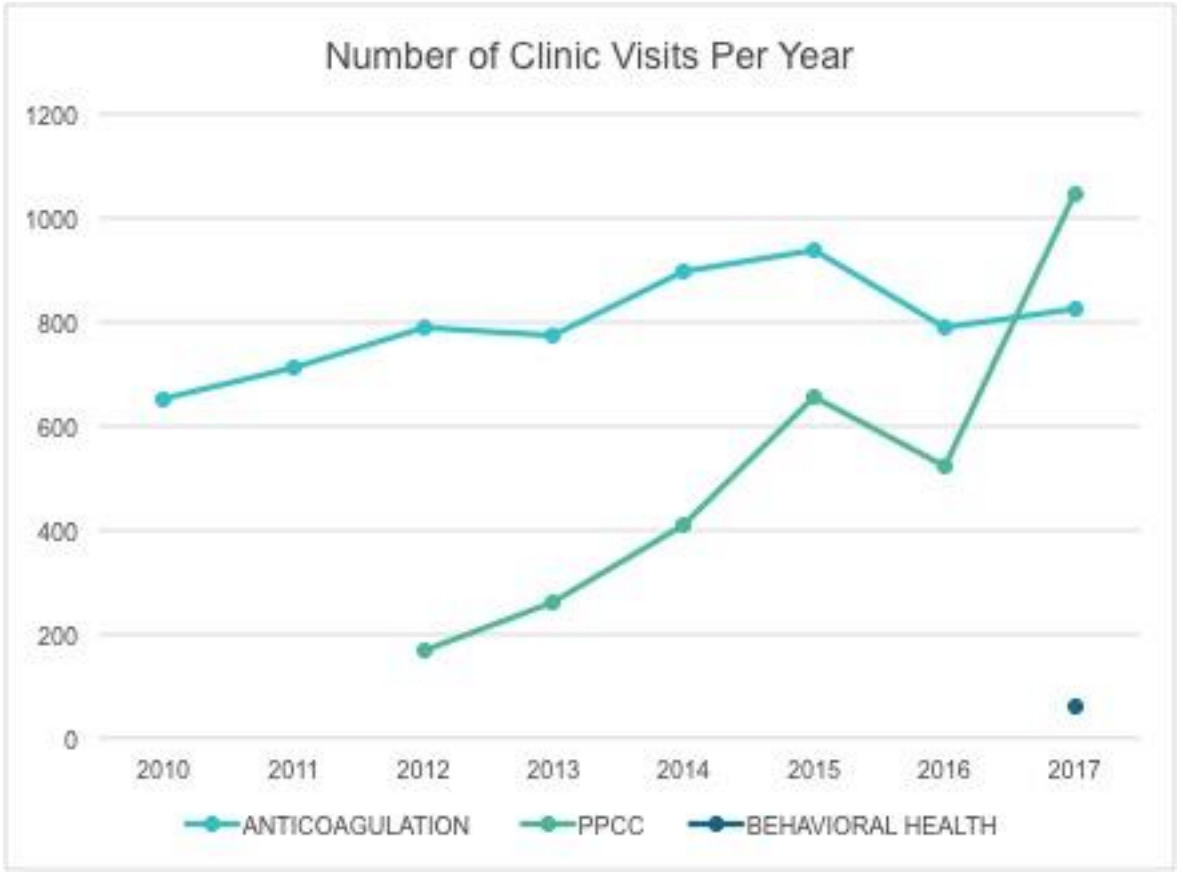
Revenue Generation:

