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Sustainable Business Models: Systematic Approach toward Successful Ambulatory Care Pharmacy Practice

Gloria Sachdev

Gloria Sachdev, B.S.Pharm, Pharm.D., is Clinical Assistant Professor of Primary Care, Department of Pharmacy Practice, Purdue University College of Pharmacy, and Adjunct Clinical Assistant Professor, Indiana University School of Medicine, Indianapolis (gsachdev@iupui.edu).

Abstract

Purpose. This paper discusses how to make pharmacist ambulatory care services at least cost neutral and, ideally, generate a margin that allows for service expansion.

Summary. The four pillars of business sustainability are leadership, staffing, information technology, and compensation. A key facet of leadership in ambulatory care pharmacy practice is creating and expressing a clear vision for pharmacists' services. Staffing considerations include training needs, maximizing efficiencies, and minimizing costs. Information technology is essential for efficiency in patient care delivery and outcomes assessment. The three domains of compensation are cost savings, pay for performance, and revenue generation. The following eight steps toward designing and implementing an ambulatory care pharmacy service are discussed: (1) prepare a needs assessment, (2) analyze existing strengths, weaknesses, opportunities, and threats, (3) analyze service gaps and feasibility, (4) consider financial opportunities, (5) consider stakeholders' interests, (6) develop a business plan, (7) implement the service, and (8) measure outcomes. Potential future changes in national health care policy (such as pharmacist provider status and expanded pay-for-performance) could enhance the opportunities for sustainable ambulatory care pharmacy practice.

Conclusion. The key challenges facing ambulatory care pharmacists are developing sustainable business models, determining which services yield a return on investment, and demanding payment for valuable services.

Introduction

Developing sustainable business models for ambulatory care pharmacist services is not a *preferred* vision; it is an *essential* vision. Many of the services deemed as "best practices" 20 years ago have unfortunately closed their doors over the years. These were practices that benefited patients and were valued by referring providers. Examples of casualties that I am aware of include a physician-based heart failure clinic in Kentucky, a community pharmacy-based medication therapy management clinic in Hawaii, and a hospital-based outpatient transitions-of-care clinic in Indiana. The one thread that weaves through the fabric of their stories is that they were unsuccessful in demonstrating the value proposition to those who controlled their fate (e.g., administrators and payers).

Developing and implementing a pharmacist service that is not financially sustainable is quite straightforward: Simply provide the service at no charge (or at a charge that does not cover costs) and do not collect patient outcomes information. A pharmacist's salary with benefits averages $150,000 per year. This translates to $750,000 in five years, per pharmacist. No organization can afford to absorb these costs indefinitely. Thus, if a pharmacist service wishes to thrive for the long-term, and not merely exist in the present, it needs to demonstrate that it is *at least* cost-neutral; meaning that at a minimum, the costs of the service are covered. Ideally, the value proposition supports a level of compensation that generates profits. Profits are what permit growth of the current service and expansion into other services. The considerations in developing sustainable business models are discussed in this paper.

Fundamental Infrastructure Considerations

The four pillars of business sustainability are leadership, staffing, information technology, and compensation.

Leadership. Effective leaders must not only develop and articulate a clear vision, they must also motivate staff to follow their vision. As John Maxwell notes in his book, *Developing the Leader Within You*, "people don't care how much you see until they see how much you care."[1] If a leader develops an exceptional vision yet has no followers, what are the chances of his vision being achieved? Effective leaders must also nurture potential stakeholder relationships to generate interest and enthusiasm for pharmacist services. Leaders should ensure that staff members have the ability to function at the top of their licenses, and they should make themselves available to provide guidance to staff. In short, effective leaders must have effective communication skills.

A key responsibility of leadership is to identify the potential internal and external partners with whom collaboration might be feasible. Leadership's challenge is to determine how best to leverage existing relationships and forge new ones. Practice leaders must stay abreast of changes that influence their local health care market.

Administrative commitment to provide adequate staff resources to lead the development or expansion of a service is critical if one hopes to have a service implemented within six months. A dedicated pharmacist champion must ensure that all tasks move along until completion. This pharmacist must have the skill set to lead and be accountable for achieving success. A team consensus approach is generally ineffective when controversies arise; for example, if several people are in discussions with legal or billing staff, inefficiencies, miscommunications, and frustrations for all parties are likely to occur. Having one dedicated person who is recognized by all stakeholders as the leader of the initiative yields the highest rate of success in addressing unresolved issues and controversies.

Considerable time and effort are required to assess if a viable business model opportunity

exists, write a business plan, and then implement the service. It helps everyone on the team persevere if the leader recognizes that managing occasional rough spots is part of the implementation process.

Staffing. Staffing considerations include training needs, maximizing efficiencies, and minimizing costs. Not all pharmacists are trained equally. Many have completed residency programs, participated in certificate programs, or otherwise gained specialized experience. Once the needs assessment is completed (discussed below), further pharmacist training may be required. Training may also be required of pharmacy technicians, clerical staff, billing staff, nursing staff, and others who are involved with ensuring that the pharmacist service functions as efficiently as possible.

