Provider Status

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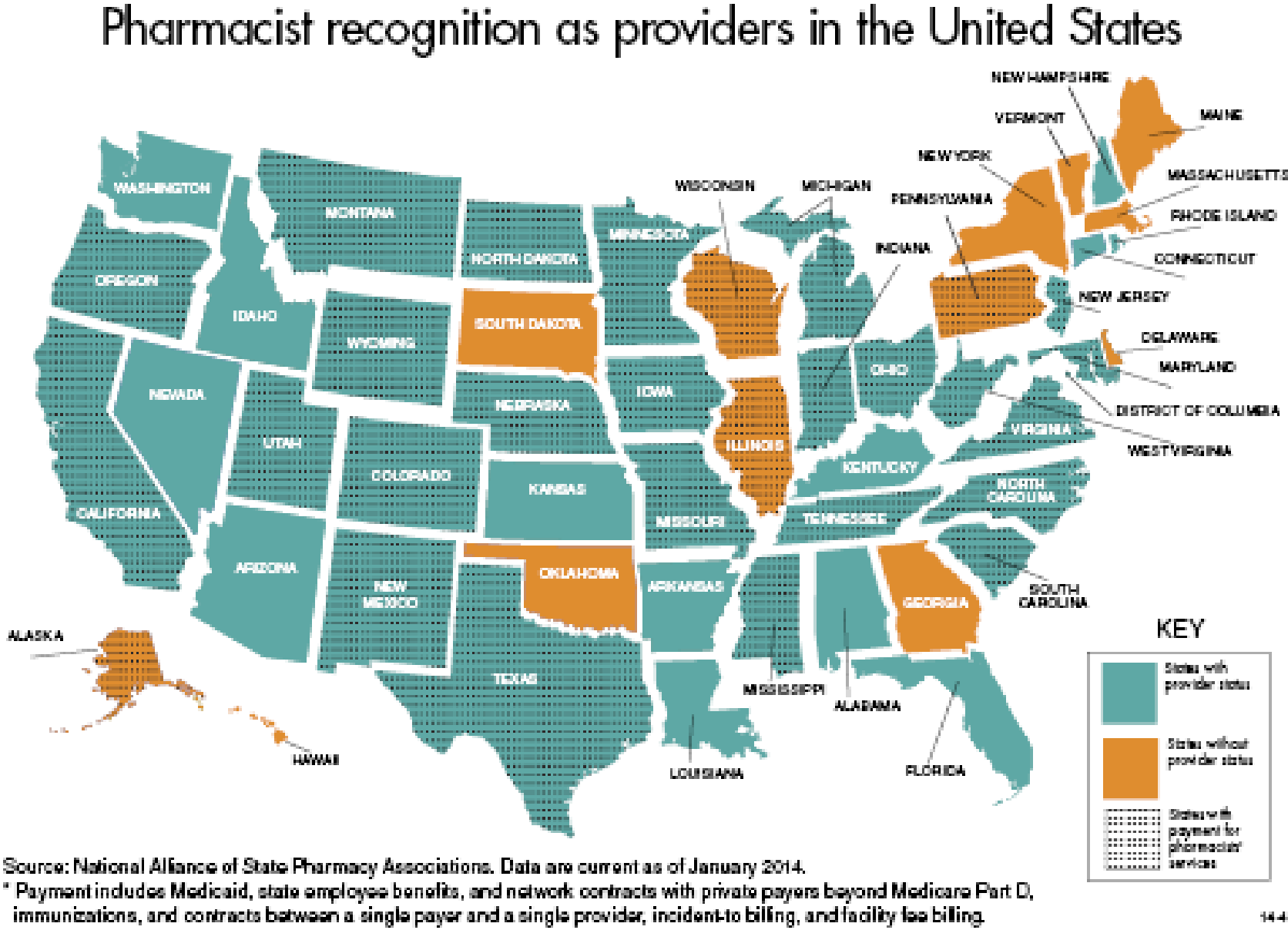
Provider Status



Source: National Alliance of State Pharmacy Associations. Data are current as of January 2014.

