# Developing Trends in Delivery and Reimbursement of Pharmacist Services

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**Prepared by:**
Avalere Health LLC

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# EXECUTIVE SUMMARY

## The Role of Pharmacist Services in Healthcare Today

Research suggests that demand for primary care physicians will increase 14 percent from 2010 to 2020—while primary care physician supply will increase by just 8 percent[1]—creating greater demand for interdisciplinary, team-based approaches to deliver primary care services.[2]

Pharmacists are increasingly providing direct patient care based on state scope of practice regulations in a variety of settings spanning inpatient, outpatient, and community pharmacies. Community pharmacists are among the most accessible healthcare practitioners, with 93 percent of Americans living within 5 miles of a community pharmacy,[3] and they are delivering care beyond the traditional prescription medication dispensing function, offering direct patient care services such as:

- immunizations,
- wellness and prevention screening,
- medication management,
- chronic condition management, and
- patient education and counseling.

Pharmacists are licensed by the states and state-by-state regulations outline the provision of the scope and types of healthcare services that can be delivered by pharmacists.

## Current Landscape for Reimbursement for Pharmacist Services

While opportunities for pharmacists to provide direct patient care services emerge, options for obtaining reimbursement for these services continue to be limited for community pharmacists. Pharmacists practicing in a hospital outpatient or physician office setting may bill for services provided under a mechanism that is tied to supervision by a physician or other providers such as a nurse practitioner or a physician assistant, as well as a number of other requirements that must be met. While the pharmacist delivers the services in this setting, payment is made to the supervising physician or other provider as an “incident to” service.

Outside of traditional Medicare Part D medication therapy management (MTM), the mechanisms through which pharmacists in the community setting may obtain

reimbursement for services allowed under state scope of practice regulations are limited and vary by payer; the lack of reimbursement has been identified as a key challenge in delivering pharmacist-provided direct patient care services on a widespread basis.[4]

Factors that would facilitate broader reimbursement of pharmacist services include:

- Establishment of federal statutory recognition of pharmacists as healthcare providers under Medicare Part B;
- Standardization of billing methods from a federal and state perspective for specific services outlined in scope of practice regulations that pharmacists provide through direct patient care; and
- Improved coordination between the pharmacy and medical benefit, enhanced through health information exchange that delivers clinical and administrative information to and from the pharmacy to other healthcare providers within the patient care team.

### Future Outlook for Payment for Pharmacist Services and Their Role in Value-Based Alternative Payment Models

Moving forward, the development of new care delivery models will create opportunities to test new mechanisms for pharmacist reimbursement in the context of alternative payment models' (APMs) transition to value-based care. Pharmacists are trained medical professionals who have been shown to improve the clinical and cost outcomes of patients, and are likely to play a critical role in determining the continued growth and success of APMs given their unique access to, and relationship with, the patient community.[5] This mechanism for shared responsibility will enable physicians participating in accountable care organizations (ACOs) and other APMs to maximize time spent with high-cost high-need patients, while simultaneously providing substantially greater access for patients and satisfying the basic primary care needs of the broader population.

In order for this paradigm to be successful, pharmacists would need to be adequately compensated for their contributions and expanded role in the healthcare team, either through portions of shared savings or separate service-based fee contractual agreements with APMs that pay for their services. The specific nature of pharmacist remuneration will vary by APM and individual APM participants. These entities are held accountable for population health against a global budget (which may include pharmacy spending) over an extended period of time, emphasizing a need to foster a more comprehensive partnership with pharmacists. With a greater focus on improving the value of care, the opportunities for pharmacists to provide a variety of direct patient care services will continue to evolve as incentives for reimbursement of these services are established.

## 1. BACKGROUND AND INTRODUCTION

Patient demands on the healthcare system are expected to increase significantly and outpace current provider supply over the next few years. By 2020, demand for primary care physicians is expected to increase by 14 percent from 2010, while supply for primary care physicians will increase by 8 percent.[6] With greater projected demand for primary care services anticipated for the future, interdisciplinary, team-based approaches have been acknowledged as a key strategy to meet expected needs.[7]

Pharmacists are increasingly providing direct patient care in a variety of settings spanning inpatient settings, outpatient/ambulatory clinics, and community pharmacies. Community pharmacists are considered to be among the most accessible healthcare practitioners, with 93 percent of Americans living within 5 miles of a community pharmacy according to a 2011 report.[8] Pharmacists in this setting are continuing to provide services distinct from the traditional prescription dispensing function, offering direct patient care services such as immunizations, screenings, and point-of-care (POC) testing; medication management; chronic condition management; and patient education and counseling. State-by-state regulations outline the provision of the scope and types of services that can be delivered by pharmacists.

In general, direct reimbursement to pharmacies by health plans for direct patient care services delivered by pharmacists has been limited. Medication therapy management (MTM) for Medicare Part D beneficiaries is among the most prominent types of direct patient care services that are reimbursed by payers today. Select state Medicaid agencies also provide compensation to pharmacies for MTM delivered to eligible beneficiaries, though services and level of compensation varies by state. Likewise, pharmacists have been reimbursed for immunization services, within select state Medicaid agencies and through a mechanism established within Medicare. Pharmacist-provided services such as screening, counseling, education, and disease management activities typically do not have widely used pharmacist-specific standardized billing methods established, requiring the establishment of negotiated partnership agreements with local plans and/or providers to reimburse pharmacies for these discrete services.

Furthermore, because pharmacists are not recognized as healthcare providers in federal statute (as defined in the Social Security Act, Section 1861), there is no mechanism for direct fee-for-service reimbursement to pharmacies for providing direct patient care services to individual patients under Medicare Part B. Interestingly, although 34 states (as of 2014) have recognized pharmacists as healthcare providers in state statute, a formal mechanism to provide direct reimbursement for these services is typically unavailable.[9]

As advances in healthcare technology and ongoing health reform continue to take shape with a focus on team-based care in patient-centered medical homes (PCMHs), accountable care organizations (ACOs), and other innovative delivery models, new opportunities exist to integrate pharmacists into the healthcare team to deliver patient-care services in coordination with other healthcare providers. Within these developing care delivery models, it is important to identify opportunities to incentivize and recognize the contributions of all healthcare providers that play a role in delivering high-quality and cost-effective care resulting in improved outcomes for patients. Here, we explore the current status of reimbursement for pharmacist services and the future opportunities for care delivery by pharmacists, and how reimbursement of these services may continue to evolve.

