Billing Opportunities in Ambulatory Care: What Pharmacists Need to Know

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Associate Professor of Clinical Pharmacy
The Ohio State University College of Pharmacy
Objectives

• Identify billing techniques that can be used by pharmacists
• Understand how to leverage value-based payments to expand pharmacy services
• Describe the Ohio Department of Health Transformation impact on primary care payments
OSU General Internal Medicine (GIM)

- Martha Morehouse GIM Clinic
- CarePoint East GIM Clinic
- Stoneridge GIM Clinic
- Grandview Yard GIM Clinic
- Hilliard GIM Clinic
- CarePoint Upper Arlington GIM Clinic
- CarePoint Lewis Center Primary Care

National Committee for Quality Assurance (NCQA) tier 3 patient-centered medical homes (PCMH)
OSU General Internal Medicine

• 50 attending physicians
• >90 Internal Medicine residents
• >60,000 patients
• 6 pharmacists; 3 pharmacy residents
• 6 nurse practitioners
• 15 care coordinators (RN)
• 2 social worker
• 1 medication assistance programs coordinator
“I suppose I’ll be the one to mention the elephant in the room.”
Definitions

**Billing** – to submit charges in order to receive payment

**Reimbursement** – receiving payment for service

- *HB188 for the state of Ohio is only for practice of pharmacy*
Payors

**Medicare** – federally funded and operated program
- **Part A** – covers hospitalization, no premium
- **Part B** – covers outpatient visits and other costs not covered by Part A, monthly premium (~$120, usually taken directly out of social security check)
- **Part C** – combination of A & B; supplied through private insurers
- **Part D** – prescription drug benefit, coverage through PDP chosen annually

**Medicaid** – federal and state funded program for low-income patients
- Ohio: 2014: $13.5 billion federal; $7.3 billion state*

**TPA (Third Party Administrator)** – insurer of all health care-related costs for patients (often use HMO or PPO model).

*Source: ODM Executive Budget Medicaid Services Forecast Book*
Ambulatory Pharmacy’s Battle

• Payors reimburse a “dispensing/professional fee” for each prescription dispensed (product-oriented payment)

• When a prescription is dispensed, regulations of OBRA ’90 must be followed (DUR, patient counseling, patient records)

• Insurers already reimburse for pharmacist time (“professional fee”), which includes OBRA ’90 so they may not want to pay for other pharmacy services (service-oriented payment)
Historic Billing Options

- Incident-to
- Contracted service
- Fee-for-Service
- MTM under Medicare Part D
Incident-to

• Use current procedural terminology (CPT) codes. Pharmacists are not considered providers; therefore, supervision of a physician is required and visit is limited to lowest level code.

• **APC (Ambulatory Payment Classification)** code modifier may be added if practice setting is located within a facility (inpatient or outpatient hospital, emergency department, ambulatory surgical center, skilled nursing facility). APC code modifier reimburses at a higher rate than incident-to billing.
Incident-to

• Reimbursement rates released annually by CMS (gold standard); Medicaid and most third parties pay a percentage of the CMS rate.

• Services are set up with pharmacists billing under the physician’s name. In some practices, the physician collects the reimbursement and pays the pharmacist’s salary.

  • NOTE: the physician must be a contracted provider with each insurer in order to bill.
Incident-to

• Pharmacist salary - $100,000

• Number of visits needed to break even?
Historic Billing Options

• Incident-to
• **Contracted service**
• Fee-for-Service
• MTM under Medicare Part D
Contracted Service

• Contract between pharmacist(s) and employer or 3rd party to perform a service for employees/beneficiaries.

  • Due to visits with the pharmacist, health care costs (in particular, drug costs) may increase initially, but decrease over time from decreased hospitalizations and ED visits.

• Reimbursement rate is negotiated directly with employer/3rd party.
Historic Billing Options

• Incident-to
• Contracted service
• Fee-for-Service
• MTM under Medicare Part D
Fee-for-Service

• Charge patient directly for service
  • Americans feel health care is a right and often are not willing to pay for the service.