Although pharmacists can schedule their own patients, submit their own bills, and call patients who fail to keep their appointment, is this the best use of such highly trained and highly compensated professionals? No. Pharmacists should integrate their service with the processes of other practitioners in their clinic. They should adopt the same process for referrals, scheduling, ordering tests, etc., as this permits them to maximize their time seeing patients, which in turn results in greater compensation. Many pharmacists make the mistake, upon starting a new service, of performing their own clerical work so as not to disrupt clinic flow. They think that after their service gets busier, they will off-load the clerical responsibilities to clinic support staff. However, what they find is a reluctant clinic support staff that is perplexed as to why pharmacists have asked them to help now when clearly they are capable of performing these functions. The key is to start your service with the end in mind. Develop the service from the beginning in the way you want it to function in five years.

Minimizing staffing costs, at least until the value proposition is established, is a top

priority of administrative leaders who are considering whether to establish or expand ambulatory care pharmacist services. One opportunity that is underutilized is to engage pharmacist learners in the assessment, development, and implementation phases. Find pharmacist students, residents, and fellows who are knowledgeable, talented, eager to learn, and passionate about refining their skills. Exposure to business-sustainability considerations is of high value to many learners who recognize that they might need to develop a service at some point in their careers. Another reason to engage learners is to identify future staff members. Reach out to a college of pharmacy to see if it has students available for a four- to eight-week rotation.

If yearlong support is desired, consider funding or cofunding a residency program. Colleges may also be interested in cofunding or contracting a pharmacist staff position. The benefit to contracting with a college for faculty is that no official position has to be approved, and the terms of the contract can specify that the position expires in one or two years, with the option to renew based on achievement of specific results. Funding a position with soft money helps ensure that all parties are fully committed to the success of the program. The benefits to the college include gaining experience in developing an innovative practice and using the clinic as a site for experiential education and research. Similar opportunities for cofunding or contracting may exist with retail pharmacy corporations, pharmacy benefit management companies, or independent consultants. Think outside of the box and leverage community relationships to identify options for staffing.

Information technology. Information technology (IT) drives efficiencies in all aspects of patient care delivery and outcomes assessment. Technology is evolving rapidly in areas such as electronic medical record dashboards, apps on a tablet for counseling, monitoring devices with Bluetooth capabilities, documentation systems that permit bidirectional electronic transmission

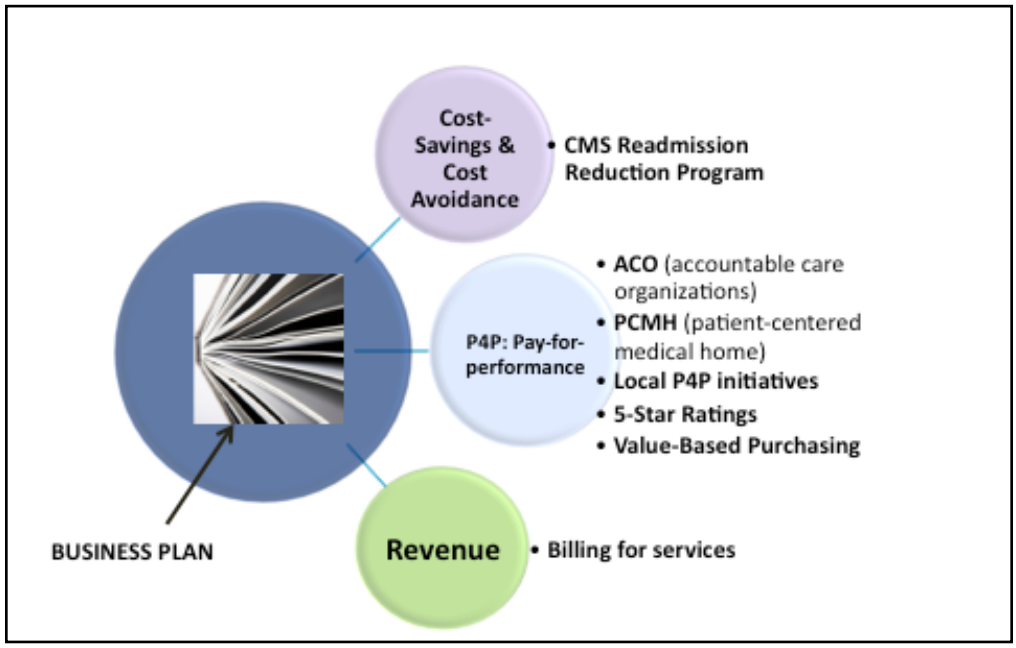
of records, and health information exchanges that send alerts and reminders. One way to keep up with all the technology is to identify someone in your organization who has interest in this topic and have them engage with the informatics task groups or committees of various health organizations and associations.