## 2. OVERVIEW OF CURRENT BILLING MECHANISMS FOR PHARMACIST SERVICES

The process through which pharmacists may bill for their services outside of the medication dispensing function, where applicable, remains somewhat unstandardized across systems and settings of care. However, the mechanisms by which payment can be made to pharmacists for direct patient care services have made some measured advancement in recent years. For example, in the community pharmacy setting, pharmacists can establish a direct billing mechanism for patients (cash transaction), provide services under a third-party insurance-contracted service, or use pharmacist-specific MTM Current Procedural Terminology (CPT) codes. In an online survey conducted in 2011, 64.7% of community pharmacists reported charging patients directly for the service, 61.8% reported reimbursement through a third-party insurance-contracted service, and 55.9% reported using pharmacist CPT codes for MTM.[10]

Other approaches to reimbursement that have been established such as “incident to” billing and outpatient facility-based billing, which facilitate payment for pharmacist services delivered outside of the community pharmacy setting, are largely limited to pharmacists practicing in an ambulatory care clinic or hospital outpatient clinic, respectively. Alternative mechanisms for reimbursement may be established through negotiating contracts with different payers or self-insured employers. Below, we provide a summary of each of these types of billing mechanisms and their applicability for community pharmacists.

## 2.1. BILLING MECHANISMS FOR PHARMACIST SERVICES IN THE COMMUNITY PHARMACY SETTING

Although options for billing for pharmacist direct patient care services in the community pharmacy setting are somewhat limited, in certain instances pharmacists have been able to establish reimbursement for services, though they vary substantially by the particular payer and state where services are delivered. In many instances, pharmacists may not be able to bill independently, especially within the Medicare Part B program, due to the lack of provider status of pharmacists in federal statute. However, selected state Medicaid agencies and private payers may provide reimbursement for particular pharmacist services under their own set of requirements and within the scope of practice as defined by state regulations. In this section, we provide a brief overview of some of the distinct types of reimbursement mechanisms that currently exist for billing pharmacist services in particular care settings.

### 2.1.1. CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

Depending on the payer, certain types of CPT codes may be available for the pharmacist to utilize when seeking reimbursement for services. Among the CPT codes available, only three pharmacist-specific CPT codes (99605-99607) have been established, all of which are for delivery of MTM services. These codes are not used under Medicare Part B, but may be used by Medicaid, private health insurers, or Medicare Part D plan administrators in determining reimbursement.

Following passage of the Medicare Modernization Act of 2003, which established the requirement for MTM services to be offered to select Medicare beneficiaries, the American Medical Association (AMA) CPT panel created three temporary pharmacist-specific CPT codes to facilitate reimbursement of MTM services, which became effective on January 1, 2006.[11] On January 1, 2008, permanent CPT codes were created to replace the temporary codes (99605-99607).[12] These codes (see Table 1) are strictly time-based rather than intensity-based. Reimbursement amounts for these CPT codes and the specific services depend on the individual payers that utilize these codes, including Medicaid, Medicare Part D plans, and commercial health plans.

**Table 1: Descriptions of Pharmacist-Specific CPT Codes for MTM Services**

| CPT Code | Description |
|---|---|
| 99605 | Medication therapy management service(s) (MTM) provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided; initial 15 minutes, new patient |
| 99606 | Medication therapy management service(s) (MTM) provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided; initial 15 minutes, established patient |
| 99607 | Medication therapy management service(s) (MTM) provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service) |

In a 2011 study by Beatty et al., these codes were found to be the most commonly reported billing technique when seeking reimbursement for MTM, though less than 50 percent of pharmacists (ambulatory and community) reported using the codes. In many instances, the pharmacist used other codes such as "incident to" codes (described later) or directly charged the patient, depending on the setting. Furthermore, pharmacists did not consistently bill for the services due to lack of consistent reimbursement and confusion with the billing processes.[10]

## 2.1.2. REIMBURSEMENT THROUGH CONTRACTS WITH THIRD-PARTY PAYERS

Though not widespread, pharmacies may receive reimbursement from self-insured employers or other third-party commercial insurers for a pre-specified set of pharmacist services under a separately negotiated contract. Reimbursement rates are negotiated with the payer and mechanisms are implemented by which pharmacists may bill for the services rendered. These types of contracts may apply to pharmacists in community pharmacies along with other settings. Such arrangements may require separate contracts for each type of service provided.[13] Arrangements for payment may include fee-for-service or may be covered under capitation or similar arrangements.

In some instances, third-party insurers may require a credentialing process in order to submit claims for services rendered. As part of this credentialing process, certification or training requirements may apply and the types of CPT codes that may be used for billing may vary. The types of specific services that a pharmacist may provide will be guided by the contract, in addition to the types of services pharmacists are allowed to provide within their scope of practice as permitted by state boards of pharmacy.

**Case Study: MTM Reimbursed by Self-Insured Employer**

A study by Wittayanukorn et al., examined an MTM service offered to employees of a public university. Pharmacists staffed the university campus "pharmaceutical care center" and provided dispensing, wellness, and disease prevention services for employees, their dependents, and retirees. The pharmaceutical care center billed the employer for services provided to employees or other eligible members. The service targeted those with cardiovascular disease and the intervention consisted of face-to-face consultations, follow-up visits as necessary, medication reviews, identification and assessment of drug-related problems (DRP), resolution and monitoring of DRPs, adherence assessment, and interventions. Pharmacists also provided patients with point-of-care tests, which included blood pressure, lipid panels, and body mass index. In an analysis comparing intervention patients with a matched control group, those in the intervention group had lower cardiovascular-related pharmacy, all-cause medical, and total expenditures, with a positive return on investment.[14]

### 2.1.3. DIRECT PATIENT PAYMENT

Finally, pharmacists may also be reimbursed through directly charging patients for the services on a cash transaction basis. The reimbursement rate and billing structure may vary and is established by the pharmacist. The patient may pay for the service out of pocket and may receive documentation to obtain potential reimbursement from his or her health plan or through a flexible benefit program. It has been estimated that approximately two-thirds of community pharmacists may charge patients directly for their services.[10]

## 2.2. BILLING MECHANISMS FOR PHARMACIST SERVICES WITHIN HOSPITAL OUTPATIENT OR PHYSICIAN OFFICE SETTINGS

Pharmacist services are delivered across various settings of patient care. This includes services provided outside of the community pharmacy setting. Often in settings such as a hospital outpatient or physician office, pharmacists who provide services do so under

the direct supervision, and in collaboration with a physician or recognized non-physician practitioner (NPP), such as a nurse practitioner or a physician assistant. Under this scenario, which includes certain supervisory requirements, reimbursement within hospital outpatient or physician office settings offer an alternative approach to the ways that pharmacists may bill for their services. Some of the more commonly used examples of billing methods in these settings include "incident to" billing and ambulatory payment classification (APC) facility billing. Below we provide a brief overview of each of these methods.

