Thinking Outside the Box: Pharmacists’ Role in Ambulatory Care

Michigan Society of Health-System Pharmacists
2014 Annual Meeting
November 7, 2014

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Learning Objectives

- Identify indicators that predict the continued growth of ambulatory care as outlined by the Ambulatory Care PPMI Summit and Conference.
- Describe the role of the pharmacist in successful contemporary practice models.
- Describe key metrics being utilized in Ambulatory Care practices and how pharmacists can impact these measures.
- Discuss Provider Status and evolution of the Ambulatory Care practice model

Overview

- The ASHP Ambulatory Care Conference and Summit
- State of the ambulatory care environment
- Best practice models and metrics
- Provider status
Importance of Ambulatory Care Model Advancement

We Ain’t Getting Any Younger!

Data Points on U.S. Home Healthcare

- 8.8 million of 52 million people receive home health care from a home health care agency (American Association for Home Care & Hospice, 2015).
- By 2030, 27 million people are expected to receive home health care (Home Care & Hospice, 2013).
- More than 1 million home healthcare and hospital workers can care for these patients (The Joint Commission, 2013).
- 2.5 million home and family caregivers care for the U.S. adult population age 55 or older with a disability, or aged (Family Caregiver Alliance, 2012).
- 41.5 million adult family caregivers provide care for someone with a chronic condition (Family Caregiver Alliance, 2012).
- The aging population 55 or older means that the number of adults aged 85 or older is expected to rise from 5.6 million in 2010 to 75.3 million by 2050 (Family Caregiver Alliance, 2012).
- Estimates of the size of the home healthcare market range from $13 billion (Shapell et al., 2013) to $72.4 billion (Baker, 2012).

Percentage of adults 45-64 and 65 and over with two or more of nine selected chronic conditions

- Significantly different from 1999-2000, p < 0.05.

### Changes in Source of Hospital Revenues: Outpatient vs. Inpatient

<table>
<thead>
<tr>
<th>Year</th>
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<th>Inpatient</th>
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<tbody>
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<tr>
<td>2010</td>
<td>42%</td>
<td>58%</td>
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### Need for Pharmacists

- Increasing need for pharmacists in ambulatory care settings:
  - Hospital and Health-System Clinics
  - Federally Qualified Health Centers
  - Patient Centered Medical Homes
  - Community Pharmacies
  - Physician offices
- Increasing focus on smooth transitions in care between settings

### ASHP Strategic Plan

**Mission**

The mission of pharmacy is to help people achieve optimal health outcomes. ASHP helps its members achieve this mission by advancing and supporting the professional practice of pharmacy in hospital, health-system, primary care, specialty, and other settings including the ambulatory care setting. ASHP extends the profession's influence in health policy development, research, and education.

**Goal 1**

Advance pharmacy practice in hospitals, health systems, and ambulatory care settings

- Optimize patients' medication outcomes in and across all settings of care
  - Work collaboratively to help maintain and improve patient care outcomes in hospitals, clinics, and other primary care settings
  - Convene a consensus conference to study and make recommendations to enhance the ambulatory care services provided by pharmacists

- Expand pharmacy practice in ambulatory clinics and other primary care settings
ASHP Ambulatory Care Summit and Conference

Circle the Wagons

**Everyone Had a Say**
- Ample time allotted for public consensus activities
- Panel’s role explained clearly
- All active practicing members had a final vote
- All documents were made available prior to the summit

Advancing Practice through Education & Consensus Building
2014 Ambulatory PPMI Summit: Consensus-Building Process

- Organic – domain and recommendation development originated from members
- 40-member Consensus Panel
- Domains
  - Defining Ambulatory Care Pharmacy Practice
  - Patient Care Delivery and Integration
  - Sustainable Business Models
  - Outcomes Evaluation
- Iterative Process with Large Group (>400) Participation

Consensus-Building Process: Plenary Speakers
Key Summit Recommendations

Domain 1: Defining Ambulatory Pharmacy Practice
1.2 ... Pharmacists who provide ambulatory care services perform patient assessments, have prescribing authority to manage disease through medication use and provide collaborative drug therapy management, order, interpret, monitor medication therapy-related tests, coordinate care and other health services for wellness and prevention of disease, provide education to patients and caregivers... and document care processes in the medical record.