• Reimbursement rate is determined by pharmacist.
Historic Billing Options

• Incident-to
• Contracted service
• Fee-for-Service
• MTM under Medicare Part D
MTM Codes

- CPT codes created by CMS specifically for pharmacists performing MTM under Medicare Part D
  - 99605 – initial visit (first 15 minutes)
  - 99606 – follow up visit (first 15 minutes)
  - 99607 – modifier to add for each additional 15 minutes to either type of visit

- Pharmacists must contract with individual PDP in order to receive payment for provision of MTM to individual patient
  - NPI number is required to bill
  - NAPDP number required for most PDP
Other uses of MTM CPT Codes

• Caresource™
• Contracted services with private insurers*

*May require credentialing/privileging
Federally Qualified Health Center (FQHC)

• Offer services to all persons, regardless of ability to pay
• Serve a medically underserved area or population
• Qualify for specific reimbursement under Medicare and Medicaid
  • Receive per-visit bundled payments
• May be eligible for federal grants and programs
• May be eligible for 340B drug pricing program

It was true. They both had a way to go.
US Health Care Spending Breakdown

Center for Medicare and Medicaid Services, 2010
IHI Triple Aim of Health Care Transformation

• Improve the patient experience
  • Access to care
  • Satisfaction

• Reduce costs (*improve efficiency*)
  • Bundled payments
  • Pay for outcomes vs. pay for volume
  • Decrease payment for services and products

• Improve health of the population
  • Population management
  • Health and wellness
  • Integrated care models

AAMC Releases Physician Workforce Projection Report

Significant Primary Care, Overall Physician Shortage Predicted by 2025

March 03, 2015 04:41 pm Sheri Porter – America faces a significant physician shortage by 2025, according to a physician workforce projection report [www.aamc.org] released by the Association of American Medical Colleges (AAMC) today titled The Complexities of Physician Supply and Demand: Projections from 2013 to 2025.

According to an AAMC press release, the United States could be short between 46,000 and 90,000 physicians overall by that time.

The analysis, compiled for the AAMC by IHS Inc., a global information company headquartered in Englewood, Colo., estimates a primary care shortage of 12,500 to 31,100 primary care physicians and a shortfall of 28,200 to 63,700 nonprimary care physicians, "most notably among surgical specialists.

"The doctor shortage is real – it's significant – and it’s particularly serious for the kind of medical care that our aging population is going to need," AAMC President and CEO Darrell Kirch, M.D., said in the release.

He pointed out that it takes five to 10 years to train a physician and urged immediate action to forestall "serious physician shortages" by the end of the next decade.
Where are we headed?

Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

Now that the Affordable Care Act (ACA) has expanded health care coverage and made it affordable to many more Americans, we have the opportunity to shape the way care is delivered and improve the quality of care systemwide, while helping to reduce the growth of health care costs. Many efforts have already been initiated on these fronts, leveraging the ACA’s new tools. The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients.

As we work to build a health care system that delivers better care, that is smarter about how dollars are spent, and that makes people healthier, we are identifying metrics for managing and tracking our progress. A majority of Medicare fee-for-service payments already have a link to quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment models include accountable care organizations (ACOs) and bundled-payment arrangements under which health care providers are accountable for the quality and cost of the care they deliver to patients. This is the first time in the history of the program that explicit goals for alternative payment models and value-based payments have been set for Medicare. Changes assessed by these metrics will mark our progress in the near term, and we are engaging state Medicaid programs and private payers in efforts to make further progress toward
Value-Based Payments

- Capitated Payments
- Bundled Payments
- Medicare Wellness Visits
- Shared Savings
Capitated Payments

• Insurer pays established amount for care of patient population
  • Per-member-per-month
  • Expect outcomes for population
  • May be tied to pay-for-performance measures

• Often paid by 3rd parties with PCMH credentialing
  • Helps pay for additional staff and EHR
Capitated Payment Example

• HealthyOhio Insurance
  • 2,000 patient lives at your PCMH; 1,000 have diabetes
    • $5 per month for each patient at practice
    • $10 per month for each patient with DM

• Result is $10,000 per month to practice to provide care to HealthyOhio patients
  • Expect lowering of A1c, hospitalizations, etc.
Value-Based Payments

- Capitated Payments
- **Bundled Payments**
- Medicare Wellness Visits
- Shared Savings
Transitional Care Management