### 2.2.1. "INCIDENT TO" BILLING

Under this reimbursement mechanism, NPPs, are eligible to bill select services as "incident to" a physician. In the physician office, the physician bills for the services of an NPP as if the physician performed the services themselves. The physician then receives the full amount for the service and remuneration can be made to the NPP. In the hospital outpatient department (HOPD), the "incident to" service is captured on the facility claim and no provider claim is submitted. Additionally, healthcare staff such as a pharmacist can bill "incident to" a physician or NPP. In March of 2014, the Centers for Medicare & Medicaid Services (CMS) reaffirmed in a public statement that in appropriate settings, services provided by pharmacists represent an opportunity to bill for services through a physician as an "incident to" service.[15]

However, in order to bill "incident to," there are a number of requirements that must be met. A physician must have initiated the course of treatment for which the "incident to" services will be rendered. "Incident to" services must also be performed under the direct supervision of the physician. Direct supervision is defined in the physician office as presence of the physician in the office suite where the services are being rendered while the services are being rendered and the physician must be immediately available to assist if needed. Whereas direct supervision in the HOPD is defined that the physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure.

The codes used to bill "incident to" services are the same as if the physician performed the service. They describe the procedure that was performed and not who performed the procedure or under what circumstance care was delivered. As an example, evaluation and management (E&M) CPT codes (99211-99215, see Appendix) may be used by pharmacists in the ambulatory care setting for "incident to" services depending on the payer, with each code varying in accordance with increasing levels of intensity or effort. Services that may be billed via this type of "incident to" billing include disease management and medication dosing adjustments, among others.[16] Because pharmacists in most jurisdictions do not

have provider status, many insurance companies do not reimburse pharmacists beyond the lowest intensity of service (99211).[17] However, pharmacists in certain states where regulations allow pharmacists in the ambulatory care setting to provide "incident to" services beyond those as described by 99211 may bill at higher intensity levels depending on the Medicare contractor or health plan.[18]

Most recently in the CY 2015 rule affecting the Medicare physician fee schedule, CMS relaxed the rule for "incident to" services billed under chronic care management (CCM) and transitional care management (TCM) services. Under CCM or TCM, non-physician clinical staff may provide CCM services under the general supervision (instead of direct supervision) of a practitioner, whether or not they are direct employees of the practitioner or practice that is billing for the service, however, they must have the appropriate contractual relationship under "incident to" billing (Code of Federal Regulation §410.26). General supervision means that they are under the direction of a physician but the physician does not need to be in the area or immediately available to intervene. CMS has also specifically clarified in February 2015 that pharmacists' services may be billed "incident to" physician services under CCM and TCM as well, within their scope of practice and qualifications.[15]

### 2.2.2. BILLING SERVICES IN THE HOSPITAL OUTPATIENT SETTING

Another avenue for billing for pharmacist services in the HOPD facility setting is through the outpatient prospective payment system (OPPS) via "incident to" billing. CPT codes are also used to bill in this setting, however, they are mapped to APCs that determine the facility-based payments separately from professional component fees. APCs are only applicable in HOPD settings, such as hospital outpatient clinics and emergency departments (EDs). Historically, hospital outpatient billing for CPT codes 99211 to 99215 (see section 2.2.1. for details) for clinic visits were available to code "incident to" services by pharmacists in this setting, and corresponded to three different levels of APC facility reimbursement. Examples may include services such as patient education, disease management, and dose management.[16] However, in the CY 2014 OPPS Final Rule, these aforementioned CPT codes were discontinued for use in this setting by Medicare and replaced with a single alphanumeric Healthcare Common Procedure Coding System (HCPCS) code, G0463, corresponding to a single APC code 0634 (Hospital Clinic Visits).[19] This change eliminated the variation of levels of E&M services in the HOPD setting to one, regardless of complexity. Pharmacists may also bill for "incident to" services that qualify under CCM using CPT code 99490, corresponding to APC code 0631 (Level 1 Examinations & Related Services) in the hospital outpatient setting.

### 2.2.3. APPLICABILITY OF "INCIDENT TO" BILLING IN THE COMMUNITY PHARMACY SETTING

Although the "incident to" codes may be useful for indirect reimbursement of pharmacist services for Medicare patients, they have limited applicability in the community pharmacy setting. This is largely due to statutes that dictate that services delivered via "incident to" codes must be provided under direct supervision of the physician or NPP, and that a contractual agreement is in place between the physician and pharmacist for the pharmacist to provide services under the physician's supervision. Furthermore, there is no mechanism for pharmacists to directly bill CMS for the services rendered, and statutes require that a physician or NPP bill for the services with non-clinical staff billing via an "incident to" method. As such, the result is that pharmacist services cannot be practically reimbursed under this method when services are delivered in a community pharmacy setting since the requirements under this methodology cannot be feasibly met. Though "incident to" billing can be used by pharmacists who provide services on-site at physician (or NPP) practices, community pharmacists providing care in the retail pharmacy setting are generally restricted from using these services due to the requirement that the service is rendered in the physician (or NPP) clinic with direct supervision.

## 2.3. EXAMPLES OF REIMBURSEMENT FOR PHARMACIST SERVICES IN THE MARKETPLACE

In the 2011 study by Beatty et al., that sampled community and ambulatory care pharmacists, the most commonly reported types of reimbursed services provided by community pharmacists included immunization delivery, comprehensive/targeted medication review, hypertension screening, medication adherence service, and diabetes management.[10] Houle et al., conducted a systematic literature review to identify remunerated pharmacist clinical care programs worldwide. The authors found 37 unique programs in the U.S. from publicly available data sources, most of which focused either on MTM or disease management programs, with fixed fees according to different types or levels of service. The most frequently observed services included comprehensive medication review, adherence-directed interventions, patient education and monitoring, prescriber consultations, and MTM. Other less frequently identified services included tobacco/smoking cessation counseling, diabetes management, and adherence consultations, among others.[20]

## 2.3.1. MEDICATION THERAPY MANAGEMENT (MTM)

For the purposes of Medicare Part D, CMS considers MTM to be a service provided by a prescription drug benefit plan and included as an administrative cost (a component of the plan's bid); the fees and mechanisms for billing are largely left up to the discretion of the plan sponsor. As such, establishment and delivery of the services may be performed in-house, negotiated with an outside MTM vendor, or may make use of local community pharmacists. In 2014, 19.5% of programs made use of a local pharmacist and 11.2% made use of a long-term care pharmacist.[21]

MTM may also be provided outside of Medicare Part D. A select number of Medicaid and state-based programs provide and reimburse pharmacists to deliver MTM, including Colorado, Iowa, Maine, Minnesota, Missouri, and New Mexico, as examples.[20] These types of services are generally provided on a "fee-for-service" basis, though Medicaid managed care plans may offer their own MTM services for their beneficiaries. The scope of services provided and reimbursement mechanisms for Medicaid MTM services vary according to state and health plan.