Key Summit Recommendations

Domain 2: Patient Care Delivery and Integration
2.2 Pharmacists who provide ambulatory care services must collaborate with patients, caregivers, and health care professionals to establish consistent and sustainable models for seamless transitions across the continuum of care.

Domain 3: Sustainable Business Models
3.1 Pharmacists must be recognized as health care providers.

Key Summit Recommendations

Domain 4: Outcomes Evaluation
4.2 Through partnering with patients, and as members of the interprofessional health care team, pharmacists who provide ambulatory care services must demonstrate measureable and meaningful impact on individual patient and population outcomes.
Outcomes

- Twenty-Five Visionary and Forward-Thinking Recommendations
- High Percentage of Participant Agreement
- High Percentage of ASHP Active Practitioner Member Agreement

Summit Next Steps

- Immediately after the Summit, a follow-up survey was sent to all ASHP members asking for input on the Summit recommendations.
- A final report that combined the work at the Summit with the outcomes of the survey was published in AJHP in the August 15, 2014 issue.
- The ASHP Foundation will be developing an Ambulatory Care Self-Assessment Survey similar to the PPMI Hospital Self-Assessment Survey and Ambulatory Business Case Resources (webinars with sample business cases)
- Overall, the recommendations resulting from the Summit will infuse the PPMI’s national direction and future efforts.
- Advance the practice of pharmacy in ambulatory care

Advancing Existing Practice Models

Evolution of Pharmacy Primary Care
Medication Therapy Management
Transition of Care
Annual Wellness Visits
Pharmacy Primary Care
- Chronic disease state management - earliest model of direct patient care
  - "Coumadin" Clinics
  - Diabetes Management
  - HIV Management
  - Preventative Care
  - One trick pony or care for the entire herd?
- Collaborative Practice Agreements
  - Formalized the relationship with other HC professionals
  - Each state is different in defining scope of practice
- Freestanding vs. Integration
  - Community/Retail practice sites
  - Integrate into physician office space
  - Hospital based clinics
  - Academic settings

Pharmacy Primary Care
- Reimbursement Dilemmas
  - Facility billing and/or Incident-To billing
  - Employee value programs, Grants, State driven
  - Can billing work in community setting?
  - Pharmacists direct billing a 3rd party payor for patient care?
  - Where does Revenue Stream flow?
- Expansion of services
  - Value Based Payment vs. Fee Based Reimbursement
  - Broadening of Care beyond anticoagulation
  - Shift in community pharmacists' role beyond MTM
  - "Reassigning" FTEs within department of pharmacy
  - Rural expansion – how to shift the limited workforce
  - Shift in pharmacy administration attitude

Medication Therapy Management
- Formalized medication review and/or reconciliation
- CMS defined pharmacy driven billing codes
  - Defined type of patient
  - Number of medications to qualify
  - Which chronic disease states matter
- Third party payor systems created
- Community pharmacy found value in direct patient contact
- Altered the expectation of a pharmacist
- Was it revolutionary?
- Did it further our cause?
Transition of Care (TOC) Model
- Huge potential for integration
  - MTM and CDM
- Elements for Success
  - Multidisciplinary support and collaboration
  - Data available to justify resources
    - Readmissions
    - Length of stay
    - Emergency Department visits
    - Medication-related problems at med rec (e.g., Duplication of Therapy)
    - Disease-specific metrics
    - Patient satisfaction or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) – related metrics
  - Electronic patient information and data transfer between inpatient and outpatient partners
  - Strong partnership network

TOC Visits
- Effective January 1, 2013, new HCPCS codes for Transitional Care Management Services
- Codes are used to bill physician and “qualified non-physician providers” care management following discharge from:
  - Inpatient setting
  - Observation setting
  - Skilled nursing facility
- Pharmacists are providing these services under supervision of physician or qualified non-physician practitioners