- Revenue tracked and reported annually
- Payers: Minnesota Medicaid

Ongoing Quality Improvement

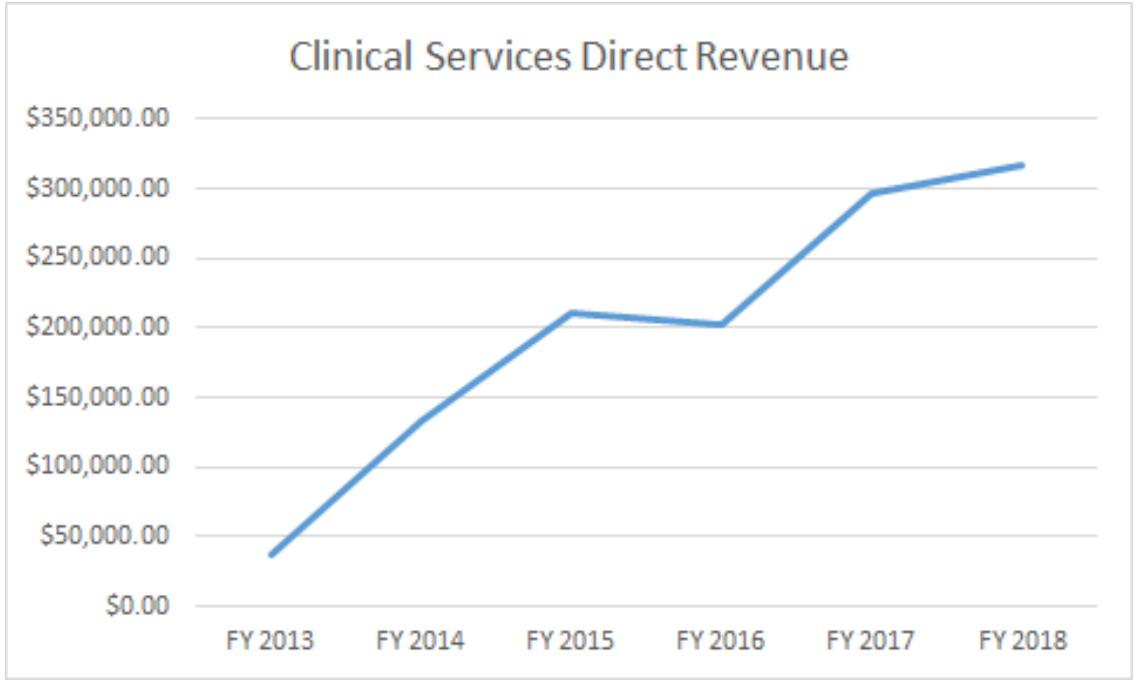
- Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)
  - Initial competencies to practice in clinic
  - Pharmacists participate in quarterly peer review
  - Required continuing education credits for privileged disease states

Successful Direct Revenue Example for Funding and Sustaining Services



Successful Direct Revenue Example for Funding and Sustaining Services

- Average reimbursement: $64.50 per visit
  - Includes visits not billed to 3rd party
- Includes:
  - 1-2 clinical pharmacists with 30 min patient encounters
  - Walk-in patients

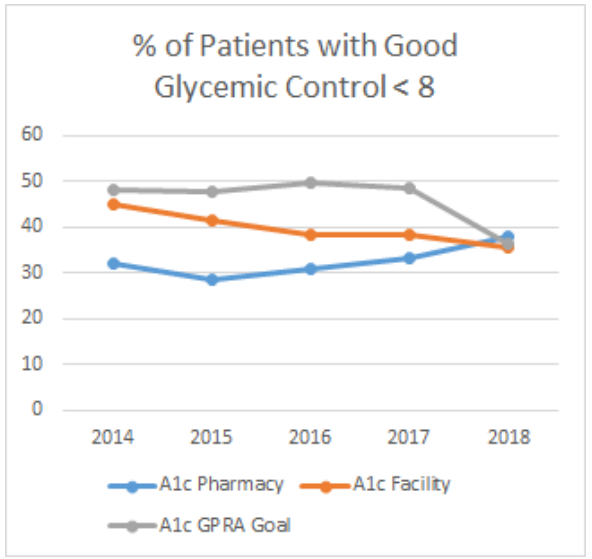


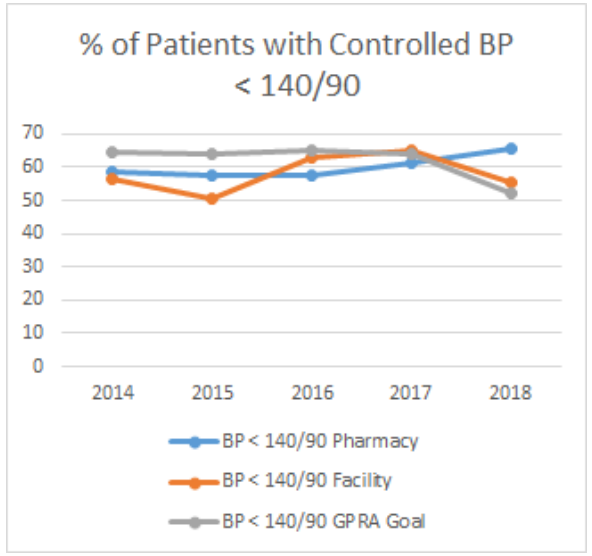
Successful Direct Revenue Example for Funding and Sustaining Services