MTM services may also be provided with beneficiaries of employer-sponsored or commercial health plans. A number of examples exist where these types of health plans reimburse for MTM.[14,22,23] Under such arrangements, the scope of the services, reimbursement guidelines, and levels of reimbursement for MTM services may also vary according to health plan.

**Case Study: Medicaid-Provided MTM**

The Minnesota Department of Human Services (DHS) started paying qualified pharmacists for MTM services for Medicaid beneficiaries, effective April 1, 2006.[24] The program is one of the more comprehensive MTM services that are provided by state Medicaid programs. Covered services include face-to-face or interactive video encounters, health assessment, formulation of a medication treatment plan, monitoring and evaluation of therapy, comprehensive medication review, documentation and communication of findings to providers, and coordination within broader healthcare management services being provided to the patient. Notably, the program allows for delivery of MTM services remotely via interactive video, allowing MTM to be delivered to qualified recipients who are more than 20 travel miles from an enrolled MTM service provider.

The program utilizes MTM CPT codes, described earlier, with different fees according to the time required to provide the service. These codes and their associated fees are outlined below:

### Table 2: Minnesota Department of Human Services (DHS) MTM Program Codes and Associated Fees

| CPT Code | Description | 2015 Fees |
|---|---|---|
| 99605 | Medication therapy management service(s) (MTM) provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided; initial 15 minutes, new patient | $52.00 |
| 99606 | Medication therapy management service(s) (MTM) provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided; initial 15 minutes, established patient | $34.00 |
| 99607 | Medication therapy management service(s) (MTM) provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service) | $24.00 |

Source: Minnesota Department of Human Services Medication Therapy Management Services (Revised 8/25/2015)

These codes may be combined to reflect the level of assessment, the identification of drug therapy problems, and complexity of care planning. The Minnesota DHS provides guidance as to how these codes can be used according to the level of effort associated with each service:

### Table 3: Examples of Combination Codes Used to Reflect Level of Assessment and Complexity of Care Planning

| Level | Assessment of Drug-Related Needs | Identification of Drug Therapy Problems | Complexity-of-Care Planning and FU Evaluation | Approximate Face-to-Face Time | Bill CPT Code | Units | 2015 Rate |
|---|---|---|---|---|---|---|---|
| 1 | Problem-focused—at least 1 medication | Problem-focused—0 DTPs | Straightforward—1 medical condition | 15 mins. | 99605 or 99606 | 1 unit | $52.00 or $34.00 |
| 2 | Expanded problem—at least 2 medications | Expanded problem—at least 1 DTP | Straightforward—1 medical condition | 16-30 mins | 99605 or 99606 and | 1 unit | $76.00 or $58.00 |
| | | | | | 99607 | 1 unit | |
| 3 | Detailed—at least 3-5 medications | Detailed—at least 2 DTPs | Low complexity—at least 2 medical conditions | 31-45 mins. | 99605 or 99606 and | 1 unit | $100.00 or $82.00 |
| | | | | | 99607 | 2 units | |

| Level | Assessment of Drug-Related Needs | Identification of Drug Therapy Problems | Complexity-of-Care Planning and FU Evaluation | Approximate Face-to-Face Time | Bill CPT Code | Units | 2015 Rate |
|---|---|---|---|---|---|---|---|
| 4 | Expanded detailed—at least 6-8 medications | Expanded detailed—at least 3 DTPs | Moderate complexity—at least 3 medical conditions | 45-60 mins. | 99605 or 99606 and | 1 unit | $124.00 or $106.00 |
| | | | | | 99607 | 3 units | |
| 5 | Comprehensive—at least 6-8 medications | Comprehensive—at least 4 DTPs | High complexity—at least 4 medical conditions | 60+ mins. | 99605 or 99606 and | 1 unit | $148.00 or $130.00 |
| | | | | | 99607 | 4 units | |

Source: Minnesota Department of Human Services Medication Therapy Management Services (Revised 8/25/2015)

**Case Study: MTM Provided Within Self-Insured Employers**

Contracting with self-insured employers is another avenue through which MTM services can be provided, such as the Auburn University Pharmaceutical Care Center (AUPCC).[25] The AUPCC was established as a free-standing clinic that functioned separately from distributive pharmacy functions. Aside from MTM services, the clinic also offered health and wellness services, smoking cessation, women's health assessment, asthma counseling, diabetes counseling, among other services conducted by trained pharmacists.

The fee schedule was organized based upon whether or not the visit was an initial consultation or a follow-up for patient care services. The price of the visit was calculated based on the average amount of time required for an experienced practitioner to provide care. Once the price was determined, the employer (i.e., the university) billed a flat fee for the service. As part of the negotiation process with the employer, certain pro forma assessments for particular MTM services were created to evaluate specific outcomes related to the type of service provided (e.g., improved medication use).[25]

## 2.3.2. MEDICATION RECONCILIATION DURING TRANSITIONS OF CARE

New payment models have intensified provider focus on robust medication reconciliation (MR). In particular, Medicare's bundled payment programs and readmissions penalties have catalyzed intensive work to improve transitions of care, including a recognition of the

critical role that medication redundancy, interactions, and complex management play in forcing patients back into the inpatient setting. Improved communication between hospitals and community pharmacists can help ensure reconciliation of medication lists.[26] Although not yet common, innovative approaches to MR within community pharmacies have the potential to support providers operating under these new payment models.[27,28,29] In addition, in the ambulatory care setting, MR services may be billed using "incident to" billing codes, though formal mechanisms through which community pharmacists may specifically seek reimbursement for this service do not exist.