- 99495/99496 introduced in January 2013
- Contact by “licensed clinical staff” within 2 business days of discharge from acute care setting

**Type of contact**

- Phone
- Email
- Face-to-face

**Acute Care Setting**

- Acute or rehabilitation hospital
- Observation unit
- Nursing facility

- Face to face visit with physician within 7-14 days
- Continued coordination 30 days post-discharge
# Transitional Care Management

<table>
<thead>
<tr>
<th>CPT code</th>
<th>tRVU</th>
<th>wRVU</th>
<th>tRVU - wRVU</th>
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<tbody>
<tr>
<td>99214</td>
<td>3.13</td>
<td>1.49</td>
<td>1.64</td>
</tr>
<tr>
<td>99495</td>
<td>4.82</td>
<td>2.11</td>
<td>2.71</td>
</tr>
<tr>
<td>99215</td>
<td>4.20</td>
<td>2.10</td>
<td>2.10</td>
</tr>
<tr>
<td>99496</td>
<td>6.79</td>
<td>3.05</td>
<td>3.74</td>
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</table>
Chronic Care Management

- Introduced by CMS in January 2015
  - Billing/reimbursement for non-face-to-face service

<table>
<thead>
<tr>
<th>CPT Code 99240</th>
<th>At least 20 minutes of clinical staff time by qualified health care professional, per calendar month:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Two or more chronic conditions expected to last at least 12 months</td>
</tr>
<tr>
<td></td>
<td>• Chronic condition(s) place the patient at significant risk of death, acute</td>
</tr>
<tr>
<td></td>
<td>exacerbation/decompensation, or functional decline</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive care plan established, implemented, revised, or monitored</td>
</tr>
</tbody>
</table>

Chronic Care Management

• Patient agreement documented for service
Consent Example

Dear [Name],

Your doctor has asked our medical team to work with you more closely, with a goal of improving your health and wellbeing. We understand that managing multiple health problems can be difficult and that coming to the clinic is not always possible. By working with you between office visits, we can do a better job in helping you manage your health and prevent illnesses from developing. We have developed a medical team of nurses, pharmacists, social workers, and medical assistants that will be available between visits with your physician. We will communicate with the clinic and share your information.

I have reviewed the information above regarding Chronic Care Management (CCM) services and I agree to receive Chronic Care Management Services as described.

Patient Signature ___________________________ Date ___________________________
Chronic Care Management

• Patient agreement documented for service
• Requires comprehensive care plan
• Requires 24/7 access to care management services
• Restrictions
  • One practitioner per month
  • Can not be billed within same calendar month as transitional care management codes
  • Incident-to requirements must be met
  • Hospital-based clinics and FQHC were not eligible in 2015; changed for 2016
Chronic Care Management Update

- In 2015, only utilized in 275,000 Medicare beneficiaries

CCM changes beginning January 2017:
- Documented consent will not be necessary, but must be mentioned
- Supervision of non-physician personnel can be general instead of direct

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Approximate Reimbursement</th>
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<tbody>
<tr>
<td>99490</td>
<td>20 minutes CCM per month</td>
<td>~$40</td>
</tr>
<tr>
<td>99487</td>
<td>60 minutes CCM per month</td>
<td>~$90</td>
</tr>
<tr>
<td>99489</td>
<td>Modifier for each additional 30 minutes</td>
<td>~$45</td>
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</table>

Diabetes Prevention Program

• Medicare payment to begin January 2018
  • Considering both in person and virtual
  • Registered CDC-recognized Diabetes Prevention Program

• 16 intensive ‘core’ group-based sessions
  • Long-term dietary changes
  • Increased physical activity
  • Behavior changes for weight control

• Monthly follow-up

• Goal intervention of at least 5% average weight loss

Value-Based Payments

• Capitated Payments
• Bundled Payments
• Medicare Wellness Visits
• Shared Savings
Medicare Wellness Visits

• CPT: G0438 (initial); G0439 (subsequent annual)
• Should be performed annually
• Reimbursed separately from office visit
• Must be performed by licensed health professional
  • This includes pharmacists
• Want to know more:
  • *Am J Health Syst Pharm* 2014;71(11):44-49
  • *J Am Pharm Assoc* 2014;54(4):427-34
  • *J Am Pharm Assoc* 2014;54(4):435-40
Value-Based Payments