TOC: CMS Requirements
- Initial Patient Contact in 2 business days
  - 2 attempts counted
  - More than just scheduling a call
- Face-to-Face OV
  - High Complexity: 7 days
  - Mod Complexity: 14 days
- Medication Reconciliation during OV
- Includes all communications with patient
- Documentation within EMR
- Aligns with PCMH concept
TOC: Pharmacists Impact

- Transitional Care Management Codes
  - Face-to-Face visit within 7 days of discharge
    - HCPCS Code 99496
    - High complexity
    - 2012 Medicare reimbursement: $231
  - Face-to-Face visit within 14 days of discharge
    - HCPCS Code 99495
    - Moderate complexity
    - 2012 Medicare reimbursement: $164
- Claim submitted under recognized CMS provider

Annual Wellness Visits

- Yearly "Wellness" visits:
  - Patient has had Part B for longer than 12 months
  - Patient fills out questionnaire, "Health Risk Assessment," as part of visit.
  - Develop a personalized prevention plan
  - Develop or update a list of current providers and prescriptions
  - Take Height, weight, blood pressure, and other routine measurements
  - Review patient’s potential risk for depression and level of safety
  - Develop a list of risk factors and treatment options for patient
  - Visit is covered once every 12 months (11 full months must have passed since the last visit).

AWV: We ARE Eligible Providers

- Providers of AWVs
  - A physician who is a doctor of medicine or osteopathy
  - A physician assistant, nurse practitioner, or clinical nurse specialist
  - A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision
AWV: Documentation Required
- Medical and family history
- Listing current providers and suppliers
- Vital signs including ht, wt, BMI, waist circumference
- Detection of cognitive impairment
- Review for depression
- Review functional ability and level of safety
- Establish 5-10 yr screening plan
- Development of list of risk factors or conditions
- Furnishing of personalized health advice and referrals aimed at preventive services

AWV: Revenue Stream Expansion
- CMS based
  - Initial Visit is by PCP: G0438
  - Subsequent Annual Visits: G0439
  - Diagnosis Code: V70.0
  - Medicare Part B benefit
- SIGNIFICANT revenue potential!
  - Subsequent Visit: $91.23 to $140.09
  - Do not forget your diagnosis code
  - Modifier -25 if E/M is needed

Medicare Wellness Visits
Resources:
- http://www.ajhp.org/content/71/1/44.full.pdf
Contemporary Practice Models

Education Advancement
Patient Centered Medical Homes
Accountable Care Organizations

Education Advancement

- Layered learning - concept of a pharmacy team
  - Pharmacy attending
  - Residents
  - Students
  - Technicians
- Learners play a significant role in model advancement – there is no free ride
- Active learning leads to extension of services offered
- Appropriate autonomy – not all learners are created equal
- Co-exist with new broad based practice models

Education Advancement

- Minimum standards for providers
  - What will 3rd party payors mandate?
  - Residency training for those in direct patient care?
- Are new practitioners prepared/educated to practice immediately after graduation?
- Expansion of residency slots to meet need or continue to be exclusive
- Continuing education has to be overhauled
- Should there be a certification for every practice model/site?
- Standardizing Students’ Clinical experiences
- As model shifts so must educational curricula
Patient-Centered Medical Home

- Patient-centered, physician-guided, cost-efficient, longitudinal care that promotes continuous healing through relationships and delivery of care by a “team” of health care providers
- Funded by national grants, state Medicaid pilot programs, and the Affordable Healthcare for America Act (Reform bill) via demonstration projects

Exactly what is PCMH?

- 13 definitions with 123 different elements
- Common themes as to what PCMH is:
  - Coordinated – providers responsible for communicating
  - Broad in scope – “whole patient”
  - Has continuity – on going long term
  - Linked to community – coordinates with community resources
  - Meets quality standards
  - Active management – access and follow up
  - Team based care

Must-Pass Elements

- PCMH 1; element A: access during office hours
- PCMH 2; element D: use data for population management
- PCMH 3; element C: care management
- PCMH 4; element A: support self-care process
- PCMH 5; element B: referral tracking and follow-up
- PCMH 6; element C: implement continuous quality improvement
Enhance Access and Continuity