**Case Study: Pharm2Pharm Pharmacist-Led Medication Reconciliation Program**

University of Hawaii at Hilo's Pharm2Pharm program is a Health Care Innovation Award (HCIA) program in Hawaii that aims to develop a formal care coordination model between hospital and community pharmacists to address medication management risks during post-discharge transitions of care, especially in rural communities.[30] Those targeted include elderly patients and others who have been hospitalized and are at risk for subsequent medication-related hospitalizations and ED visits. Specifically, these patients include those people:

- aged 65 years and older
- taking multiple medications and certain high-risk drugs
- experiencing an acute episode due to a drug therapy problem
- with previous acute care episodes or hospitalizations due to uncontrolled chronic conditions
- discharged and on a new home medication regimen for newly diagnosed acute coronary syndrome, atrial fibrillation, chronic obstructive pulmonary disease, congestive heart failure, or diabetes.[30]

A hospital consulting pharmacist (HCP) identifies patients during hospitalization and then provides medication management services and follow-up with patients after discharge. After discharge, the program refers patients to a community consulting pharmacist (CCP) who then provides the post-discharge medication management services and interventions. The components of the intervention include HCP medication management services, handoff to CCPs, CCP-coordinated medication management, and payment restructuring for pharmacists.[30]

The payment structure for the pharmacists is based on the time during which the patient remains in the program after handoff from the HCPs. Prior to the program, no compensation was available to HCPs or CCPs for the program. Currently, the CCPs receive four fixed payments per beneficiary per year for a total of $695 per patient per year, or prorated if a patient exits the program before completing one year.[30]

## 2.3.3. IMMUNIZATIONS

Pharmacists are authorized to administer influenza vaccines in all states, and may also immunize patients for many other conditions. Current state scope of practice regulations vary with regard to the types of vaccines and patient populations that pharmacists may administer or immunize, respectively. While Medicare Part B covers patient vaccinations for influenza, pneumococcal vaccines, hepatitis B, and vaccines directly related to treatment of injury or disease (e.g., rabies and tetanus vaccines), direct reimbursement to pharmacists for administration of vaccines under Part B is limited to influenza and pneumococcal vaccines under the CMS mass immunizer program.[31,32] Under Medicare Part D, covered vaccines for which pharmacies may receive reimbursement through a negotiated fee with the prescription drug plan (and subject to state scope of practice) include diphtheria, hepatitis A, herpes zoster, human papillomavirus, Lyme disease, measles, meningococcal, mumps, pertussis, polio, rabies, rotavirus, rubella, tetanus, typhoid, varicella, and yellow fever.[33] Selected state Medicaid programs may offer coverage for vaccines, although administration fees and types of vaccines covered vary by state.[33] Commercial coverage of pharmacist-provided vaccination is somewhat limited, with provider status acknowledged as one potential barrier to achieving reimbursement for pharmacist services.[34]

## 2.3.4. SCREENING AND POINT-OF CARE (POC) TESTS

Pharmacist screening described in the literature includes cholesterol testing, blood glucose screenings, blood pressure, breast cancer risk assessments, bone mineral density screening, and depression screening.[35] In certain states, pharmacists may conduct specific types of Clinical Laboratory Improvement Amendments (CLIA)-waived POC testing. The extent to which pharmacists may provide a professional opinion varies according to state statute. Across states, POC testing by pharmacists may be addressed specifically in regulations or through collaborative drug therapy management (CDTM) provisions.[36] Formal mechanisms currently do not exist for pharmacists to receive reimbursement for time spent on POC tests. Where established, current billing mechanisms account only for the cost of the test and not for the time involved in the testing. Detailed examples by which pharmacists receive reimbursement for these services are very limited. Despite the lack of formal reimbursement for screening services, pharmacists may provide these services on a direct charge basis to patients.

### Case Study: Osteoporosis Screening Within Community Pharmacies

Osteoporosis risk screening programs have been established and described in the literature in which a pharmacist provides bone mineral density screening as well as patient education. In addition, the pharmacist discusses screening results with the patient, provides an overview of osteoporosis, and outlines specific recommendations. An example of this service was delivered by a community pharmacy in a metropolitan area in Iowa using a protocol that was developed with a local physician. The results and recommendations (including calcium intake recommendations) were then faxed to the patient's PCP at the patient's request. The listed price for the screening service was 35 dollars, which was charged to the patient or, in some cases, billed to the patient's health insurance plan. Over a 48-month period, data was collected on 444 women (of which one-third were over the age of 65) that identified 58% as high risk for osteoporosis through the screening service.[37]

## 2.3.5. PATIENT EDUCATION AND COUNSELING

Another area where pharmacists provide direct patient care is focused on patient education and counseling. Examples have been described for adherence counseling,[38] disease management,[39,40] and tobacco cessation counseling.[41,42] These types of services may be offered as a standalone service or as part of a larger medication management intervention, and vary in scope and target populations. Standardized mechanisms for reimbursement of these types of services do not exist, though previous interventions among self-insured employers have been documented in the literature.

### Case Study: Pharmacist-Provided Patient Self-Management Program for Diabetes

The Diabetes Ten City Challenge (DTCC) was a voluntary patient self-management program conducted with selected employers in which a trained pharmacist ("coach") counseled patients with diabetes on managing their diabetes medications; goal setting; proper use of medications; and tracking the progress of their condition through cholesterol tests, blood pressure, foot exams, and eye exams.[40] The program was conducted in community independent

pharmacies, chain community pharmacies, and ambulatory care clinics across 10 cities in the U.S. Physicians and other providers were encouraged to share the care plan with the pharmacist, and pharmacists created written documentation of the visit for the physician along with referrals as necessary. Clinical laboratory data were obtained from the physician, through a laboratory or through POC testing. All visits were recorded using a web-based documentation system.

Pharmacists were compensated for their services by the employer offering the service according to fee schedules negotiated by the local pharmacy network. At a minimum, employers provided incentives for participation in the program through waived copayments for medications and certain supplies. The program was able to demonstrate decreases in total costs, and improved cholesterol, hemoglobin A1c, blood pressure, and influenza vaccination rates.

**Case Study: Tobacco Cessation Counseling Services in Indiana Medicaid**

Since 1999, Indiana Medicaid has implemented coverage of smoking cessation treatment services for patients. Eligible practitioners providing the service include physicians, physician assistants, nurse practitioners, registered nurses, psychologists, and pharmacists. To obtain coverage, a minimum of 30 minutes is required for each counseling session to a maximum of 150 minutes within the 12-week course of smoking cessation treatment. Services are billed for each 15 minutes using the code 99407-U6, priced at $22.63 per unit.[43,44,45,46]

## 2.3.6. COLLABORATIVE DRUG THERAPY MANAGEMENT (CDTM)

CDTM is performed under a collaborative practice agreement between one or more physicians and a pharmacist under a protocol whereby the physician makes the diagnosis, supervises patient care, and refers the patient to the pharmacist for performing services such as: patient assessments; ordering drug-therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens.[47]

Though most states today allow some type of CDTM between pharmacists and physicians, the specific scope of permitted tasks for CDTMs under which a pharmacist may operate largely varies according to state statutes and regulations. Furthermore, the restrictiveness of protocols required for establishment of CDTM will vary across states.

