Financial implications of pharmacist-led Medicare annual wellness visits

Irene Park, Susan E. Sutherland, Lisa Ray, and Courtenay Gilmore Wilson

Abstract

Objective: To determine if pharmacist-led Medicare Annual Wellness Visits (AWVs) are a feasible mechanism to financially support a pharmacist position in physicians' offices.

Setting: Large, teaching, ambulatory clinic in North Carolina.

Practice description: The Mountain Area Health Education Family Health Center is a family medicine practice that houses a large medical residency program. The Department of Pharmacotherapy comprises five pharmacists and two pharmacy residents providing direct patient care.

Practice innovation: In April 2012, pharmacists began conducting Medicare AWVs for patients referred by their primary care physicians within the practice.

Main Outcome Measures: Visit reimbursement, annual revenue, number of patients who must be seen to cover the cost of a pharmacist's salary.

Results: A small practice requires all eligible Medicare patients to complete an AWV to generate enough revenue to support a new pharmacist position. A medium-sized practice requires a 54% utilization rate, and a large practice requires an 18% utilization rate. Two additional AWVs per half-day of clinic are needed to support an existing pharmacotherapy clinic. A total of 1,070 AWVs per year are required to support a pharmacist's salary, regardless of practice size.

Conclusions: AWV reimbursement may significantly contribute to supporting the cost of a pharmacist, particularly in medium- to large-sized practices. In larger practices, enough revenue can be generated to support the cost of multiple pharmacists.

Keywords: Ambulatory care services, preventive health services, physicians' offices, reimbursement mechanisms, medical coding

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Pharmacists who work in a direct patient care role have demonstrated an impact on the management of chronic disease states.[1–9] However, most physicians' practices lack the financial resources to incorporate a pharmacist without supportive funding from an outside institution.[10,11]

Pharmacists are not presently recognized as health care providers under the Social Security Act, which significantly limits reimbursement opportunities in the outpatient setting.[12] In 2013, a coalition of 14 national organizations collaborated to advocate for federal legislation addressing pharmacy provider status.[13]

Because of the lack of provider status, a variety of complex billing techniques must be used to offset a pharmacist's salary in physicians' offices.[14,15] Typically, "incident-to" billing is used, whereby the pharmacist bills for clinical services incident to the physician via Current Procedural Terminology (CPT) Evaluation and Management (E&M) codes. Without provider status, the pharmacist must bill at Level 1 (99211, nurse visit), which has an average reimbursement rate of only $19.[14] The limited revenue-generating potential of nondispensing pharmacy services thus has remained an obstacle to including a pharmacist in physicians' offices and has necessitated innovative reimbursement models to expand pharmacy practice in this setting.[15]

At a Glance

Synopsis: Pharmacist-led Medicare Annual Wellness Visits (AWVs) may be a viable mechanism to support a pharmacist's salary in physicians' offices. This Experience paper describes the implementation and financial implications of pharmacist-led AWVs in a large family medicine practice with an established pharmacotherapy presence in North Carolina. The authors present a financial model that recommends the number of patients the pharmacist must see in a half-day to generate sufficient annual revenue to offset the cost of the position. An extended analysis also offers recommended numbers for small, medium, and large theoretical family practices. Overall, the authors' analysis demonstrates that pharmacist-led AWVs can potentially generate sufficient revenue to recoup the cost of a pharmacist in physician offices of varying sizes.

Analysis: *Pharmacists are not currently recognized as health care providers under the Social Security Act, which limits reimbursement potential and impedes the ability to establish outpatient clinical pharmacy services. The Affordable Care Act of 2010 presents a unique opportunity for higher reimbursement than that traditionally available via AWVs. By conducting wellness visits, pharmacists can be both valuable assets to the primary care team in practices of varying sizes and generators of revenue to support their positions.*

Consistent with its focus on preventive care, the Patient Protection and Affordable Care Act (ACA) introduced the Annual Wellness Visit (AWV) in 2011 at no cost to Medicare beneficiaries.[16,17] Patients are eligible to receive the AWV once every 12 months, beginning 1 year after their initial Part B coverage.[18] The language of the ACA affords any health professional, including pharmacists, who work under the supervision of a physician, the opportunity to conduct these visits, regardless of provider status.[18] The Centers for Medicare & Medicaid Services (CMS) published a useful guide for completing initial and subsequent AWVs, which is available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf.

Required elements of these visits include completion of a health risk assessment, development of a personal prevention plan, and individualized health advice.[18] With little information gathered from the patient before the visit, a single provider can expect to complete all elements within 30–60 minutes. Because a complete medication review is required, pharmacists are uniquely suited to conducting AWVs.[18,19] The visits generate substantially more revenue than current billing models and at the same time afford Medicare patients the opportunity to have an annual comprehensive medication review by a pharmacist.

Objective

In this article, we analyze whether pharmacist-led AWVs are a viable mechanism to financially support the salary of a pharmacist in physicians' offices.

Setting

The Mountain Area Health Education Center (MAHEC) is a large family medicine practice providing care for 15,000 patients in western North Carolina.[14,20] Its multidisciplinary staff includes 17 faculty physicians, 27 family medicine residents, 5 faculty pharmacists, 2 pharmacy residents, and 3 behavioral medicine faculty. In 2010, MAHEC was recognized as a Level 3 Patient-Centered Medical Home by the National Committee for Quality Assurance.

Pharmacists at MAHEC have doctor of pharmacy degrees and are residency-trained. They work together with physicians under North Carolina's Clinical Pharmacist Practitioner (CPP) collaborative practice agreement, which allows them to independently initiate, adjust, and discontinue medications.[21] Under this practice model, CPPs provide disease state management in pharmacotherapy, anticoagulation, transitions-of-care, osteoporosis, and wellness clinics.

Practice innovation

Physicians at MAHEC began conducting AWVs in 2011. These visits proved challenging to complete within the