- Patients have access to culturally and linguistically appropriate routine/urgent care clinical advice during and after office hours
- The practice provides electronic access
- The focus is on team-based care with trained staff

Identify and Manage Patient Populations

- The practice collects demographic and clinical data for population management
- The practice assesses and documents patient risk factors
- The practice identifies patients for proactive and point-of-care reminders

Plan and Manage Care

- The practice identifies patients with specific conditions, including high-risk or complex care needs
- Care management emphasizes:
  - Assessing patient progress toward treatment goals
  - Addressing patient barriers to treatment goals
- The practice reconciles patient medications at visits and post-hospitalization
- The practice uses e-prescribing
Provide Self-Care and Community Support

- The practice assesses patient/family self-management abilities
- The practice works with patient/family to develop a self-care plan and provide tools and resources
- Practice clinicians counsel patients on healthy behaviors and medications

Track and Coordinate Care

- The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals)
- The practice follows up with discharged patients

Measure and Improve Performance

- The practice uses performance and patient experience data to continuously improve
- The practice tracks utilization measures such as rates of hospitalizations and ER visits
- The practice identifies vulnerable patient populations
- The practice demonstrates improved performance
Certified PCMH

- National Committee for Quality Assurance (NCQA) has 3 levels of recognition
- Each level reflects the degree to which a practice meets the requirements of the elements and factors that compose the 6 standards
- Recognition Levels
  - Level 1: 30-59 points and all 6 Must-pass elements
  - Level 2: 60-84 points and all 6 Must-pass elements
  - Level 3: 85-100 points and all 6 Must-pass elements

Growth in NCQA Recognized PCMH

Growth in NCQA Recognized Clinicians and Sites

Accountable Care Organizations

- Voluntary groups consisting of physicians, health systems, LTC, and other providers
- Primary goal of ACOs is to reduce the total cost of care for a given population while maintaining and improving quality and satisfaction...this is called VALUE BASED PAY!!!
- An effective ACO should include a pharmacist!
- Key is to look at prevention and wellness
- CMS started recognizing voluntary ACO’s in 2012
Core Functions of the ACO
- Facilitating provider partnerships with patients, families and communities
- Redesign primary care medicine and advance the medical home concept
- Integrate the health care system across the continuum of care
- Provide tools and resources to health care providers
- Population health management

ACO: 33 Quality Measures Are Medication Driven
- Patient Satisfaction - 7 measures CAHPS
  - Education
- Care Coordination and Patient Safety - 6 measures
  - Hospital readmissions for COPD, CHF and all conditions
  - Medication Reconciliation
- Preventive Health – 8 measures
  - Pneumococcal and Influenza vaccinations
  - Obesity, Smoking
  - Depression, HTN

ACO: 33 Quality Measures Are Medication Driven
- At Risk Populations – 12 measures
  - DM: HgA1c, LDL, BP, ASA, smoking
  - HTN: BP
  - Ischemic Vascular Dx: LDL, ASA or anti-thrombotic
  - HF: beta-blocker
  - CAD: LDL, ACE/ARB
Pharmacists’ Impact

- Key player between clinician prescribers and pts
  - Medication management
  - Medication reconciliation
  - Monitoring contraindications and overuse
  - Patient safety
- Developing personal medication care plan for each patient
  - Chronic disease state management + MTM
  - Self management goals
- Communicating/Counseling on the care plan with the patient and others in the PCMH

Pharmacists’ Contribution to the Triple Aim: Proof Required

Importance of Star Ratings?

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<th>Stars Rating</th>
<th>QBP Percentage for 2012/2013</th>
<th>QBP Percentage for 2014</th>
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*QBP is a percentage increase in payment to the plan above the standard rate. For plans with less than 5 stars, the standard rate may be capped at pre-ACA rates. For more details, https://www.cms.gov/Medicare/Prescription-Drug-Cov-Info/PrescriptionDrugCovContra/Downloads/Announcement2012final.pdf
2014 Clinical Quality Measures

- National Quality Strategy Domains - There is also a new requirement in 2014 that the quality measures selected must cover at least 3 of the 6 available NQS domains, which represent the Department of HHS’ NQS priorities for health care QI
  1. Patient and Family Engagement
  2. Patient Safety
  3. Care Coordination
  4. Population/Public Health
  5. Efficient Use of Healthcare Resources
  6. Clinical Process/Effectiveness

2014 Recommended Core Set

- CMS is not requiring the submission of a core set of electronic CQMs (eCQMs). Instead, there are two recommended core sets of eCQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery.
  - 9 eCQMs for adult populations that meet all of the program requirements
  - 9 eCQMs for pediatric populations that meet all of the program requirements


Where Do We Go Next?