Before investing in new technology, assess the prospect of using existing resources that are available to serve your needs. Consider using existing billing technology to capture pharmacist service workload. Internal provider numbers can be established so that individual workload can be tracked. Reports on the number of new patient visits, follow-up patient visits, patient diagnoses, and revenue generation can be produced readily by most billing software. Most electronic medical record systems can produce custom clinical reports, which can be useful in monitoring performance related to quality measures. Also, many local health information exchanges and payers participate in public reporting of quality performance based on claims data.

Compensation. The fourth pillar of sustainability for ambulatory care pharmacist services, which is perhaps the least well understood, is compensation. The three domains of compensation are cost-savings, pay-for-performance, and revenue generation (see Figure 1 on the next page).

In years past, the pro forma section of the business plan focused primarily on billing opportunities for clinical pharmacist services. However, with the advent of health care reform, cost-savings and pay-for-performance opportunities are now center stage alongside billing opportunities. Cost-savings denote real dollars that were not lost due to financial penalties imposed on the organization by various payers. This should not be misconstrued as cost-avoidance (e.g., costs avoided by preventing a thromboembolic event). Hospital chief financial

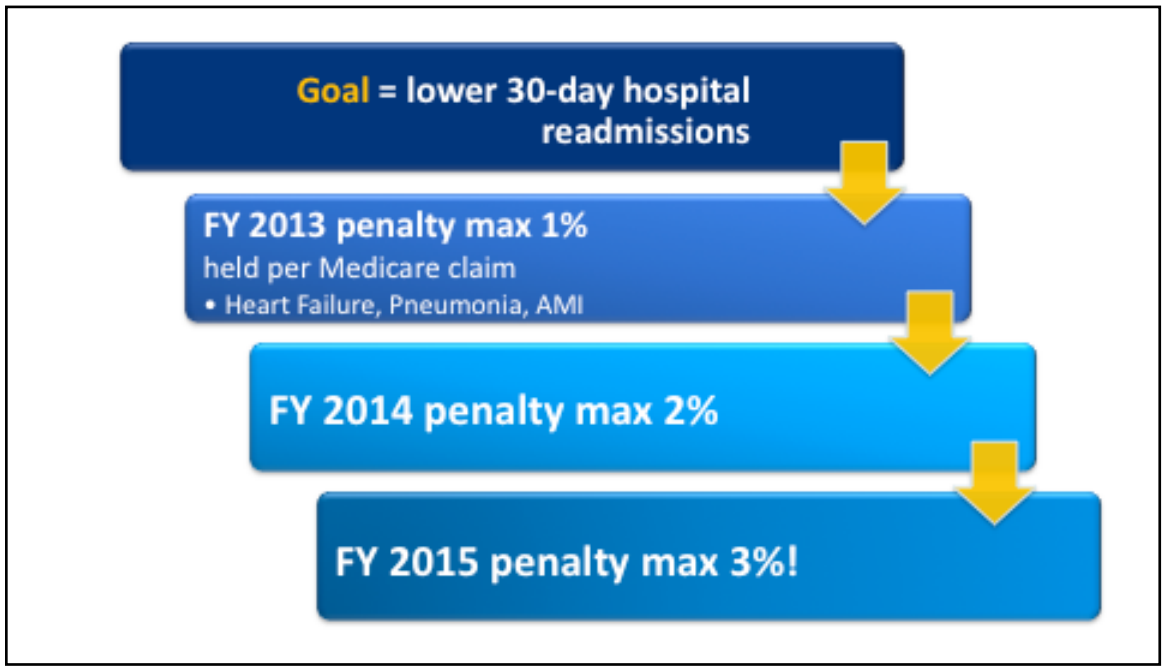
Figure 1. *Compensation factors to consider in an ambulatory care pharmacy service.*



officers (CFOs) typically have difficulty accepting "soft" cost-avoidance numbers. From their perspective, the avoided hospital admission (due to optimal care delivery) is lost revenue for the hospital. A shocking perspective, but real! It is important to understand who benefits from the pharmacist service. Who benefits from avoiding a hospitalization? The payer, not the hospital. This is why health care payers, including Medicare, are aligning financial incentives around achieving quality outcomes, not quantity of services provided. An example of a program that focuses on quality is the CMS Hospital Readmission Reduction Program,[2] which financially penalizes hospitals that have high readmission rates for acute myocardial infarction, pneumonia, and heart failure. (CMS has proposed to add other conditions in 2015.) The penalties for all-cause readmissions began in fiscal year 2013 and will continue to increase over the next two years, as noted in Figure 2 on the next page.

It is challenging to determine the ambulatory care pharmacist's contribution to the

Figure 2. *The Centers for Medicare & Medicaid Services' 2013–2015 staging of financial penalties related to hospital readmission performance.*[2]



reduction in financial penalty incurred by a hospital. To establish the value proposition of the ambulatory care pharmacist service, consider comparing pre/post readmission rates (and penalty dollars incurred) (1) before/after service implementation, (2) among similar populations, with and without a pharmacist service, or (3) between organizations with similar populations, with and without a pharmacist service. The documented revenue saved can be used, in part, to justify a transitions-of-care service.