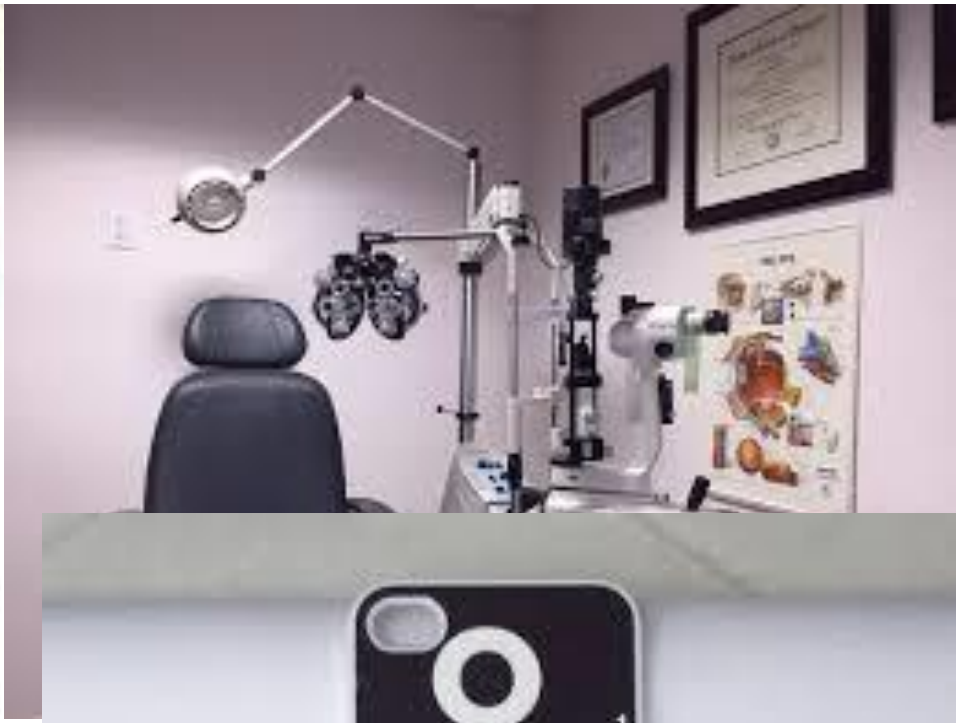
* Payment includes Medicaid, state employee benefits, and network contracts with private payers beyond Medicare Part D, immunizations, and contracts between a single payer and a single provider, incident-to billing, and facility fee billing.

14-454

Changing Paradigms of Pharmacy...

The Columbus Dispatch
dispatch.com

Think About Optometrists...

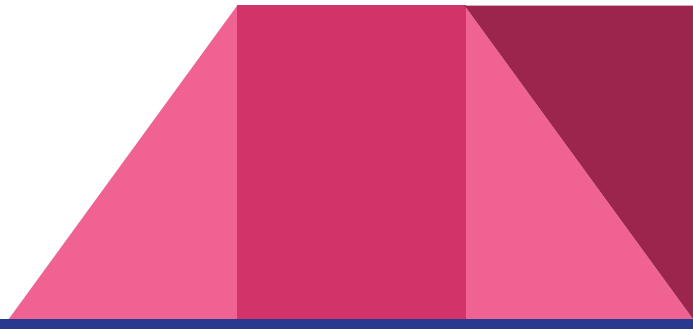


Pharmacies vs. Pharmacists

- Do you see your Doctor or your Doctor’s Office?
- Do you see your Optometrists or LensCrafters?
- Do you see your Surgeon or the Surgery Center?
- ***Do you see your Pharmacist or the Pharmacy?***

Health Care Changes

- Price Vs. Cost
- Service Vs. Value
- Patient Vs. Product
- Outcomes Vs. Process