• Capitated Payments
• Bundled Payments
• Medicare Wellness Visits
• Shared Savings
Shared Savings
Shared Savings Example #1 – Total

Buckeye Health Care

• 10,000 total beneficiaries
  • Average total cost per patient for HealthyOhio: $2000
    • Total of $20 million spent per year

• PCMH network sees 2000 patients and enter 50/50 shared savings contract with HealthyOhio
  • Total cost per patient: $1900
  • $100 savings x 2000 patients = $200,000 savings total/$100,000 for practice
Shared Savings Example #2 - Episodic

Heart Valve Replacement average cost $100,000
• Increasing 8% every year

Medicare will pay your health-system $100,000 for all care related to heart valve replacement for 90 days
• Better coordination = cheaper care

Patient 1: 90 day cost: $85,000 = $15,000 profit
Patient 2: 90 day cost: $145,000 = $45,000 loss
Other Billing Opportunities

• Caresource
• Contracted services with private insurers*
• Education codes
• Procedure-based codes (e.g., spirometry)

*May require credentialing/privileging
Ohio can get better value from what is spent on health care

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2014)

Ohioans spend more per person on health care than residents in all but 17 states

29 states have a healthier workforce than Ohio

Sources: CMS Health Expenditures by State of Residence (2011); The Commonwealth Fund, Aiming Higher: Results from a State Scorecard on Health System Performance (May 2014).
<table>
<thead>
<tr>
<th>State</th>
<th>Total Number Commercial HMOs</th>
<th>Largest Insurer Market Share</th>
<th>2nd Largest Insurer Market Share</th>
<th>3rd Largest Insurer Market Share</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>18</td>
<td>73%</td>
<td>12%</td>
<td>7%</td>
<td>92%</td>
</tr>
<tr>
<td>Indiana</td>
<td>18</td>
<td>60%</td>
<td>15%</td>
<td>12%</td>
<td>87%</td>
</tr>
<tr>
<td>Michigan</td>
<td>24</td>
<td>51%</td>
<td>16%</td>
<td>11%</td>
<td>78%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>16</td>
<td>45%</td>
<td>29%</td>
<td>20%</td>
<td>94%</td>
</tr>
<tr>
<td>Ohio</td>
<td>23</td>
<td>39%</td>
<td>21%</td>
<td>17%</td>
<td>77%</td>
</tr>
</tbody>
</table>

http://kff.org/state-category/health-insurance-managed-care/
Ohio’s Comprehensive Primary Care (CPC) Timeline


CPC “Classic”
Year 3 Year 4

Ohio CPC Program

- Ohio’s SIM-sponsored PCMH model
- Southwest Ohio’s federally-sponsored, multi-payer PCMH model
High performing primary care practices engage in these activities to keep patients well and hold down the total cost of care

- **Patient Experience:**
  Offer consistent, individualized experiences to each member depending on their needs

- **Patient Engagement:**
  Have a strategy in place that effectively raises patients’ health literacy, activation, and ability to self-manage

- **Potential Community Connectivity Activities:**
  Actively connect members to a broad set of social services and community-based prevention programs (e.g., nutrition and health coaching, parenting education, transportation)

- **Behavioral Health Collaboration:**
  Integrate behavioral health specialists into a patients’ full care

- **Provider Interaction:**
  Oversee successful transitions in care and select referring specialists based on evidence-based likelihood of best outcomes for patient

- **Transparency:**
  Consistently review performance data across a practice, including with patients, to monitor and reinforce improvements in quality and experience

- **Patient Outreach:**
  Proactive, targeting patients with focus on all patients including healthy individuals, those with chronic conditions, and those with no existing PCP relationship

- **Access:**
  Offer a menu of options to engage with patients (e.g., extended hours to tele-access to home visits)

- **Assessment, Diagnosis, Care Plan:**
  Identify and document full set of needs for patients that incorporates community-based partners and reflects socioeconomic and ethnic differences into treatment plans

- **Care Management:**
  Patient identifies preferred care manager, who leads relationship with patients and coordinates with other managers and providers of specific patient segments