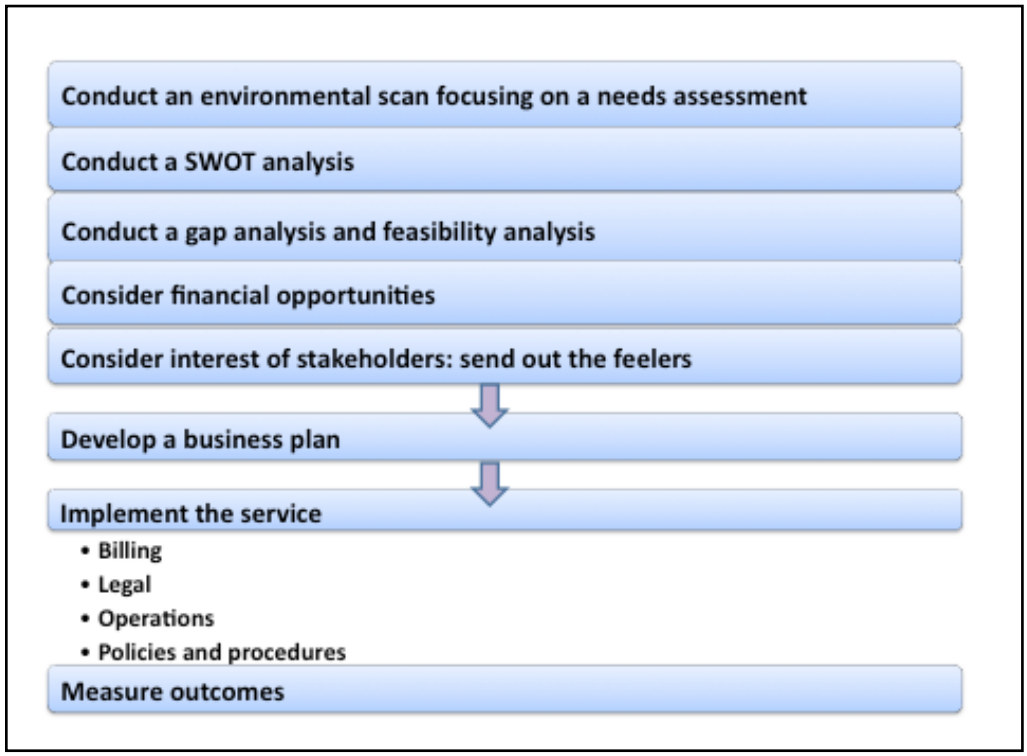
Pay-for-performance (P4P) involves revenue gained as a financial reward for achieving specific quality measures. The quality measures vary significantly among payers, thus it is important to understand which measures hospitals and provider groups are aiming to achieve. Pharmacist contribution to attainment of these P4P measures is another potential revenue stream to sustain ambulatory care pharmacist services. Examples of programs that offer such financial

rewards include accountable care organizations (ACOs),[3] various patient-centered medical home (PCMH) models, meaningful use (MU)[4] of the electronic medical record, local P4P programs, hospital value-based purchasing (VBP),[5] the physician quality reporting system (PQRS),[6] and the 5-star quality rating system.[7] The leaders of ambulatory care pharmacist services must understand which quality-related performance goals are of priority to potential collaborating stakeholders.

Where to start?

Building on the above discussion of the fundamental pillars of a sustainable business model for an ambulatory care pharmacy service, the next level of consideration is how to make specific plans for the service. The following sections offer a strategic approach to designing and implementing a service (see Figure 3 for an overview of the steps).

Figure 3. *Recommended strategic approach to designing and implementing an ambulatory care pharmacy service.*



(1) Conduct an environmental scan focusing on a needs assessment. An environmental scan assesses the current situation and how it is changing or trending. An environmental scan allows for adaptive strategic planning that takes into account anticipated trends.

Begin by conducting a needs assessment to understand gaps in care that are amenable to pharmacist improvement. For example, one should not develop a diabetes service because it "seems like a good idea" or because that is what the pharmacist is interested in providing. A needs assessment involves identifying what the specific gaps in quality measures are for each potential collaborating stakeholder. Stakeholders include self-insured employers, commercial insurance carriers, Medicaid, Medicare, independent physician groups, hospitals, home health agencies, and long-term care facilities. It is imperative to discover stakeholder performance on quality measures for which they are either financially rewarded or penalized. This understanding will provide a path to determining what team-based pharmacist services could be developed to help these stakeholders achieve higher performance.

It may be that poor performers who have the most to gain through financial rewards/penalties become a high priority for further dialog about potential collaboration. However, some poor performers are in their situation because they have ineffective leadership. For such stakeholders, move on and do not waste time in trying to support their efforts. Often, high performers have achieved their success because they truly wish to be best in class and have set higher quality standards than those established by payers. Rank all stakeholders from poorest performance to highest performance for each quality measure and establish priorities for approaching them.