Community pharmacists may receive reimbursement for services provided under CDTM by negotiating agreements with payers through the establishment of CDTM programs and billing under the medical reimbursement system.[48,49] However, these types of services are not necessarily universally covered by payers and may be a barrier to providing this service to patients. The Centers for Disease Control and Prevention (CDC) funded a study to understand how collaborative practice agreements are implemented in community pharmacies and explore ways for more pharmacists to provide CDTM.[50] Representatives from three CDTM models were queried about key barriers for implementing these services and found that lack of reimbursement for CDTM-based approaches is a key barrier for implementation.

**Case Study: CDTM-Facilitated Disease Management Program in Community Pharmacies**

Scott & White Health Plan implemented a CDTM program for diabetes, heart failure, and asthma, under which community pharmacists provide care in retail pharmacies under a collaborative practice agreement with Scott & White Health Plan.[48, 51] Pharmacies are able to bill directly for pharmacist services under this health plan. This particular program utilizes pharmacists from an ambulatory residency program or those who have established evidence of certification. In 2012, pharmacists were reimbursed $105 for the initial visit and $55 for the monthly follow-up visit.[51] It has been estimated that the program saved $1,800 per patient among those in the diabetes program.

## 3. CURRENT LIMITATIONS IN BROADER REIMBURSEMENT OF PHARMACIST SERVICES

Compensation for pharmacist services is integral for pharmacists to sustainably provide these services to patients. The lack of reimbursement has been identified as one of the top challenges contributing to pharmacists being able to feasibly provide direct patient care services on a widespread basis.[50] Currently, pathways for community pharmacy-based

reimbursement for pharmacist services across the entire range of services allowed under state scope of practice regulations are generally limited outside of traditional Medicare Part D MTM. Furthermore, the mechanisms through which pharmacists may obtain reimbursement are not necessarily universally used by all payers.

Although other challenges exist, one of the key issues around securing reimbursement remains the lack of recognition of pharmacists as healthcare providers in federal statute.[52,53,54,55] Many states have adopted statutes that formally recognize pharmacists as providers. Notwithstanding, the National Alliance of State Pharmacy Associations found that though state-level recognition is widespread, reimbursement for the services that can be provided under this recognition remains limited without a viable mechanism that could be established through provider status recognition at the federal level.[9] The presence of a mechanism at the federal level may serve as a reference for payers in establishing reimbursement policies at the local and regional level.

Another key issue is the lack of standardized billing methods to describe the specific services that pharmacists provide, both with MTM and with other types of direct patient care services.[10,13,56,57] Many types of intensive patient care services that are currently provided outside of traditional MTM are provided in the physician office or hospital outpatient setting, where pharmacists may bill using secondary mechanisms by using the "incident to" codes for Medicare. More comprehensive medication management interventions are typically not provided in community pharmacy settings, though examples exist where these types of interventions may be provided and reimbursed by specific health plans.[48,51] Standardization of billing processes can help provide a consistent mechanism through which pharmacists, in accordance with state requirements, can provide these services and seek reimbursement from payers.

State-by-state differences in permitted pharmacist services according to state statute (scope of practice) may also be a limiting factor for broader reimbursement for pharmacists. Establishing a reimbursement mechanism that could be applied at a national level or among states would likely require reconciliation of differences in state regulations to facilitate and standardize reimbursement approaches. This is especially relevant for Medicare beneficiaries who receive non-MTM pharmacy services and for commercial or private health plans that serve beneficiaries spanning multiple states.

Yet another factor is the ability for different systems to communicate with each other to provide the most relevant clinical and administrative information at the time care is provided, and to ensure that services are coordinated across different practitioners. Traditional systems today have limited interoperability, constraining the community pharmacist's ability to have access to medical record information that can allow for interventions to be made and coordinated with the primary care physician (PCP). Previous examples of the most

successful interventions in terms of improved outcomes have incorporated communication with PCPs and other providers; establishing this infrastructure allowing for seamless exchange of information can further facilitate pharmacist interventions.

This lack of interoperability further inhibits coordination between pharmacy and medical benefits. If clinical information and care strategies are siloed from one another, this creates a missed opportunity to inform the delivery of care to patients that integrates different practitioners in a coordinated fashion. In an expert consensus panel conducted in 2013 consisting of 12 representatives from health plans, large employers, or professional organizations, representatives were queried about several key areas around implementing a pharmacy-based vaccine benefit for commercial payers, including benefit design, billing, regulatory/scope of practice considerations, immunization documentation and communication, responsibility for vaccination rates, and future research.[34] Panelists agreed that the lack of coordination between the pharmacy and medical benefit and the administration of which by the pharmacy benefit manager (PBM) and health plan are significant barriers. In particular, billing may be duplicative if efforts are not coordinated. Panelists noted that traditional reporting methods (i.e., fax or letter to provider) are generally not effective. The panelists suggested the use of electronic medical records to allow for pharmacists and medical providers to interface and coordinate the care of patients.

Finally, healthcare payers are also increasingly sensitive to costs, and are looking to improve the value and efficiency of care delivered. As providing reimbursement for pharmacists may increase a health plan's costs, health plans will be interested in assessing the value for the services paid for. Previous studies have demonstrated that pharmacist services have a positive return on investment when considering downstream costs.[58,59] Building on this evidence base and continued demonstration of value that pharmacist services provide to health plans and providers under new models is going to be increasingly more relevant in the future, especially with the ongoing shift from fee-for-service to value-based (e.g., pay-for-performance) reimbursement models and broader alternative payment models (APMs). Indeed, all providers will be studied for their specific contributions to delivering value in patient care.

## 4. LOOKING AHEAD: COMPENSATION WITHIN NEW PAYMENT AND DELIVERY MODELS

At the center of the transition from volume- to value-based healthcare are emerging APMs. The Department of Health and Human Services' (DHHS) ambitious goals to transition 50 percent of Medicare fee-for-service payments to APMs by 2018, coupled with APM incentives in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will only strengthen the healthcare community's resolve to yield better health outcomes while

constraining cost growth. By necessity, healthcare providers hoping to succeed in this evolving healthcare landscape are exploring new ways of providing high-touch, high-value care for their patients, engaging them across the care continuum. Given their unique access to, and relationship with, the patient community, pharmacists will play a critical role in determining the continued growth and success of APMs, particularly in their efforts to engage patients with chronic conditions in the community setting.

Though the public and commercial sector are pursuing an array of different APMs, ACOs and episodic bundled payments present near-term opportunities for pharmacists to have their value recognized through non-traditional compensation. Despite varying program structures, these models share key attributes. Most notably, they define a budget for a specified time and care experience, and therefore challenge providers to develop efficient approaches to care management in order to share in savings to the system. Both ACO and Bundled Payments for Care Improvement (BPCI) participants may seek to partner with pharmacists in these models, recognizing the value they provide to population health through MTM, CCM, counseling, and education. APM participants may recognize the value pharmacists provide in preventing downstream costs, and establish direct financial incentives for their partnership in driving value in care delivery.

