Primary Care Pharmacist Integration and Reimbursement Models

May 20, 2015

MODERATOR:
Marie Smith, PharmD – Palmer Professor and Assistant Dean, Practice and Public Policy Partnerships, UConn School of Pharmacy

SPEAKERS:
Craig Logemann, PharmD – UnityPoint Clinics, Iowa
Mary Ann Kliethermes, PharmD – Vice Chair, Professor Chicago College of Pharmacy, Midwestern University
PRISM: Transforming the Future of Pharmacy through PeRformance Improvement for Safe Medication Management

**Mission:** To improve the health of the people of Connecticut through safe and effective medication use that involves interdisciplinary educational programs, community-based research collaborations, health care transformation policy opportunities, and team-based care delivery.
Webinar Objectives

1. Provide a brief overview of clinical practice settings, clinical team members, patient mix, and payer mix.

2. Describe the current medication management programs provided by pharmacists at your clinical practice site.

3. Explain how you established current reimbursement mechanisms for pharmacist-provided medication management programs.

4. Discuss the facilitators and barriers to obtaining reimbursement from Medicare, Medicaid, and commercial payers for your clinical services.
Medication Management in Primary Care Clinics

Craig Logemann, PharmD, BCACP, CDE
UnityPoint Clinics
UnityPoint Health

In 9 Regions:
- 17 UnityPoint Health Hospitals
- 280+ UnityPoint Clinic Locations
- 15 Community Network Hospitals
- 12 UnityPoint at Home Locations
- 4 Accredited UnityPoint Health Colleges
- 30 Affiliated Clinic and Home Care Locations

01/2014
Successful Population Health Segments Care Management Models

- **High Risk Patients**: 5% of patients; Complex, Comorbidities
  - High Risk Care Manager 1:1 w/ Wraparound Services

- **Rising Risk Patients**: 15%-35% of patients; May have conditions not under control
  - Patient Centered Medical Home

- **Low Risk Patients**: 60-80% of patients; any minor conditions are easily managed
  - Low-Acuity Access and Education E-World

Adapted from: Advisory Board 2013
My Clinics

UnityPoint Family Medicine Urbandale
- 4 Family Medicine Physicians + 1 NP + 2 PA
- Clinic Pharmacist position started 2001

UnityPoint Family Medicine West Des Moines
- 6 Family Medicine Physicians
- Clinic Pharmacist position started 2006

UnityPoint Family Medicine Ankeny
- 3 Family Medicine Physicians + 1 NP + 1 PA
- Clinic Pharmacist position started 2014
<table>
<thead>
<tr>
<th>Pharmacist Positions (5 FTE)</th>
<th>One UnityPoint Employed PharmD and Four University-affiliated PharmD Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population</td>
<td>Chronic Care Clinic Patients (predominately diabetes and anticoagulation)</td>
</tr>
<tr>
<td>How Service Delivered</td>
<td>Face-to-Face Predominately; Some telephonic follow-up</td>
</tr>
<tr>
<td>Referral Sources</td>
<td>UnityPoint FM &amp; IM Providers; Care Coordination Nurses</td>
</tr>
<tr>
<td>Start Date</td>
<td>Services since 1995</td>
</tr>
<tr>
<td>Billing</td>
<td>99211 (Incident-to-billing) Primarily</td>
</tr>
</tbody>
</table>
# High-Risk Pharmacists – Multiple Regions

<table>
<thead>
<tr>
<th>Pharmacist Positions (2.5 FTE; 2 FTE added by 6/2015)</th>
<th>Funded by UnityPoint Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Population</td>
<td>Self-insured employees (~30K lives); High-risk triggers</td>
</tr>
<tr>
<td>How Service Delivered</td>
<td>Telephonic Predominately; Some face-to-face</td>
</tr>
<tr>
<td>Referral Source</td>
<td>AdvancedCare Team (Analytic driven)</td>
</tr>
<tr>
<td>Start Date</td>
<td>Services since 2013</td>
</tr>
<tr>
<td>Billing</td>
<td>None currently; Exploring possibility of CCM billing in future for the team-based care</td>
</tr>
</tbody>
</table>
Current Reimbursement Strategies for Clinic-Based Pharmacist Services

**Pharmacist Only Visit**
- 99211 (Level One) Visit Code
- Submit charge under supervising physician

**Physician/Pharmacist Same Day Visit**
- Do not submit charges for Pharmacist visit
- Physician Submits Appropriate E&M Code
  - Potential for billing at higher level of service
Services Provided by Clinic Pharmacist

Individual Appointments for Medication Management
- Anticoagulation, Diabetes, Pre-DM, Obesity, Lipids, Asthma, Smoking cessation
- Monitor and manage medication therapy
- Patient self-management education

Shared Medical Appointments (Phys/Pharm/RN Same Day Visit)

Care Management for Diabetic Patients
- Glucometer downloads
- Insulin Pump Management
- Continuous Glucose Monitoring

Drug Information Resource for Care Team
UnityPoint Clinics
Collaborative Practice Agreement