It can be difficult to determine whom within an organization to approach about quality

measure performance. Go armed with as much information as is publicly available because this demonstrates interest in being a constructive partner. A critical review of how local stakeholders are performing will elucidate gaps in care and opportunities for partnership. Table 1 below gives the Web addresses for performance measures related to several CMS programs.

An environmental scan is not complete without also evaluating potential environmental changes that might affect the future of the clinical service (i.e., demographic, economic, social, political, cultural, clinical, administrative, and technologic trends). Such trends may elucidate what the market demand may be for future services and should be considered in the three- to five-year strategic plan. The annual *Pharmacy Forecast* reports by the ASHP Center for Health-System Pharmacy Leadership can be helpful in analyzing trends (www.ashpfoundation.org/pharmacyforecast).

(2) Conduct a SWOT analysis. Once service opportunities are identified through the needs assessment, it is important to understand one's own internal organizational *strengths* and *weaknesses* for implementing potential services as well as external *opportunities* and *threats* for such services. Strengths might include having appropriately trained staff or a strong physician

Table 1.
References to Information about Selected Quality Performance Measures from the Centers for Medicare & Medicaid Services (CMS)

CMS Program	**Web Site** (accessed 2013 Oct 28)
Hospital Readmission Penalty	www.checkmypenalty.com
Hospital Compare	www.medicare.gov/hospitalcompare/search.html
Nursing Home Compare	www.medicare.gov/nursinghomecompare/search.html
Health Plan Compare (using 5-star ratings)	www.medicare.gov/find-a-plan/questions/home.aspx
Recognized Accountable Care Organizations	innovation.cms.gov/initiatives/aco/
Value-Based Purchasing	innovation.cms.gov/initiatives/Nursing-Home-Value-Based-Purchasing/

referral base. Weaknesses might include not having existing clinic space to establish services or the lack of staff knowledge about billing for pharmacist services. Opportunities might include a local payer that recognizes pharmacists as providers or a clinic patient population that has a high incidence of chronic diseases. Threats might include competing organizations providing similar services nearby or a poor local economy.

The SWOT analysis provides an opportunity to answer the following questions:

1. How can we use our strengths to take advantage of our biggest opportunities?
2. How can we use our strengths to overcome our biggest threats?
3. What do we need to do in order to overcome our weaknesses so that we are better able to take advantage of our opportunities?
4. How can we minimize our weaknesses so that we are better positioned to overcome our threats?

(3) Conduct a gap analysis and feasibility analysis. In contrast to the needs assessment, which identifies potential viable services, a *gap analysis* assesses where an organization is today, where it wishes to go, and the resources needed to close the gap. Consider the following example:

> Upon completing a needs assessment, it is noted that a local health plan has a 2.5 CMS star rating. Hence, the plan is not eligible for a P4P financial bonus from CMS. If it achieves a 3.0 star rating, the plan would get a 3% P4P bonus. Three of the star-rating measures contributing to poor performance are related to the medication adherence measures for diabetes-control, cholesterol-lowing, and antihypertensive medications. Developing a medication adherence service around these three drug classes is an opportunity for an ambulatory care pharmacy service. It appears that no service within the organization or the community is currently addressing this opportunity. The steps required to get from opportunity to service development comprise the gap analysis.

After conducting a gap analysis, a *feasibility analysis* determines if the steps that are identified can actually be accomplished within one's own organization. Perhaps a lack of pharmacist interest or the magnitude of the costs associated with adopting the payer-requested documentation process makes the opportunity not feasible. If this is the case, go back to the needs assessment and focus on other potential opportunities.

(4) Consider financial opportunities. From the needs assessment, SWOT analysis, gap analysis, and feasibility analysis, it should be clear what services merit further consideration. Many patient-, provider-, and pharmacist-valued services may not have a revenue option (e.g., a pill box filling service). It is important to determine the specific revenue opportunity for each service under consideration. Revenue opportunities include payment for services provided, downstream services affected by the pharmacy service, product sales, and potential grant support. Projected revenue from downstream services might include an anticipated increase in laboratory tests or referrals to specialty groups such as podiatry, ophthalmology, and dietary. It might also include the referring physician gaining additional capacity to see more complex patients at a higher billing rate. Projected revenue from product sales might include an anticipated increase in prescription volume or durable medical equipment sales. The opportunity for grant support, which increases through collaboration with a college of pharmacy, might be available for providing care to an underserved population. However, the primary revenue opportunity is likely to be billing for the clinical service provided. It is essential that an ambulatory care pharmacy service have access to the specialized expertise needed for handling billing and the related compliance issues.

The specific billing option for clinical services depends on three variables: (1) clinic practice site location, (2) payer mix, and (3) type of service provided. The four practice site location options are (1) hospital-based outpatient clinic, (2) physician-based outpatient clinic, (3) community pharmacy-based clinic, and (4) employer-based clinic. The billing rate is in part determined by the location of the service. For example, in a community pharmacy-based clinic, transitional care management billing codes cannot be used because they are specifically defined for a hospital-based clinic or a physician-based clinic.