Payment Programs
- Collaborative Practice

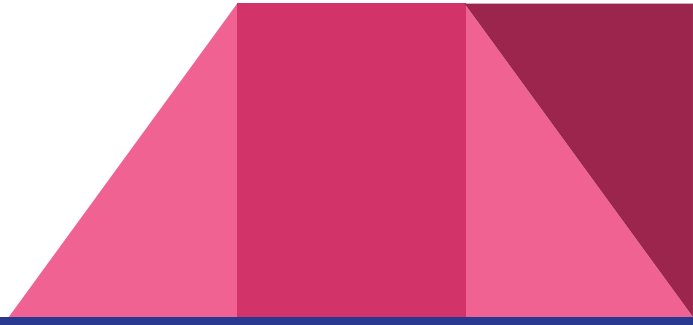
Comprehensive Primary Care Programs

- Ohio CPC - Medicaid
- CPC+ - Medicare

Ohio CPC

- **Requirements (Must pass 100%)**
  - Same-day appointments
  - 24/7 access to care
  - Risk stratification
  - Population management
  - Team-based care management
  - Follow up after hospital discharge
  - Tracking of follow up tests and specialist referrals
  - Patient experience
- **20 Quality Metrics (Must pass 50%)**
  - Clinical measures aligned with CMS/AHIP core standards for PCMH
- **4 Efficiency Measures (Must pass 50%)**
  - ED visits
  - Inpatient admissions for ambulatory sensitive conditions
  - Generic dispensing rate of select classes

  Behavioral health related inpatient admits



B Overview of Quality and Efficiency Metrics (1/2)

Must pass 50%

Category	Metric name	Population	Threshold[1]	State average[2]
Pediatric Health (4)	Well-Child Visits in the First 15 Months of Life	Pediatrics	11%	30%
	Well-Child visits in the 3rd, 4th, 5th, 6th years of life	Pediatrics	41%	61%
	Adolescent Well-Care Visit	Pediatrics	15%	34%
	Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI assessment for children/adolescents	Pediatrics	10%	5%
Women's Health (5)	Timeliness of prenatal care	Adults	56%	62%
	Live Births Weighing Less than 2,500 grams	Adults	< = 11%	9%
	Postpartum care	Adults	41%	48%
	Breast Cancer Screening	Adults	52%	51%
	Cervical cancer screening	Adults	36%	50%
Adult Health (7)	Adult BMI	Adults	10%	14%
	Controlling high blood pressure	Adults	10%	~0%
	Med management for people with asthma	Both	24%	35%
	Statin Therapy for patients with cardiovascular disease	Adults	28%	32%
	Comprehensive Diabetes Care: HgA1c poor control (>9.0%)	Adults	< = 90%	99%
	Comprehensive Diabetes Care: HbA1c testing	Adults	75%	80%
	Comprehensive Diabetes Care: eye exam	Adults	35%	40%

1 All metric thresholds are greater than or equal to the value except as noted

2 For informational purposes only; rates are calculated using administrative claims data only and reflect metric performance for CY2015

B Overview of Quality and Efficiency Metrics (2/2)

Must pass 50%

Category	Metric name	Population	Threshold[1]	State average[2]
Behavioral Health (4)	Antidepressant medication management	Adults	55%	55%
	Follow up after hospitalization for mental illness	Both	32%	45%
	Preventive care and screening: tobacco use: screening and cessation intervention	Both	10%	6%
	Initiation and engagement of alcohol and other drug dependence treatment	Adults	34%	36%
Efficiency metrics	ED Visits / 1,000 Member Months	Both	< = 73	88
	IP Admits for Ambulatory Conditions / 1,000 Member Months	Adults	< = 7	3.8
	Generic Dispensing Rate	Both	78%	81%
	Behavioral Health-related IP Admits / 1,000 Member Months	Both	< = 1.2	1.4

1 All metric thresholds are greater than or equal to the value except as noted
2 For informational purposes only; rates are calculated using administrative claims data only and reflect metric performance for CY2015

Quality Metrics

- Diabetes
- Dilated Retinal Eye Exam Annually (18-75 y/o)
- HbA1c Annually (18-75 y/o)
- Breast Cancer Screening (Every 2 years, 50-74 y/o)
- Cognitive Screening Annually (specific ICD-10 codes qualify)
- Colorectal Cancer Screening (Colonoscopy every 10 years, 50-75 y/o)
- Tobacco Use Annually (Screening, Counseling, Intervention, >18 y/o)
- Alcohol and other Drug Dependence Treatment (> 18 y/o)
- Cervical Cancer Screening (Women every 3 years, 21-64 y/o)
- Controlling high blood pressure (every office visit 18-85 y/o)
- Falls risk assessment (annually, > 65 years old)
- Imaging for low back pain (18-50 y/o)
- Closing the Referral Loop
- High risk medication use in the elderly (>65 y/o)
- Depression remissions at 12 months (assess every 6 months)