WE GET PAID!!
Health Care Reform – 2010-2013

2010-2013 - Initiation
- Medicare Market basket reductions
- Payer Reform—new insurance rules
- Medicare and Medicaid sponsor earliest payment innovations

2014-2017 – Market Expansion
- Rapid coverage expansion
- New federal money for new Medicaid eligibles
- Capacity constraints emerge in ED, primary care, discretionary specialty services

What is Provider Status?

- Becoming a federally designated "provider" means Pharmacists can participate in the Medicare program and bill for services that are within their state scope of practice to perform
- Attaining provider status at the federal level does not expand pharmacists’ scope of practice at the state level
- Section 1861 of the Social Security Act is the reference point for practitioners and is used as a benchmark for other commercial plans
- 38 states recognize pharmacists as providers

Currently Recognized Providers

Being listed in section 1861 of the Social Security Act (SSA) as a supplier of "medical and other health services," which includes:
- Physician
- Nurse practitioner
- Physician assistant
- Certified nurse midwife services
- Qualified psychologist services
- Clinical social worker services
- Certified nurse anesthetist
- Qualified speech-language pathologist
- Qualified audiologist
- Registered dentist
- Physical therapist
Michigan Workforce Demand
- 5,472 family physicians in Michigan
- 45 percent of Michigan's physicians plan to retire within next 10 years
- Ratio of residents to PCPs is 874:1, while the national average is 631:1.
- MI faces a physician shortage greater than the national average, and the largest shortage is in primary care.
- According to the AMA, by 2020 there will be a shortage of 8,000 to 12,000 physicians in Michigan, of which 4,000 will be primary care physicians

Impact in Michigan: Primary Care Health Professional Shortage Areas (HPSAs), 2012

<table>
<thead>
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<th>Population Living in a Primary Care HPSA</th>
<th>Michigan</th>
<th>United States</th>
<th>Michigan Rank</th>
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<tbody>
<tr>
<td>Estimated Underserved Population</td>
<td>10.20%</td>
<td>11.40%</td>
<td>28</td>
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For rank, 1=high, 51=low
Source: U.S. Department of Health and Human Services

Impact on Patient Care
- Achieving provider status is about giving patients consistent access to care that improves safety, quality, outcomes, and decreases costs
  - 30 million people will gain access to medical care in 2014
  - 17,000 primary care physicians are currently needed; another 40,000 more by 2025
  - Aging population, 58 million retiring baby boomers
  - Pharmacists represent the 3rd highest number of licensed health care professionals (approx. 300,000) – The only medication experts
Impact on Patient Care

- Acknowledging pharmacists as non-physician providers in the Social Security Act will allow licensed pharmacists to better assist patients by:
  - Working collaboratively with physicians and other providers
  - Optimizing medication therapy
  - Delivery best patient-centered care

Evolution of Profession

- Absence reduces visibility, implies secondary role, impedes care provision
- Extensive documentation of the need and improvement in outcomes, cost, and access when pharmacists provide clinical services
- Pharmacists can provide primary care and manage chronic disease
  - Improve outcomes of care
  - Enhance medication safety
  - Reduce costs of care
  - Expand access to care
- Lack of Part B eligibility has prevented universal integration – incentives are disproportionately aligned to provide the necessary workforce