Payer mix is the distribution of patients by type of insurance coverage (Medicare, Medicaid, or commercial insurance; self-insured employer coverage; or self-pay). Table 2 gives examples of billing codes that can be used for pharmacist services by practice setting. Each billing opportunity has specific criteria that must be met. Appendix A lists Web sites and other references that describe billing criteria in detail.

Knowing practice site location, payer mix, and reimbursement rates permits one to project revenue for the various services under consideration. A pro forma template to assist in estimating projected revenue is given in Appendix B. To create a complete pro forma, one could add (1) revenue from services affected downstream, (2) revenue from product sales, (3) P4P projections, and (4) cost-savings projections.

Table 2.
Examples of Medicare billing for pharmacist services in various practice settings

Billing Option	CPT Billing Code	Practice Setting	Medicare Reimbursement
Diabetes self-management training	G0108 (individual) G0109 (group)	All	$51.45* $13.79*
CLIA-waived lab test	Variable	All	Fixed per CPT code
Incident to physician: office visit	99211-99215 G0463	Physician-based clinic Hospital-based clinic	Fixed; varies by region $92.53**
Incident to physician: transitional care management	99496 (within 7 days of discharge) 99495 (within 14 days of discharge)	Physician-based or hospital-based clinic	$227.44* (PB)*** $194.97* (HB)**** $161.15* (PB)*** $132.94* (HB)****
Medication therapy management	99605-99607	Pharmacy or self-insured employers	Variable
Medicare annual wellness visit	G0438 (initial) G0439 (subsequent)	Physician-based or hospital-based clinic	$166.72* $109.85*

*Rate varies by region annually. The payment noted is for the St. Louis, Missouri, region. See Appendix A for references on rates in other regions.
**One payment rate across country, varies annually.
***Physician-based outpatient clinic payment rate.
****Hospital-based outpatient clinic payment rate.

(5) Consider interest of stakeholders: send out feelers. Once high-level financial projections are determined, plausible services with a strong business case rise to the top. The next step is to decide which of these services are of greatest value to potential partners and evaluate if there is interest in the proposed pharmacist service. Before writing a detailed business plan, one can "pitch" the business proposal to key decision makers to get their initial reaction. They may offer suggestions for tailoring the program to meet future organizational goals, offer financial resources to support aspects of the program, or offer to be the physician or administrative champion of the service. Alternatively, they may express concerns about the direction of the proposed service, comment on competing internal programs on the drawing boards, or share information about political issues that might affect implementation of the proposed service. Creating excitement for the proposed service and attaining stakeholder verbal support are the goals of this step of the process.

(6) Develop a business plan. Once a sustainable service has been identified and there appears to be stakeholder interest, the next step is to write the business plan. If hesitation is noted in step 5, consider framing the new service as a pilot project. This tends to resonate well with most stakeholders because long-term financial commitment is not requested. Waiving compensation during a pilot phase may be an option if it is clearly established that compensation will commence when specific benchmarks are achieved. Executive leaders expect business plans to discuss sustainability and growth of the proposed service. Some pharmacy administrators might not be comfortable with this type of discussion if they have minimal experience developing business proposals. If this is the case, consider reaching out to a business-minded colleague or hiring a consultant to navigate these conversations and negotiate the contracts.

Even though many administrators, supervisors, and providers may read the final business

plan, it is critical to write the plan only for the one person whose approval is paramount. If this person is familiar with pharmacist services, the background may be brief. However, if pharmacist clinical services are a new concept to the reader, consider including several references in the background. If there is a two-step approval process (e.g., CFO and then the chief medical officer [CMO]), consider writing two versions of the business plan. The version for the CFO might include extensive detail in the pro forma section, which may be the first, and perhaps only, section he or she reviews. The version for the CMO might include extensive detail on the program structure and outcomes measurement. The rationale for writing two versions in this example is that occasionally CMOs find extensive financial detail disconcerting because it suggests that money is the primary driver rather than improved patient care. Customize the business plan, taking into account the clinical background (or lack thereof), familiarity with pharmacist services, and position of the person(s) authorized to flip the switch from red to green.

Although there are many templates for writing business plans and no one accepted format, recommended components for service-oriented business plans include the following (the minimum components are noted with an asterisk [*]):

1. Executive Summary or Purpose*
2. Background* (needs assessment results)
3. Introduction
4. Program Description* (operational structure)
5. Environmental Analysis
6. SWOT Analysis*
7. Marketing Plan
8. Action Plan
9. Pro Forma* (compensation projections)
10. Exit Strategy
11. Conclusion/Summary*
12. Supportive Documents

(7) Implement the service. With the business plan approved and the celebration over, the focus on service implementation begins. For efficient implementation, it is recommended to