Metrics Involving Pharmacists

- Diabetes
- Dilated Retinal Eye Exam Annually (18-75 y/o)
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Chronic Care Management Requirements

Eligible Beneficiary Requirements

Qualified Beneficiaries

- A patient who has been diagnosed with two or more chronic conditions expected to last for at least 12 months, or until death of the patient

Obtaining Beneficiary Consent

Provider must inform beneficiary of the following:

- CCM program description
- Manner in which CCM services will be provided
- The right to stop the CCM services at any time
- Only one practitioner can provide these services during a calendar month
- Health information will be shared with other practitioners
- Medicare Beneficiary will be responsible for associated copays or deductibles
- Medicaid Beneficiary is not subject to copay or deductible

Technology Requirements

EHR Technology Requirements

- Certified EHR
- Include the following patient data: demographics, problems, medications, and medication allergies
- Allow for the creation of a structured clinical summary record
- Provider must be able to transmit the summary record for purposes of care coordination
- House the beneficiary consent of CCM services
- House the beneficiary receipt of care plan (electronic/hard copy)
- Document communication to and from home and community-based providers

Electronic Care Plan Requirements (available 24/7)

- Allow provider to create an electronic care plan based on the physical, mental, psychosocial, cognitive, functional and environmental assessment of beneficiary
- Ability to update and share care plan with other practitioners and care members on a 24/7 basis
- Opportunities for beneficiary and any caregiver to communicate with the practitioner

CCM Services Requirements

Chronic Care Management Services Requirements

- Provide 20+ minutes of non-face-to-face care management services
- Beneficiary access to care management services 24/7
- Continuity of care with a designated practitioner/care team member – ability to get successive routine appointments
- Monitor beneficiary's condition - care management of chronic conditions
- Ensure beneficiary receipt of preventive care services
- Medication reconciliation
- Oversight of beneficiary self-management of medications
- Follow up after ER visits
- Help coordinate transition of care

Chronic Care Management

CCM	
CPT 99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Comprehensive care plan established, implemented, revised, or monitored
Assumes 15 minutes of work by the billing practitioner per month	

Chronic Care Management

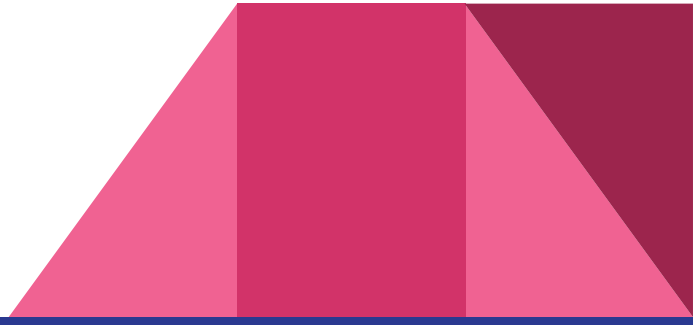
Complex CCM	
CPT 99487	Complex chronic care management services, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
CPT 99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

Fee-For-Service

May bill for Incident-to billing in provider's Office:

- Must be within pharmacist's scope of practice
- Ongoing involvement of billing provider (e.g. physician)
- Must adhere to Medicare Guidelines
- May see patient without physician (e.g. CPT 99211)
- May see patient with physician (e.g. 99213, 99214, etc.)
- Several services could be implemented
  - Diabetes Management
  - Cardiovascular Disease Management
  - Pain Management
  - Pulmonary Disease Management



Other Services

Transitions of Care Management (TCM)

Medication Therapy Management (MTM)

Select Programs Available for Reimbursement

Improvement of Quality Metrics for Physician Practices

Commercial Market

Self-Insured Employers

Brokers

Third-Party Administrators

Pharmacy Benefit Managers

Ohio…


S.B. NO. 265
PERMITS HEALTH INSURERS TO COVER
PHARMACIST-PROVIDED BENEFITS
NOV 28, 2018
OHIO
SENATE


PROVIDER STATUS
HEADS TO THE GOVERNOR!

Provider Status in Ohio...

Who are the players?

What should pharmacists expect?

How can pharmacists position themselves well?