Building Ambulatory Clinical Pharmacy Services: Demonstrating Value

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Objectives

- Develop a list of outcomes that could be used to determine the benefit of a pharmacist service
- Compare and contrast various pharmacist reimbursement models
- Determine the return-on-investment for a particular pharmacist service
- Discuss options for services that improve quality and may generate revenue
Demonstrating Value

- Clinical outcomes
- Financial outcomes
- Other outcomes
Clinical Outcomes

Disease state specific quality indicators

- Specific institution/practice quality goals
- Guideline driven goals
- National Committee for Quality Assurance (NCQA)

  - Healthcare Effectiveness Data and Information Set (HEDIS) measures
  - Accountable Care Organization (ACO) Core Measures

Financial Outcomes

- Charges and/or revenue generation
- Cost savings
- Cost avoidance
- Return on investment
Current Climate: Revenue Generation and Pharmacists

Difficult but not impossible
- Lack of uniform education on this topic
- Method used varies widely
  - Geographic location
  - Service site/type
  - Comfort level of local compliance officers

Need to continue to lobby for provider status under Medicare Part B
Methods Available

- Facility/technical fee
  - Hospital-based clinic billing
- Incident-to physician referral
  - Private physician office practice billing
- Medication therapy management (MTM)
  - Medicare Part D
  - State Medicaid programs
- Contractual arrangements
  - Employer sponsored wellness programs
- Grants
Facility/Technical Fee

Pro
- In general, has greater ability to generate revenue compared to other methods

Con
- Only charging for the facility, no professional fee
- May only be used in hospital based clinics
- Many practices do not bill technical fees

Pearl
- Can look like “incident-to physician referral” billing
  - Often codes utilized on the front end are the same (ex: 99211-99215)
  - When filing the HCFA 1450, codes are mapped to the Ambulatory Payment Classification (APC) groups (ex: 0604-0607)

https://www.cms.gov/hospitaloutpatientpps/
Incident-to Physician Referral

Pro

- Charging a professional fee based on complexity of service

Con

- Most pharmacists still having to down code to 99211, so revenue generation is poor

Pearl

- Utilize the CMS physician fee lookup tool to determine what the Medicare reimbursement rate for codes will be for your facility type and geographic location

Medication Therapy Management

**Pro**
- Can be utilized in any type of healthcare setting
- Recognized by Medicare Part D and some State Medicaid programs

**Con**
- No standard reimbursement attached to the codes, so you must negotiate payment with payers
  - Private payers will often not pay the MTM codes

**Pearl**
- Medicare Part B will not reimburse these codes so you must remember to fill out the “Advanced Beneficiary Notice of Noncoverage” form

http://www.cms.gov/BNI/02_ABN.asp
Contractual Arrangements

Pro
- Takes insurance issues out of the equation

Con
- Negotiations can be brutal

Pearl
- Show the group you are negotiating with (employer, third party, etc) relevant outcomes data so they know what they are getting for their money
- Sometimes negotiations are not needed if programs already exist
  - Ex: some state Medicaid programs
Grants

**Pro**

- Money to get started with that innovative project you have been waiting to begin
- Opportunity to show your worth

**Con**

- Grant writing processes can be tedious
- Outcomes data collection can be time consuming

**Pearl**

- Consider partnering with local Colleges of Pharmacy or other local health science educators
- Don’t forget about grants available though professional organizations or local foundations
Generating Revenue Summary

Determining the best method

- Check out programs available in your State
- Speak to compliance officer
- Find out what type of site the service will be located in

Create systems to track revenue generated back to the pharmacist service

Continue to advocate for provider status for pharmacists under Medicare Part B
Cost Avoidance Vs Cost Savings

Cost avoidance

- If a service or position is created, what costs are avoided?

- Examples
  - Overtime pay
  - Pharmacist/other healthcare professional pay

Cost savings

- How much does an intervention or service save the organization?

- Examples
  - Decreased length of hospital stay
  - Reduction in medication errors
  - Reduction in adverse drug events
Additional Thoughts

“Soft dollars”
- May not be enough to justify a service

Often difficult to obtain/calculate
- Software programs available
- Utilize numbers found in the literature
- Internal studies to determine institution specific numbers

Necessary for accurate return on investment calculations
Return On Investment (ROI)

Revenue generated + Cost Savings and Avoidance - Total Cost of the Service

Total Cost of the Service
ROI Thoughts

Has the service been diagrammed to determine all the costs and benefits?

Revenue generation helps, but isn’t necessary to have a positive ROI.