The specific nature of pharmacist remuneration will vary by APM and individual APM participant. ACOs, which are often rooted in the PCMH delivery system model and held accountable for population health against a global budget over an extended period of time, will look to foster a more comprehensive partnership with the pharmacist community, especially as ACO global budgets move toward management of pharmacy spending. In a previous survey, approximately 26.4 percent of ACOs had a pharmacy within the ACO, while 19.3 percent contracted with an outside pharmacy.[60] Pharmacists will increasingly be able to facilitate partnerships with multiple ACOs in their operating region, unlike traditional primary care providers who are limited to participating in only one ACO. However, current ACO regulations intentionally leave internal compensation distribution to the discretion of each organization, allowing each ACO the flexibility to design its own procedures for rewarding its participating providers. Since value-based APMs such as ACOs are relatively new, internal reimbursement mechanisms will likely be productivity-based (such as using relative value unit [RVU] approach) in the near-term. Lacking the ability to bill for services using methods that require provider status, pharmacists may be initially challenged to negotiate reimbursement under the traditional mechanisms. To develop models of payment for community pharmacists, engagement with ACOs to forge partnerships in their development and representation at the level of governance may set the foundation for a blending of service-based fee payments and participation in shared savings that reflects the value they add to patient care.

It's important to note that given the ACO model's foundation in a PCMH type of delivery system, pharmacists may forge partnerships with other smaller CMS and Center for Medicare & Medicaid Innovation (CMMI) PCMH-oriented payment models. The Comprehensive Primary Care Initiative (CPCI) and Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, both PCMH-based initiatives, feature per-beneficiary-per-month payments encouraging infrastructure development for care coordination. Though partnership with these initiatives would be less robust, it would allow pharmacists broadened experience and exposure to primary care delivery system innovations.

Pharmacists' role in the BPCI program and related commercial initiatives may be narrower in scope than ACOs and PCMH programs, but perhaps offers a clearer short-term pathway. There are four models in the BPCI, each focusing on a different discrete acute or post-acute episode of care for selected conditions. Pharmacists can be of greatest value to participants in Models 2 and 3, which represent 6,335 of the 6,364 participants. Model 2 episodes include inpatient stay and post-acute care services extending either 30, 60, or 90 days post-discharge. In contrast, Model 3 participants are held accountable only for post-acute care services after the inpatient stay. Pharmacists' medication reconciliation and medication therapy management services, and their ability to prevent costly readmissions, offer real value to bundled payment conveners and participants. Considering the narrower time frame in BPCI care episodes, and the central importance of care provided in the 30, 60, or 90 days after discharge from a healthcare facility, pharmacist services (such as medication management) can have a tremendous impact in determining the success or failure of a BPCI participant. As such, pharmacists could receive a rather substantial portion of any BPCI gainsharing payments, based on the contribution of their services.

In addition to the more ambitious APMs, it's important to consider the pharmacist's role in certain system-wide payment reforms. Though a less intensive payment reform, the Hospital Readmissions Reduction Program (HRRP) has broad-based impact for the pharmacist community. In their efforts to reduce preventable hospital readmissions for patients with acute myocardial infarction (AMI), congestive heart failure (CHF), pneumonia, chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA), and total knee arthroplasty (TKA), hospitals are increasingly becoming concerned with what happens to patients after discharge from the hospital. For AMI, CHF, and pneumonia, hospitals are particularly focused on preventing readmissions through medication management. Given their capacity to reduce polypharmacy-related complications and by extension prevent readmissions, pharmacists are positioned to partner with hospitals as they attempt to avoid HRRP-related penalties. Given the financial incentive structure of HRRP, where hospitals are hoping to avoid penalties as opposed to share in savings, pharmacist engagement with hospitals will be different than in other payment reforms. Pharmacists can collaborate with hospitals on a fee-for-service basis, or through separately negotiated contracts to provide select hospital patients with enhanced pharmacy-based care coordination services post-discharge.

In a 2015 study in which ACOs were surveyed around pharmacy services between 2012 and 2014, it was estimated that approximately 38.7 percent of organizations had near complete ability to integrate medication data from ACO providers with inpatient and outpatient data in electronic health records (EHRs).[60]

**Case Study: Community Pharmacy Within CMMI-Awarded PCMH**

The Wyoming Institute of Population Health (WIPH) received a $14.2 million HCIA grant to create PCMHs across 20 clinics in Wyoming. Specific components of the program included care coordination, care management, care transition, patient-centered care, integrated care teams, health information technology (HIT), and practice facilitation. The PCMHs were implemented in October 10, 2012, and the program targets patients with chronic conditions, those aged 65 years or older, and patients with Medicaid. The PCMHs are supported by the following four programs: 1) care transition, 2) telehealth, 3) community-based medication donation, and 4) virtual pharmacy.[61]

The virtual pharmacy program was originally designed to offer patients access to distant primary care practitioners at their local pharmacies, but was modified to focus away from telehealth access and instead on medication therapy management to patients at their pharmacies and sharing information between pharmacists and PCPs. Participating pharmacies began to identify, enroll, and serve eligible patients in January 2014. As of April 2014, a total of six pharmacies were participating in the virtual pharmacy program, with two additional pharmacies having begun the contracting process.[61]

## 5. FUTURE OUTLOOK AND TRENDS FOR PAYMENT OF PHARMACIST SERVICES

Moving forward, the development of new care delivery models will create opportunities to test new mechanisms for pharmacist reimbursement. Several factors will influence the willingness of payers to reimburse pharmacists directly for direct patient care services, including provider status, consistency across states in scope of practice for pharmacists, standardized coding mechanisms, the demand for active management of innovative specialty pharmaceutical products, the advancement of leveraging health information exchanges, and continued emphasis and expansion of quality measurement as part of healthcare delivery reform.

While current reimbursement mechanisms lack the ability to specifically acknowledge the value pharmacist services contribute to patients and the healthcare system, emerging payment models and industry trends offer unique short- and long-term opportunities. Pharmacists may expand their role in healthcare delivery by participating in public and commercial ACOs, bundled payment initiatives, and other APMs that reward providers for investing in services that prevent downstream complications. Given the current structure of these models, pharmacists could most likely receive reimbursement for their services indirectly in the near term based on negotiations with other providers, largely through gainsharing in any realized savings, or through service-based fees.