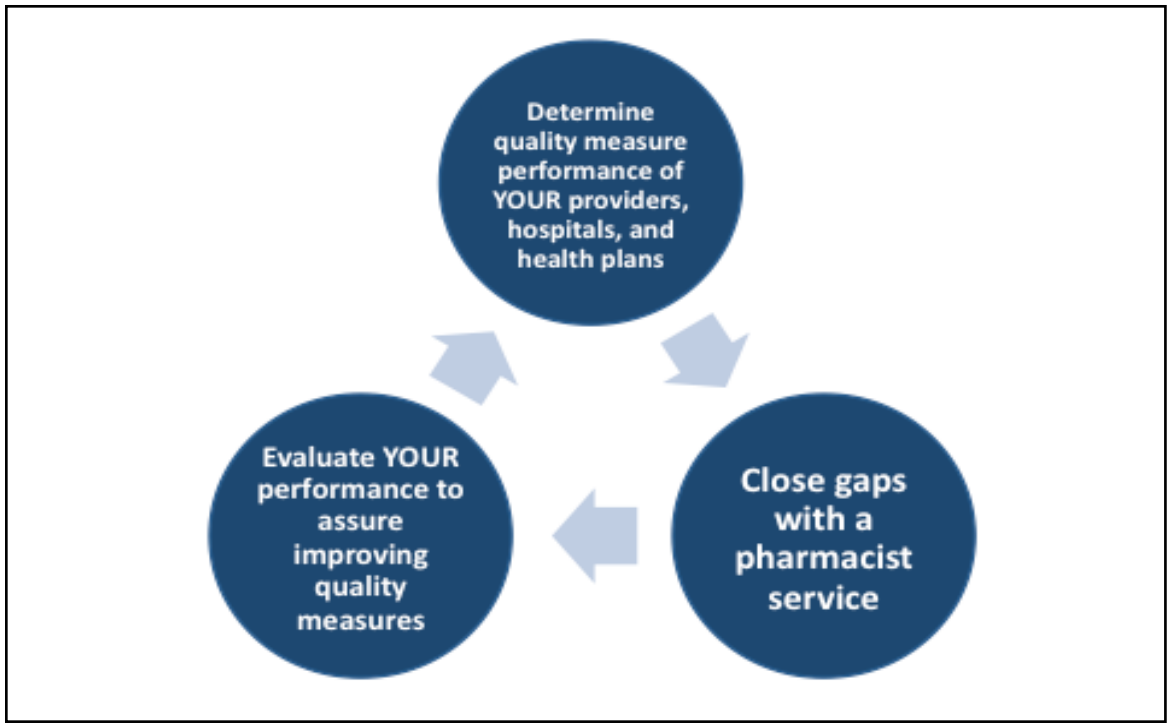
pursue four tracks simultaneously: (1) establishing policy and procedures, (2) addressing legal issues, (3) establishing billing processes, and (4) operationalizing the pharmacist service.[8] The rationale for addressing these four tracks concurrently is that each typically takes three to five months. If done sequentially, the timeline for implementation extends to 12–20 months. While the pharmacist champion can assist with these tasks, the pharmacist conducting the service is best suited to lead these processes. For example, if a collaborative drug therapy management protocol needs to be developed in collaboration with referring physicians, the clinical pharmacist is in the best position to describe the service, answer questions, address concerns, work on drafts that are amenable to all parties, and begin laying the groundwork for building a trusting collegial relationship.

(8) Measure outcomes. Implementation of the Affordable Care Act[1] has centered health systems, hospitals, physician groups, payers, patients, and supporting industries on achieving specific quality measures. Because of the associated financial rewards and penalties, astute health care stakeholders have made attainment of these quality measures a top priority. There has never been a more opportune time to develop and expand ambulatory care pharmacist services. It is paramount to align measurement of outcomes with benchmarks that are important to other health care stakeholders, not just measure traditional pharmacy benchmarks (such as number of interventions, number of recommendations accepted, number of patients seen, etc.), which do not translate directly to dollars saved or gained.

Collecting outcomes is critical to establishing a sustainable business model. Without collecting outcomes, the value proposition cannot be demonstrated. As illustrated in Figure 4 on the next page, continued success is a result of continuous improvement.

In addition to being interested in which patient-centered services are superior in

Figure 4. *The long-term success of an ambulatory care pharmacy service hinges on its ability to continuously close gaps in the quality of health care.*



attainment of quality measures, payers are keenly focused on which business models produce a positive return-on-investment (ROI). For example, a new MRI machine may provide increased quality images, but is the $1 million price tag worth the investment? That is, are the higher quality images going to yield increased cost savings that surpass the cost of the equipment? Likewise, the clinical value of pharmacist services must be translated into economic value (i.e., reducing total pharmacy costs, total medical costs, or total health care costs *beyond* the cost of the service). If internal resources to conduct such analyses are limited, consider partnering with college faculty members who have the necessary expertise, retain a consultant, or ask a payer for assistance. Establishing and marketing specific pharmacist services that produce a positive ROI will drive expansion of pharmacists as recognized providers.