Established in 2006:
• Common CPA for all clinic-based PharmDs

Defined Functions
• Adjust doses of current medications
• Therapeutic interchange
• Order & evaluate appropriate lab tests

Medication Categories in CPA
• Antihypertensives
• Antilipidemics
• Diabetes medications (Orals & Injectables)
• Smoking Cessation Medications
• Thyroid Medications
• Anticoagulants
Wellmark Collaboration on Quality Pilot Project 2009-2010

**Locations:** 9 Primary Care Clinics in Iowa and South Dakota with PharmD presence

**Data Collection:** Jan 2009 – Feb 2010

**Measures:** Diabetes, HTN, Lipids, Asthma, Generic Prescribing

Incentive payments for clinics that attain certain predetermined goal levels

- Ex: % of diabetics with A1c<8.0%
  - Level 1 > 70%, Level 2 > 75%, Level 3 > 80%
  - Thresholds set 5% higher than the Physician COQ goals
Wellmark COQ PharmD Pilot Project

Goal Levels Attained for Clinical Suites at Des Moines area PharmD Clinics (n=3) Compared to HEDIS* National Average for Commercial Insurance Plans

- Diabetes: A1c < 7%
- Diabetes: LDL < 100
- Hypertension: BP < 140/90
- Asthma: Controller Medication**

Percent

<table>
<thead>
<tr>
<th>Condition</th>
<th>PharmD Clinics</th>
<th>HEDIS National Average*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: A1c &lt; 7%</td>
<td>67.2</td>
<td>44.3</td>
</tr>
<tr>
<td>Diabetes: LDL &lt; 100</td>
<td>86.2</td>
<td>42.1</td>
</tr>
<tr>
<td>Hypertension: BP &lt; 140/90</td>
<td>100</td>
<td>64.1</td>
</tr>
<tr>
<td>Asthma: Controller Medication**</td>
<td>91.4</td>
<td></td>
</tr>
</tbody>
</table>

* Healthcare Effectiveness Data & Information Set (HEDIS) national average for commercial plans
** HEDIS data for patients 12-50 years of age with persistent asthma

Patient Scenario

Type 2 Diabetic patient not well controlled on oral diabetes medications. Physician desires to start patient on long-acting insulin product.

Process:
- Referral from Physician
- Provide patient education regarding self-injection
- Initiate insulin dosing and monitoring plan
- Adjust insulin doses over time until therapeutic goals achieved
Patient Scenario (cont.)

**Benefit to Patient:**
- Direct access to clinic personnel to review home glucometer readings (via computer download, email, fax or telephone)
- Improved blood sugar control

**Benefit to Clinic:**
- Time savings for provider
- Additional follow-up for chronic care patients
- Improved quality scores for diabetes measures
Why Involve Pharmacists in the PCMH Setting

Switch from traditional visit payment schemes to “pay for performance”

• Greater emphasis on improved patient quality vs. increased patient volume
• Financial incentives (ACO & PFP Models)

Patient Safety Initiatives

• Emphasis on high-risk medications known to be linked with readmissions
  • Ex: Anticoagulants and Insulin

Collaborative Care Model

• Interdisciplinary. HCP’s practicing at the highest level of their training. Care nurses linked to specific care pharmacist.
Mary Ann Klithermes, PharmD

Chicago area primary care models
Ambulatory Pharmacy Practice
MWU

18 ambulatory faculty (4 tenure track)

3 PGY1 ambulatory care residents  →  2 PGY2

Practicing in a PCMH/ACO Model

- Advocate Health System ACO: 9 faculty
- Illinois Health Partners: 4 faculty
- Norwegian Hospital/Northwestern University: 1 faculty
Advocate Health Care

- Not for profit faith based system
- Largest ACO in the country
  - Over 300 ambulatory care sites
  - 12 acute care hospitals
  - 1 children’s hospital
  - 112 primary care clinics

Advocate Medical Group (AMG)

Managed Care Arm

Over 1200 physicians

Pharmacists at 4 clinics
- Southeast
- Beverly
- Sykes
- Dryer
AMG Southeast

**PCMH Team:**
- 6 PCPs
- 1 Cardiologist
- 2 Pharmacists
  - Collaborative practice agreements / Practice by protocol
- 1 Advanced practice nurse
- 1 Physician assistant
- 1 Dietician
- 1 Nurse
- 3 Care managers

**Pharmacist role:**
- Decreased hospitalizations
- Improved medication adherence

**Expanded to cover:**
- Diabetes
- Hypertension
- Hyperlipidemia
- Asthma
- COPD
- MTM/Med-Rec
- Anticoagulation
- Post hospital follow-up (PHF)
Reimbursement

Capitated reimbursement model
- Medicare Advantage and Commercial Full Risk
- Focus on keeping the patient well – no additional reimbursement received

Medicare shared savings
- “Incident to” CPT code 99211
- Contribution to performance measures