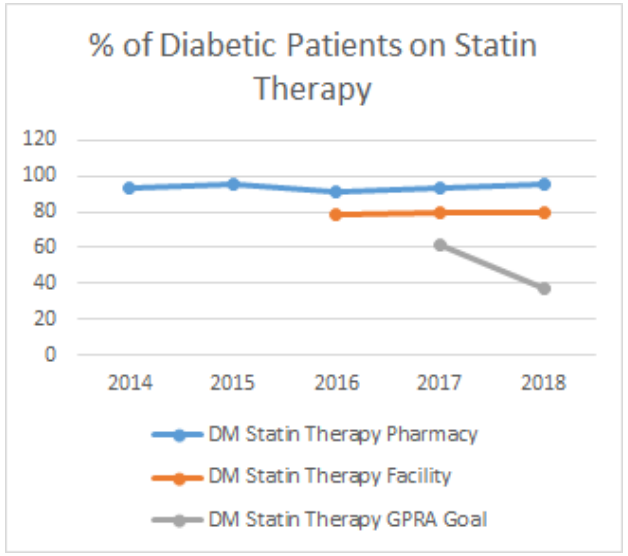
Benefits of Integration:

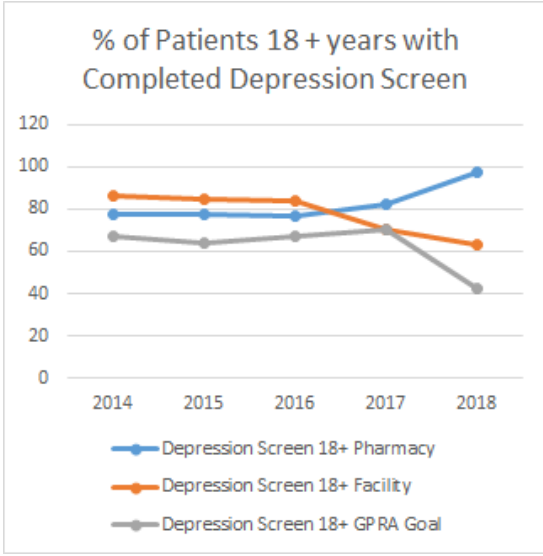
- Expanded access to primary care and/or behavioral health services
  - Patients able to present on a walk-in basis (open access model); improves patient satisfaction
  - Improves provider ability to maximize fee-for-service revenue generation (i.e. see more patients)
- Improved Government Performance & Ratings Act (GPRA) outcomes
- Enhanced interprofessional relationships

Successful Direct Revenue Example for Funding and Sustaining Services









Successful Direct Revenue Example for Funding and Sustaining Services

Facility Limitations:

- Many patients do not have 3rd party insurance
- Have not expanded billing to private payers
- No-show rate
- Referrals have decreased with provider turnover

Successful Direct Revenue Example for Funding and Sustaining Services

Implementation Limitations:

- Some 3rd party private payers not reimbursing for pharmacist services
- Pharmacist scope of practice varies by state
- Pharmacist credentialing and privileging varies by facility
- Pharmacist workforce and/or space limitations
- MTM codes do not “capture” full extent of services provided

Successful Direct Revenue Example for Funding and Sustaining Services

Future Directions:

- Updating documentation to meet documentation requirements for higher complexity evaluation and management codes
  - Review of systems
  - History: past medical, family, social+
- Chronic care management reimbursement
- Medicare annual wellness visits

Elements Required for Each Type of History

TYPE OF HISTORY	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

Recommendations

Involve pharmacy in conversations surrounding quality metrics and indicators to determine how they can support the care team.

Support pharmacist provider status and direct financing models to sustain clinical pharmacist services

Seek opportunities for cost-offset or cost-savings

Avoid stepping in reverse to devise a fee-for-service model for them

Recommendations

Research billing options for pharmacy services to identify avenues that fit with the care pharmacists are providing (or hope to provide) at your individual institution.

Consult with peer institutions who have been successful in revenue generation for pharmacy services.

Meet with payors to discuss the potential benefits of and types of financing options in light of the literature that substantiates the benefits of clinical pharmacy services

Conclusions

- Integration of clinical pharmacy services can help achieve the Quadruple Aim
- While challenges to successful integration do exist, anticipating potential barriers and proactively developing a plan can minimize obstacles – we can learn from the challenges IBH has encountered over the years
- The more programs that demonstrate successful funding and sustainment, particularly those involving direct revenue from third party payors, the higher chance that other payors will follow suit
- Publishing, promoting and disseminating information about these successes are vital to convincing other payors to reimburse for these services

Additional Helpful Resources

- Annual Wellness Visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/awv_chart_icn905706.pdf
- Chronic Care Management: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- Translational Care Management: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- CMS fee schedule for billed services: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

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