As these models evolve, so too will the pharmacist's role in collaboration with other healthcare providers. These new opportunities for collaboration may be enhanced by the growing prevalence of retail clinics co-located in pharmacies and staffed by physician assistants or nurse practitioners in the healthcare marketplace. Within larger chain pharmacy settings, retail clinics increasingly fill a critical gap in timely, convenient access to basic healthcare services. As retail clinics within pharmacies expand, patients are able to access a greater array of healthcare services within this setting.

Furthermore, a substantial evolution in health information exchange (HIE) infrastructure over the next three to five years will result in a freer flow of information among healthcare providers in coming years. Such improved interoperability of information systems and clinical information will enable pharmacists in community settings to leverage their access to patients and serve increasingly as a part of the primary care team. With a more robust data exchange infrastructure, pharmacists will be able to download a complete medical history when interacting with the patient, update their medical record to reflect the most recent visit, and then in turn send the updated record back to the patient's traditional primary care provider.

Serving the broader population health strategy of APMs, community pharmacists can provide basic primary care services to beneficiaries, including but not limited to, screening for conditions, chronic disease management and support, MR, immunizations, and medication management. This mechanism for shared responsibility will enable physicians participating in APMs to maximize time spent with highly complex patients, while simultaneously providing substantially greater access for patients and satisfying the basic primary care needs of the broader population. In addition, APMs that hold delivery systems accountable for long episodes of care or penalize hospitals for readmissions provide strong financial incentives for providers to improve MR, address issues of polypharmacy, and reduce drug interaction problems that result from multiple prescribers sometimes acting in silos for complex patients who visit multiple specialists and institutions. In order for this paradigm to be successful, pharmacists would need to be adequately compensated for their contributions and expanded role in the healthcare team, either through larger portions of shared savings or separate contractual agreements with ACOs that guarantee revenue for their services.

Innovation in the pharmaceutical and biotech industry is resulting in a growing trend of discovery and commercialization of specialty medications that treat chronic and rare disorders that improve the outcomes for patients, many of which previously had few treatment alternatives. However, the higher costs of these therapies increases the importance for private and public payers and integrated health systems to adopt and integrate approaches to medication management that seek to improve adherence to treatments to derive the fullest benefit. Pharmacists play a crucial role in both medication and disease management and as the market for specialty medications continues to grow, the opportunities for utilizing pharmacist services to ensure appropriate use of these medications will continue to expand and develop.

MACRA, which eliminated the Sustainable Growth Rate (SGR) formula and reformed provider payment, has important implications for pharmacists even though most of MACRA does not call them out specifically. MACRA may indirectly affect pharmacists through two categories of its provisions, regardless of the current provider status provisions. First, MACRA provides a strong incentive (effectively a 5 percent bonus on Medicare payments) for eligible professionals who enter into APMs. Second, for those providers not meeting APM thresholds, the new Merit-based Incentive Payment System (MIPS) will reward providers who perform well on an increasingly robust set of quality measures that feed into a 0-100 composite performance score. These shifting incentives will stimulate providers to construct innovative subcontracting arrangements with pharmacists for many of the services described in this paper.

Finally, it will be expected that as opportunities for direct payment for pharmacist services develop, so too will accompanying requirements for reporting of quality measures and performance metrics that will encourage efficient and optimal delivery of direct patient care. It is likely that the use of quality measures to encourage efficient and effective delivery of care will impact pharmacists in both the traditional and the innovative healthcare delivery models. Indeed, research has shown that ACOs that engage pharmacies to support medication management are more likely to have had previous experience with payment reform, such as with pay-for-performance programs, reporting of quality measures, and risk-bearing contracts.[60]

## 6. CONCLUSION

Pharmacists are playing a vital role in ensuring the appropriate and effective use of medications to improve patient outcomes. Through the scope of practice established across states, pharmacists are also providing direct patient care services and coordinating the care with physicians and other healthcare professionals. Avenues for obtaining pharmacist reimbursement for these services remains relatively limited and may be enhanced through recognition of provider status, improvements in health technology, and integration into new payment and delivery models that focus on reducing costs while improving outcomes. With a greater focus on improving the value of care, especially within new payment models, opportunities for pharmacists to provide a variety of direct patient services will continue to evolve as incentives for reimbursement of these services are established.

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## REFERENCES

### Table A1: National Payment Amounts and Descriptions for Current Procedural Terminology (CPT) Codes Available for "Incident to" Billing in the Physician Office Setting

| CPT CODE | DESCRIPTION | 2015 NATIONAL PAYMENT AMOUNT |
|---|---|---|
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | $20.12 |
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:<br>A problem focused history;<br>A problem focused examination;<br>Straightforward medical decision-making.<br>Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.<br>Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face to face with the patient and/or family. | $44.20 |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:<br>An expanded problem focused history;<br>An expanded problem focused examination;<br>Medical decision-making of low complexity.<br>Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.<br>Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face to face with the patient and/or family. | $73.30 |

| CPT CODE | DESCRIPTION | 2015 NATIONAL PAYMENT AMOUNT |
|---|---|---|
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:<br><br>A detailed history;<br><br>A detailed examination;<br><br>Medical decision-making of moderate complexity.<br><br>Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.<br><br>Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face to face with the patient and/or family. | $108.88 |
| 99215 | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:<br><br>A comprehensive history;<br><br>A comprehensive examination;<br><br>Medical decision-making of high complexity.<br><br>Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.<br><br>Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face to face with the patient and/or family. | $146.97 |
| 99490 | Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:<br><br>• Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient<br><br>• Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline<br><br>• Comprehensive care plan established, implemented, revised, or monitored | $43.12 |

| CPT CODE | DESCRIPTION | 2015 NATIONAL PAYMENT AMOUNT |
|---|---|---|
| 99495 | Transitional care management services with the following required elements:<br>• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge<br>• Medical decision-making of at least moderate complexity during the service period<br>• Face-to-face visit, within 14 calendar days of discharge | $166.37 |
| 99496 | Transitional care management services with the following required elements:<br>• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge<br>• Medical decision-making of high complexity during the service period<br>• Face-to-face visit, within 7 calendar days of discharge | $233.57 |

## Table A2: Facility National Payment Amounts for APC-Based Billing of "Incident to" Services in the Hospital Outpatient Setting

| HCPCS/CPT Code | Corresponding APC Code | Facility APC National Payment Amount |
|---|---|---|
| G0463 | 0634 | $96.25 |
| 99490 | 0631 | $53.72 |
| 99495 or 99496 | 0632 | $106.27 |

[APC = ambulatory payment classification; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System]

# About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. For more information, please contact info@**avalere**.com. You can also visit us at avalere.com.

# Contact Us

**Avalere Health | An Inovalon Company**
1350 Connecticut Ave, NW Suite 900
Washington, DC 20036
202.207.1300 | Fax 202.467.4455
**avalere**.com