- **Provider Operating Model:**
  Practice has flexibility to adapt resourcing and delivery model (e.g., extenders, practicing at top of license) to meet the needs of specific patient segments
## Ohio CPC eligible provider types and specialties

<table>
<thead>
<tr>
<th>Eligible provider types</th>
<th>Eligible specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Individual physicians and practices                                                   ▪ For Medical Doctor or Doctor of Osteopathy:</td>
<td></td>
</tr>
<tr>
<td>▪ Professional medical groups                                                          ▢ Family practice</td>
<td></td>
</tr>
<tr>
<td>▪ Rural health clinics                                                                  ▢ General practice</td>
<td></td>
</tr>
<tr>
<td>▪ Federally qualified health centers                                                   ▢ General preventive medicine</td>
<td></td>
</tr>
<tr>
<td>▪ Primary care or public health clinics                                                ▢ Internal medicine</td>
<td></td>
</tr>
<tr>
<td>▪ Professional medical groups billing under hospital provider types                    ▢ Pediatric</td>
<td></td>
</tr>
<tr>
<td>▢ Public health</td>
<td></td>
</tr>
<tr>
<td>▢ Geriatric</td>
<td></td>
</tr>
<tr>
<td>▪ For clinical nurse specialists or certified nurse practitioner:</td>
<td></td>
</tr>
<tr>
<td>▢ Pediatric;</td>
<td></td>
</tr>
<tr>
<td>▢ Adult health;</td>
<td></td>
</tr>
<tr>
<td>▢ Geriatric; or</td>
<td></td>
</tr>
<tr>
<td>▢ Family practice.</td>
<td></td>
</tr>
<tr>
<td>▪ Physician assistants</td>
<td></td>
</tr>
<tr>
<td>▢ (physician assistants do not have formal specialties)</td>
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</tr>
</tbody>
</table>
Ohio Comprehensive Primary Care (CPC) Program
Requirements and Payment Streams

<table>
<thead>
<tr>
<th>Requirements</th>
<th>PMPM</th>
<th>Shared Savings</th>
<th>Practice Transformation Support</th>
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</thead>
<tbody>
<tr>
<td><strong>8 activity requirements</strong></td>
<td>All required</td>
<td>All required</td>
<td>TBD for select practices</td>
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<tr>
<td>• Same-day appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 24/7 access to care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Risk stratification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Population management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Team-based care management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow up after hospital discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tracking of follow up tests and specialist referrals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Patient experience</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **4 Efficiency measures** | All required | | |
| • ED visits | | | |
| • Inpatient admissions for ambulatory sensitive conditions | | | |
| • Generic dispensing rate of select classes | | | |
| • Behavioral health related inpatient admits | | | |

| **20 Clinical Measures** | Must pass 100% | | |
| • Clinical measures aligned with CMS/AHIP core standards for PCMH | | | |

| **Total Cost of Care** | Must pass 50% | | |

Enhanced payments begin January 1, 2018 for any PCP that meets the requirements.
### Ohio CPC Clinical Quality Requirements