On the horizon

Future developments in health care delivery and payment might further strengthen prospects for the financial sustainability of ambulatory care pharmacist services. Such developments might include provider recognition for pharmacists under Medicare Part B, expanded state Medicaid program recognition of pharmacists as providers, or additional P4P quality measures that pharmacists are prepared to help achieve. The growth of ambulatory care pharmacist services depends on practice leaders being able to clearly articulate the value proposition for these services in the context of the prevailing health care payment and delivery systems.

Conclusion

Innovation in health care is in high demand, and pharmacy is well positioned to meet the demand related to ambulatory care. Ambulatory care pharmacy faces a "3D" imperative:

1. *Develop* sustainable business models,
2. *Determine* which services yield a positive ROI, and
3. *Demand* payment for services.

References

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3. Centers for Medicare & Medicaid Services. Accountable care organizations. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/ (accessed 2013 Oct 28).
4. Centers for Medicare & Medicaid Services. Meaningful use of the electronic medical record. www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html (accessed 2013 Oct 28).
5. Centers for Medicare & Medicaid Services. Hospital value-based purchasing. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing (accessed 2013 Oct 28).

6. Centers for Medicare & Medicaid Services. Physician quality reporting system. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/ (accessed 2013 Oct 28).
7. Centers for Medicare & Medicaid Services. Five-star quality rating system. www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html (accessed 2013 Oct 28).
8. Kliethermes MA, Brown TR, eds. Building a successful ambulatory care practice: a complete guide for pharmacists. Bethesda, MD: American Society of Health-System Pharmacists; 2012.

Appendix A—Billing Resources*

General

- Kliethermes MA, Brown TR, eds. Building a successful ambulatory care practice: a complete guide for pharmacists. Bethesda, MD: American Society of Health-System Pharmacists; 2012.
- Physician-based outpatient clinic—look up recognized provider professional fee reimbursement rates (determined annually): www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx, click "accept," mark PRICING INFORMATION, RANGE OF HCPCS CODES, and SPECIFIC LOCALITY; enter HCPC as "99211–99215," choose modifier as "all modifiers," and choose carrier/MAC locality (example, "St. Louis, MO")
- Hospital-based outpatient clinic—look up hospital outpatient prospective payment system (HOPPS) APC reimbursement rates (determined annually): www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html, select most recent quarter Addendum B (i.e., January 2014), click related links "Addendum B," click "Accept," Excel spreadsheet pops up, Under column A, search HCPCS code G0463

Diabetes Self-Management Training/Education

- www.diabeteseducator.org/export/sites/aade/_resources/pdf/research/Diabetes_Education_Services6-10.pdf
- www.medicare.gov/coverage/diabetes-self-mgmt-training.html

CMS Annual Wellness Visit

- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf
- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8107.pdf
- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8153.pdf

CLIA-Waived Lab

- www.cms.hhs.gov/CLIA/

- www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfclia/testswaived.cfm

Medication Therapy Management

- www.ashp.org/DocLibrary/Advocacy/ProviderStatusPrograms.aspx

- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8153.pdf
- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8153.pdf
- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8153.pdf

Incident to Physician

- CMS Manual Chapter 15, section 60
  www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- Hospital Outpatient Prospective Payment System, CMS Manual Chapter 6, Section 20.5.2
  www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf

Transitional Care Management

- www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- www.aafp.org/dam/AAFP/documents/practice_management/payment/TCM30day.pdf
- www.ashp.org/menu/News/PharmacyNews/NewsArticle.aspx?id=3885

*All websites were accessed October 28, 2013.

Appendix B—Pro Forma Financial Projection Worksheet for a Hospital-Based Outpatient Clinic[a]

A. Revenue projection for established pharmacist clinic

- Number of patient visits per ½ day clinic per week (0.1 FTE) = _____
- For 5 full days of clinic per week (1.0 FTE): _____ visits per ½ clinic/week X 10 = _____ visits/week X _____weeks patients seen in clinic per year = _____ maximum visits per year
- Assuming _____% of patient no-show for visits = _____ estimated number patients visits per year

B. Payer mix for estimated patient visits per year_____

	Reimbursement	Sub-Total
Medicare ___% = _____ bill G0463 average	$[a]_____	$_____
Medicaid ___% = _____ bill 99212 average	$[b]_____	$_____
Commercial ___% = ____ bill 99212 average	$ [b]_____	$_____
Self-Pay ___% =_____ bill 99212 average	$0.00_____	$0.00_____
Self-Insured Employer___% bill/fixed payment	$_____	$_____

<u>Total</u> Projected Service Revenue $

[a]Look up Medicare payment rate: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html, select most recent quarter Addendum B (i.e. January 2014), click related links "Addendum B," click "Accept," Excel spreadsheet pops up, Under column A, search HCPCS code G0463

[b]To determine payment rate, contact reimbursement staff at local organization or respective payer.

This worksheet may be used for any hospital-based outpatient pharmacist clinical service that meets incident to physician criteria. Of note, this does not include medication therapy management services as defined by CMS.