Critical For Our Future Pharmacists

- Shifting away from fee-for-service?
  - Traditional fee-for-service will likely be phased out and replaced with new payment systems that emphasize quality, outcomes, and shared risk/savings/bundled payments
  - Focus for pharmacists has been on their roles on interdisciplinary teams
  - However, section 1862 of the SSA remains the reference point to identify practitioners who are eligible to participate in new and emerging delivery systems and payment models (e.g. ACOs and Medical Homes)
  - Provider status will ensure that pharmacists are eligible for participation on the care team, and participate in new and current delivery and payment systems
Who Is Doing the Work?
Patient Access to Pharmacists’ Care Coalition (PAPCC)
State Societies
Grassroots Efforts

PAPCC Mission
To develop and help enact a federal policy proposal that would enable patient access to, and payment for, Medicare Part B services by state-licensed pharmacists in medically underserved communities. Our primary goal is to expand medically-underserved patients' access to pharmacist services consistent with state scope of practice law.

PAPCC
- Multi-stakeholder and interdisciplinary initiative.
- Membership is comprised of organizations representing patients, pharmacists, and pharmacies, as well as other interested stakeholders.
- Actions:
  - Enlist broader support of stakeholders also including non-pharmacy health care organizations, providers, payers, patients and public
  - Work simultaneously at national, state and local levels
  - Obtain mock CBO scores (i.e., estimated cost to the federal budget)
  - Possibly modify Federal Ask based on CBO scores
Provider Status

HR Bill 4190

House of Representatives Bill 4190

- Introduced March 11, 2014 and has 118 Co-sponsors
- Sponsored by Rep. Brett Guthrie (R-KY), along with Rep. G.K. Butterfield (D-NC) and Rep. Todd Young (R-IN)
- Bill is bipartisan with approximately equal numbers between Republicans and Democrats as cosponsors
- According to Senator Sherrod Brown’s office they are involved in an Investigatory Committee currently for the Senate
H.R. 1490
- Cost Barrier Exists
  - Investment in outcomes and impact
  - Will cost money to add pharmacists to Medicare
- Medicare was created in 1965, many health professions played ancillary roles in patient care, times have changed and so have the needs of our patients
- 58 million retiring baby boomers
  - Population needs us
  - Medication costs are a large part of the expenses seen with healthcare
- Since medications are first line therapy for majority of conditions, then why wouldn't proper medication use be paramount to good patient care?

Scope of 4190
- Legislation would amend Section 1861 (s)(2) of the Social Security Act which defines Medical and other health services
- Covers state licensed pharmacists (B.S., Pharm D., etc.)
- Covers clinical services authorized under state scope of practice laws
- Reimbursement is consistent with Medicare payment for other non-physician providers, roughly 85%

Scope of 4190
- Covers medically underserved areas, medically underserved populations, or health professional shortage areas as designated by HRSA
  - Following nurse practitioner route
  - May help scale down scope and cost
- Coalition is working on scoring (cost estimate) of the bill
- This is a multiyear effort!
- Election years trend toward less legislation due to campaigning
Here is where you can look up their area:
http://muafind.hrsa.gov/
Post-Test Question #1

Indicators that predict the continued growth of ambulatory care include:

A. The change in the distribution of inpatient versus outpatient revenues for community hospitals over a 10-year period
B. Growth in the percent of adults with two or more chronic conditions
C. The Affordable Care Act
D. All of the above
E. Just B and C.

Post-Test Question #2

To improve health outcomes during transitions in care from the inpatient to the ambulatory care setting, the following may occur:

A. Inpatient and outpatient pharmacists collaborate to determine post-discharge medication management needs for the patient
B. Pharmacists provide home-based medication reconciliation
C. Pharmacy technicians work with patients to help ensure they can afford their medications
D. All of the Above

Post-Test Question #3

What Section of Medicare is HR Bill 4190 proposing to be altered to recognize pharmacists as providers?

A. Medicare A
B. Medicare B
C. Medicare C
D. Medicare D
E. All of Medicare sections
Post-Test Question #4

Medicare Wellness visits are not reimbursable under Medicare Part B when a pharmacist performs the service.

A. True
B. False

Post-Test Question #5

What type of reimbursement system is favored by Accountable Care Organizations?

A. Fee for Service
B. Incident-To-Billing
C. Facility Billing
D. Value Based Pay
E. None of the above

Discussion or Questions