**Must pass 50%**

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Name</th>
<th>Population</th>
<th>Population health priority</th>
<th>NQF #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pediatric Health (4)</strong></td>
<td>Well-Child Visits in the First 15 Months of Life</td>
<td>Pediatrics</td>
<td>1392</td>
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</tr>
<tr>
<td></td>
<td>Well-Child visits in the 3rd, 4th, 5th, 6th years of life</td>
<td>Pediatrics</td>
<td>1516</td>
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<tr>
<td></td>
<td>Adolescent Well-Care Visit</td>
<td>HEDIS</td>
<td>AWC</td>
<td></td>
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<tr>
<td></td>
<td>Weight assessment and counseling for nutrition and physical activity for children/adolescents</td>
<td>Pediatrics</td>
<td>Obesity, physical activity, nutrition</td>
<td>0024</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Name</th>
<th>Population</th>
<th>Population health priority</th>
<th>NQF #</th>
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<tbody>
<tr>
<td><strong>Women's Health (5)</strong></td>
<td>Timeliness of prenatal care</td>
<td>Adults</td>
<td>Infant Mortality</td>
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<td>Live Births Weighing Less than 2,500 grams</td>
<td>Adults</td>
<td>Infant Mortality</td>
<td>N/A</td>
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<td></td>
<td>Postpartum care</td>
<td>Adults</td>
<td>Infant Mortality</td>
<td>1517</td>
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<td></td>
<td>Breast Cancer Screening</td>
<td>Adults</td>
<td>Cancer</td>
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<td></td>
<td>Cervical cancer screening</td>
<td>Adults</td>
<td>Cancer</td>
<td>0032</td>
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<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Name</th>
<th>Population</th>
<th>Population health priority</th>
<th>NQF #</th>
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<tbody>
<tr>
<td><strong>Adult Health (7)</strong></td>
<td>Adult BMI</td>
<td>Adults</td>
<td>Obesity</td>
<td>HEDIS ABA</td>
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<tr>
<td></td>
<td>Controlling high blood pressure (starting in year 3)</td>
<td>Adults</td>
<td>Heart Disease</td>
<td>0018</td>
</tr>
<tr>
<td></td>
<td>Med management for people with asthma</td>
<td>Both</td>
<td>Pediatrics</td>
<td>1799</td>
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<tr>
<td></td>
<td>Statin Therapy for patients with cardiovascular disease</td>
<td>Adults</td>
<td>Heart Disease</td>
<td>HEDIS SPC</td>
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<tr>
<td></td>
<td>Comprehensive Diabetes Care: HgA1c poor control (&gt;9.0%)</td>
<td>Adults</td>
<td>Diabetes</td>
<td>0059</td>
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<tr>
<td></td>
<td>Comprehensive diabetes care: HbA1c testing</td>
<td>Adults</td>
<td>Diabetes</td>
<td>0057</td>
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<tr>
<td></td>
<td>Comprehensive diabetes care: eye exam</td>
<td>Adults</td>
<td>Diabetes</td>
<td>0055</td>
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</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Name</th>
<th>Population</th>
<th>Population health priority</th>
<th>NQF #</th>
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</thead>
<tbody>
<tr>
<td><strong>Behavioral Health (4)</strong></td>
<td>Antidepressant medication management</td>
<td>Adults</td>
<td>Mental Health</td>
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<tr>
<td></td>
<td>Follow up after hospitalization for mental illness</td>
<td>Both</td>
<td>Mental Health</td>
<td>0576</td>
</tr>
<tr>
<td></td>
<td>Preventive care and screening: tobacco use: screening and cessation intervention</td>
<td>Both</td>
<td>Substance Abuse</td>
<td>0028</td>
</tr>
<tr>
<td></td>
<td>Initiation and engagement of alcohol and other drug dependence treatment</td>
<td>Adults</td>
<td>Substance Abuse</td>
<td>0004</td>
</tr>
</tbody>
</table>

Note: All CMS metrics in relevant topic areas were included in list except for those for which data availability poses a challenge (e.g., certain metrics requiring EHR may be incorporated in future years).

**Detailed requirement definitions are available on the Ohio Medicaid website:**
[http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx#1600563-cpc-requirements](http://medicaid.ohio.gov/Providers/PaymentInnovation/CPC.aspx#1600563-cpc-requirements)

**Measures will evolve over time**
- Measures will be refined based on learnings from initial roll-out
- Hybrid measures that require electronic health record (EHR) may be added to the list of core measures
- Hybrid measures may replace some of the core measures
- Reduction in variability in performance between different socioeconomic demographics may be included as a CPC requirement
Ohio’s Comprehensive Primary Care (CPC) Timeline


CPC “Classic”
- Year 3
- Year 4
- Southwest Ohio’s federally-sponsored, multi-payer PCMH model

Ohio CPC Program
- Ohio’s SIM-sponsored PCMH model
- Design
- Year 1 (early entry)
- Year 2 (open entry)
- Year 3 ...
- (open entry)

Medicare CPC+
- Medicare-sponsored
- Payers apply by region
- Practices apply within regions
- Year 1 (CMS-selected)
- Year 2 (CMS-selected)
- Year 3 ...
- 5 (CMS-selected)