Wellness Visits
## Southeast Clinic Data

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique patients</td>
<td>778</td>
</tr>
<tr>
<td>Average age</td>
<td>69 (14-96)</td>
</tr>
<tr>
<td>Visits per patient per year</td>
<td>5.4</td>
</tr>
<tr>
<td>Full Risk Medicare and Commercial</td>
<td>70%</td>
</tr>
<tr>
<td>Medicare Shared Savings</td>
<td>19.4%</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>2.2%</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>2009 Results (%)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>≥ 65 yo Annual Eye Exam</td>
<td>35</td>
</tr>
<tr>
<td>≥ 65 yo Annual Foot Exam</td>
<td>71</td>
</tr>
<tr>
<td>≥ 65 yo A1c Performed</td>
<td>80</td>
</tr>
<tr>
<td>≥ 65 yo A1c Performed &lt; 8%</td>
<td>32</td>
</tr>
<tr>
<td>≥ 65 yo A1c Performed &gt;9%</td>
<td>41</td>
</tr>
<tr>
<td>≥ 65 yo LDL Performed</td>
<td>78</td>
</tr>
<tr>
<td>≥ 65 yo LDL &lt; 100 mg/dL</td>
<td>40</td>
</tr>
<tr>
<td>≥ 65 yo LDL &gt; 130 mg/dL</td>
<td>39</td>
</tr>
<tr>
<td>≥ 65 yo HTN Control (&lt; 140/90)</td>
<td>62</td>
</tr>
<tr>
<td>≥ 65 yo Nephropathy Testing</td>
<td>85</td>
</tr>
</tbody>
</table>
## AMG Southeast Outcomes

<table>
<thead>
<tr>
<th>Medication Use</th>
<th>2009 Results (%)</th>
<th>2013 Results (%)</th>
<th>2014 Results (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Medication Use</td>
<td>80</td>
<td>92</td>
<td>92</td>
</tr>
<tr>
<td>Use of Generic Statins</td>
<td>75</td>
<td>96</td>
<td>95</td>
</tr>
<tr>
<td>Heart Failure Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Medication ACEI or ARB</td>
<td>74</td>
<td>88</td>
<td>95</td>
</tr>
<tr>
<td>Appropriate Medication HF Beta-blocker</td>
<td>82</td>
<td>80</td>
<td>83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rehospitalizations</th>
<th>2009 Results</th>
<th>2010 - 2011</th>
<th>2013 Results (%)</th>
<th>2014 Results (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 day</td>
<td>313</td>
<td>3/150</td>
<td>8</td>
<td>14</td>
</tr>
</tbody>
</table>
BreakThrough Care Center
BreakThrough Care Center

**Partnership:** private physician owned group & Medicare Part C payer

- 425 physicians
- 39 primary care/ internal medicine clinics

**High risk patients:** 3 centers

- John Hopkins PRA score
- Charleston score
- Predictive modeling tool

**Expanded**

- Self insured employees
- ACO Medicare Shared Savings
The BCC

Team Members
- Physician
- Nurse Practitioner
- Health coaches
- Pharmacist(s)
- Dietician (3 days per week)
- Social Worker
- Gym with trainer
- Lab
- Radiology
- Physical Therapy
- Orthopedist (4 hrs/wk)
- Psychiatrist (4 hrs/wk)

MTM Services
- Comprehensive medication review (CMR)
- Identify drug-related problems (DRPs)
- Work with patient to set goals
- Maintain patient’s medication list
- Assess adherence
- Address access issues
- Provide drug therapy recommendations
- Provide action plan for patient
- Pill boxes
- Education
Reimbursement

Capitated reimbursement model

- Medicare Advantage Full Risk
- MTM codes (99606, 99607) are used to track productivity

Medicare shared savings

- “Incident to” CPT code 99211
- Contribution to performance measures

Transition of Care Visits
# Outcome Measures

## Pre- and Post-BCC Biometrics

<table>
<thead>
<tr>
<th>Data element</th>
<th>Average before BCC</th>
<th>Average of most recent value</th>
<th>Percent difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C</td>
<td>128.046</td>
<td>113.176209</td>
<td>-11.61%</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>230</td>
<td>203.406360</td>
<td>-11.56%</td>
</tr>
<tr>
<td>A1C</td>
<td>9.59141</td>
<td>8.939062</td>
<td>-6.80%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>146/83</td>
<td>132/76</td>
<td>-9.01%</td>
</tr>
<tr>
<td>BMI (too low)</td>
<td>20.6737</td>
<td>20.907298</td>
<td>1.13%</td>
</tr>
<tr>
<td>BMI (too high)</td>
<td>41.7077</td>
<td>34.707229</td>
<td>-16.78%</td>
</tr>
</tbody>
</table>
Questions

**Now:** please type your question in the “chat” box

**Future:** please post a question at prism@uconn.edu and the most pertinent speaker will respond

Slides and recording of this webinar will be posted on the PRISM web site at:

http://pharmacy.uconn.edu/research/centers-collaboratives/prism/