Depending on the pharmacist service, may be published data available to utilize.
ROI Example

Your home institution would like to create a PGY2 Ambulatory Care pharmacy residency program. You have been asked to submit a ROI report to your clinical coordinator and director of pharmacy in order to advocate for the position to upper administration.
<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary/benefits</td>
<td>53,320</td>
</tr>
<tr>
<td>Travel</td>
<td>1500</td>
</tr>
<tr>
<td>Technology</td>
<td>1300</td>
</tr>
<tr>
<td>Total</td>
<td>56,120</td>
</tr>
</tbody>
</table>
## Revenue Generation

<table>
<thead>
<tr>
<th></th>
<th>Estimated Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Medicare Wellness Visits</td>
<td>41,917</td>
</tr>
<tr>
<td>Zostavax referral</td>
<td>80,750</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>122,667</strong></td>
</tr>
</tbody>
</table>
# Cost Savings and Cost Avoidance

<table>
<thead>
<tr>
<th></th>
<th>Estimated Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulation Savings</td>
<td>30,100</td>
</tr>
<tr>
<td>Pharmacist FTE</td>
<td>20,000</td>
</tr>
<tr>
<td>Total</td>
<td>50,100</td>
</tr>
</tbody>
</table>
ROI Calculation: Year 1

\[
\frac{122,667 + 50,100 - 56,120}{56,120} = 2:1
\]
Other Outcomes

- Patient satisfaction surveys
- Provider satisfaction surveys
- Quantitative practice info
  - Number of patients seen
  - Number of interventions made
  - Time or number of visits to goal
- Relative value units (RVU)
  - Often used for provider productivity
- Hospital Consumer Assessment of Healthcare Providers Systems Scores (HCAHPS)
  - Medicare “hospital compare” website
So, What if I Want it All?

**Current strategies**
- State Medicaid programs
- Employer sponsored wellness programs
  - “Asheville Project” model
- Medicare Annual Wellness Visit (AWV)

**Future directions**
- Patient Centered Medical Home (PCMH)
State Medicaid Programs

Check locally to see what is available and how to participate

Differ greatly from State to State

- One time med review Vs ongoing MTM
- Use of complexity based billing Vs flat fee

Many states have limited or cut these programs due to hard economic times
Employer Sponsored Wellness Programs

Ideal business targets
- Self insured businesses
  - Local health-systems, school districts, city/county governments

Work directly with employers to create a program for their employees
- Employer pays pharmacist for services

Proven outcomes
- Decreased employee sick days
- Decreased total healthcare costs
  - Cost shifting to more preventative medicine
Resources


Medicare Annual Wellness Visit

What it is

- Created as part of the Affordable Care Act
- Visit to provide “Personalized Prevention Plan Services” (PPPS)
- Coding
  - G0438: AWV, includes PPPS, initial visit
  - G0439: AWV, includes PPPS, subsequent visit

What it is not

- An Initial Physical Preventative Examination (IPPE)
  - aka the “Welcome to Medicare Exam/Visit”
- An annual/routine physical exam
Additional Basic Facts

Eligibility

- Beneficiaries who have had Medicare Part B for 12 months
- Patient has not had an IPPE or an AWV providing PPPS in the past 12 months

Who can provide the service

- Any healthcare professional
  - List doesn’t specifically name pharmacists, but does state “…any other licensed practitioner.”
Visit Requirements

Histories
- Past medical history, surgical history, family history, medication history

Review functional ability and level of safety
- ADLs, home safety, fall risk, hearing impairment

Assess body measurements
- Height, weight, BMI, blood pressure

Screenings
- Depression, cognitive impairment
Visit Requirements Continued

Health risk assessment

- Self-assessment of health status, demographics, ADLs, IADLs, psychosocial and behavioral risks
- Takes no longer than 20 minutes

Establish the following

- Current list of healthcare providers and suppliers
- Written screening schedule
- List of risk factors/conditions for which intervention is recommended or underway

Furnish personal health advice and/or referral as needed
Why Utilize a Pharmacist?

- **Visits are lengthy (45-60 minutes at best)**
  - Can free up physicians, nurse practitioners and physician assistants to do other things

- **Pharmacologically complex patients**
  - Opportunity for comprehensive med review
    - Prevent ADRs and poly-pharmacy
    - Identify medication related problems
  - Collaborative Drug Therapy Management
    - Education and disease management
Benefits

- Improved clinical outcomes through preventative medicine
- Direct revenue generation to the clinic
  - Check the Medicare physician fee look up website to see the rates in your area
- Revenue generation for the health system
  - Referrals, laboratory, imaging, immunizations
- Improved patient satisfaction
Other Considerations

Relative Value Unit (RVU) generation

Use of Modifier -25
- Additional revenue generation if physicians are available to see patient during the visit

Utilization of students and residents to aid in provision of care

To learn more
The Future

Patient Centered Medical Home
- Team approach to healthcare emphasizing the patient and quality

Watch for…
- More primary care practices obtaining NCQA accreditation as a PCMH
- Literature demonstrating various models of care within this structure
- Payment reform related to this model of care
  - Ex: Bundled payment Vs fee-for-service
Concluding Thoughts

Demonstrating the value of a pharmacist service is typically a mixed picture

- Improved clinical quality measures
- Positive financial projections
- Other outcomes

To further our profession, we must advocate for innovative ways to connect within the healthcare team
Questions?