Early Entry into the Ohio CPC Program
- CPC+ practices with 500+ Medicaid members
- Practices with 500+ Medicaid members with claims-only attribution AND NCQA III
- Practices with 5,000+ Medicaid members and national accreditation

Ongoing Enrollment in the Ohio CPC Program
- Any practice with 500+ Medicaid members that meets Ohio CPC program activity, efficiency and clinical quality requirements

Ongoing Enrollment in the Ohio CPC Program
- Any practice with 500+ Medicaid members that meets Ohio CPC program activity, efficiency and clinical quality requirements
Ohio CPC “Early Entry” Practice Eligibility
(January 1, 2017 to December 31, 2017)

<table>
<thead>
<tr>
<th>Required</th>
<th>• Eligible provider type and specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• One of the following characteristics:</td>
</tr>
<tr>
<td></td>
<td>− Practice with 5,000+ attributed Medicaid individuals and national accreditation(^1)</td>
</tr>
<tr>
<td></td>
<td>− Practice with 500+ attributed Medicaid individuals determined through claims-only data at each attribution period and NCQA III accreditation</td>
</tr>
<tr>
<td></td>
<td>− Practice with 500+ attributed Medicaid individuals at each attribution period and enrolled in Medicare CPC+</td>
</tr>
<tr>
<td></td>
<td>• Commitment:</td>
</tr>
<tr>
<td></td>
<td>− To sharing data with contracted payers/ the state</td>
</tr>
<tr>
<td></td>
<td>− To participating in learning activities(^2)</td>
</tr>
<tr>
<td></td>
<td>− To meeting activity requirements in 6 months</td>
</tr>
</tbody>
</table>

| Not required | • Planning (e.g., develop budget, plan for care delivery improvements, etc.) |
|--------------|• Tools (e.g., e-prescribing capabilities, EHR, etc.) |

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1 Eligible accreditations include: NCQAII/III, URAC, Joint Commission, AAAHC
2 Examples include sharing best practices with other CPC practices, working with existing organizations to improve operating model, participating in state led CPC program education at kickoff
U.S. Health-care System

RE-FORM...
RE-FORM...
RE-FORM...
Comprehensive Primary Care Plus (CPC+)

• 5 year program to be launched January 2017
• Up to 5,000 practices to be selected
  • 14 statewide or multi-county regions
  • 57 payers
  • Estimated 3.5 million beneficiaries
• Applicants apply for 1 of 2 tracks
  • Track 1: offers upfront funding for care transformation investments
  • Track 2: higher financial reward to provide specific medical home capabilities

CPC+ Offered in Fourteen Regions

Only Practices in Selected States/Counties May Apply

1. Arkansas: Statewide
2. Colorado: Statewide
3. Hawaii: Statewide
4. Kansas and Missouri: Greater Kansas City Region
5. Michigan: Statewide
6. Montana: Statewide
7. New Jersey: Statewide
8. New York: North Hudson-Capital Region
9. Ohio: Statewide and Northern Kentucky Region
10. Oklahoma: Statewide
11. Oregon: Statewide
12. Pennsylvania: Greater Philadelphia Region
13. Rhode Island: Statewide
14. Tennessee: Statewide


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Application Period Currently Open

Next Step: Practice Applications Due Mid-September

CPC+ Rollout Timeline

April 11, 2016
CPC+ unveiled

August 1, 2016
CMS announces 14 selected regions, 57 payers; begins soliciting applications from practices within those regions

January 1, 2017
Program begins for five years

June 8, 2016
Deadline for payer proposals

September 15, 2016
Deadline for practices in selected regions to apply

2,500
Maximum number of practices selected under each track

150
Minimum number of Medicare beneficiaries attributed to each practice to qualify

Two Tracks to Choose From in CPC+¹

Track One

Up to 2,500 primary care practices.

$15 average PBPM² care management fee, $2.50 PBPM performance incentive payment

No Health IT partnership required

Choice for practices ready to build the capabilities to deliver comprehensive primary care

Track Two

Up to 2,500 primary care practices.

$28 average PBPM² care management fee, $4 PBPM performance incentive payment

Must have letter of support from Health IT vendor

Choice for practices poised to increase the comprehensiveness of care by:

- Enhancing health IT
- Improving care of patients with complex needs
- Supporting patients’ psychosocial needs

¹) Practices must remain in the same track for the duration of the program.
²) Per beneficiary per month.

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Source: CMS, Advisory Board interviews and analysis
# Three Types of Payment Provided to Practices

<table>
<thead>
<tr>
<th>Objective</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Payment Structure Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Support augmented staffing and training for delivering comprehensive primary care</td>
<td>Reward practice performance on utilization and quality of care</td>
<td>Reduce dependence on visit-based fee-for-service to offer flexibility in care setting</td>
</tr>
<tr>
<td><strong>How calculated</strong></td>
<td>Based on HCC(^1) risk quartile</td>
<td>Prospective, based on quality and utilization score</td>
<td>Offers prepayment for fee-for-service</td>
</tr>
<tr>
<td><strong>Track 1</strong></td>
<td>$15 average PBPM</td>
<td>$2.50 PBPM</td>
<td>N/A (Standard FFS(^2))</td>
</tr>
<tr>
<td><strong>Track 2</strong></td>
<td>$28 average PBPM; including $100 to support patients with complex needs</td>
<td>$4.00 PBPM</td>
<td>Reduced FFS in exchange for upfront “Comprehensive Primary Care Payment” (CPCP)</td>
</tr>
</tbody>
</table>

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1) Hierarchical condition category
2) Fee for service

Source: CMS, Advisory Board interviews and analysis
CPC+ Care Management Fees by Risk Tier

Track 1: Four Risk Tiers (Average $15)

- $6
- $8
- $16
- $30

Track 2: Five Risk Tiers (Average $28)

- $9
- $11
- $19
- $33

1st risk quartile HCC  2nd risk quartile HCC  3rd risk quartile HCC  4th risk quartile HCC
0%  25%  50%  75%  90%  100%

Care Management Fees in Brief

- Risk-adjusted, PBPM (non-visit-based) payment
- Designed to augment staffing and training, according to specific needs of patient population
- No beneficiary cost sharing; risk tiers relative to regional population
- Precludes practices from billing the CCM\(^1\) code for CPC+ attributed beneficiaries

Complex Tier: $100
Top 10% of risk or dementia diagnosis

1) Chronic Care Management.

Source: CMS; Advisory Board interviews and analysis.
Who’s In and Who’s Out?

Eligibility Criteria for CPC+ by Clinician, Organization and Risk Model

**Clinicians**

**Eligible Types:**
- Physicians, NP\(^1\), PA\(^2\), CNS\(^3\)
- Specialty designations:
  - Family medicine, Internal medicine & Geriatric medicine

**Organizations**

**Eligible:**
- Independent, hospital-sponsored
- Primary care-only, multispecialty
- Practices involved in IPA\(^4\)s, CIN\(^5\)s

**Preferred:**
- CPC\(^6\)I participating practices

**Ineligible:**
- FQHC\(^7\), RHC\(^8\) and concierge practices
- Pediatric practices

**Risk Models**

**Eligible:**
- Medicare Shared Savings Program (MSSP) Tracks 1, 2 and 3
- The Oncology Care Model
- BPCI\(^10\), CJR\(^11\)

**Ineligible:**
- Next Generation ACO Model
- ACO Investment Model

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1) Nurse practitioner.
2) Physician assistant.
3) Clinical nurse specialist.
4) Independent practice association.
5) Clinically integrated network.
6) CPC\(^I\) practices, assuming application demonstrates requirements needed, will not be subject to lottery if number of eligible applying practices exceeds slots available.
7) Federally qualified health center.
8) Rural health clinic.
9) Defined as a practice that charges a monthly retainer fee.
10) Bundled Payments for Care Improvement Initiative.
11) Comprehensive Care for Joint Replacement Model.

Source: CMS, Advisory Board interviews and analysis.
Summary

• Historic billing techniques exist, but are difficult to justify full-time pharmacist

• New payment methods are available and forthcoming

• Pharmacists need to be knowledgeable to where practices are moving to help justify addition of resources
  • Bundled payments
  • Shared savings plans
  • Ohio CPC
  • CMS CPC+ opportunities
"Whoa! That was a good one! Try it, Hobbs — just poke his brain right where my finger is."