



Opportunities for Sustainable Pharmacy Services in Federally Qualified Health Centers (FQHCs) Date of Publication: April 2017

The intent of this resource document is to introduce opportunities for pharmacy services and billing in an FQHC. This document **highlights** practice sites currently providing and billing for services in an FQHC rather than providing thorough explanations of each service or billing guidelines. If you would like more information on how a practice site implemented or bills for a service or have additional questions, please contact the site directly via the contact information specified.

Disclaimer: ASHP is not responsible for verifying the legality of these billing practices. Be sure to work with your billing manager to determine what is allowable for your practice in your state.

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Introduction

What is an FQHC?

FQHC's are "safety net" providers, and include:

- Community health centers
- Public housing centers
- Outpatient health programs funded by the Indian Health Service
- Programs serving migrants and the homeless

Their primary purpose is the provision of primary care services in underserved urban and rural communities.

What requirements for FQHC's are different from other traditional practice models?

- An FQHC is unique only in the way it is paid for services eligible for an encounter payment, not by the scope of coverage for which it is paid.
- Participating FQHCs receive an encounter payment under the Prospective Payment System (PPS) from the Centers for Medicare & Medicaid Services (CMS) that includes medical services, supplies, and the overall coordination of the services provided to the agency client. This amount is based on reasonable costs as reported on its annual cost report, and is different at each FQHC.
- Since payments to FQHC's come from CMS, only those practitioners who are recognized as "Health Care Providers" by CMS can bill directly for services. The Centers for Medicare & Medicaid Services has clarified that physicians may bill Medicare for a Part B covered service provided by a pharmacist in the practice as long as all of the incident-to rules are otherwise met. Therefore, while pharmacists can provide services such as Annual Wellness Visits (AWV's) at FQHC's, they must be billed by the physician in order to be reimbursed. This is similar to the process utilized with medical residency programs where medical residents see the patients with Medicare insurance, but the attending physician (who is the recognized provider by CMS) also goes in to briefly talk with the patient during the visit, provides general supervision to the visit, and is then the provider who bills for the visit.
- FQHCs must offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Additional Resources/Information on FQHC's:

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>
- <https://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>
- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>

Medication Therapy Management (MTM) (OutcomesMTM, Mirixa, other)

Health Partners of Western Ohio (HPWO)

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How is this service being used in your practice?

MTM services are incorporated into both our clinical pharmacy practice and our in-house dispensing pharmacy practice. All pharmacists are using both OutcomesMTM and Mirixa portals for billing.

Requirements unique to the use of the MTM billing portals in an FQHC: N/A

Clinical Pearls:

You must get leadership support, provider champions, and meet patients where they are. Ask what patients and providers want help with and grow from there. It is about building relationships and working as a team with the patient to reach health goals.

Roadblocks:

The hardest part was integration into the traditional care team. Once the providers have a pharmacist on their care team, they do not want to go a day without them.

Role of Resident and Students:

Our site currently has a PGY1 residency. The residency has a dispensing and ambulatory care experience integrated into the program. The resident is able to complete some of the MTM work. However, the program is not dependent on the resident as we also employ full time clinical pharmacists. We also host students on rotation most months in both community pharmacy and ambulatory care experiences. Each new student needs trained on our system each month, which takes a pharmacist away from patient care. This makes it difficult to fully embed the students into our workflow and depend on them for sustainability.

Recommended Resources:

We participated in a Health Resources and Services Administration (HRSA) collaborative years ago that really helped move us forward. At the time the collaborative was called Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) and is now called Alliance for Integrated Medication Management (AIMM).

Medication Therapy Management (MTM) (OutcomesMTM, Mirixa, other)

PrimaryOne Health

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How is this service being used in your practice?

MTM services are one of the programs offered by our clinical pharmacists. We are using the OutcomesMTM portal for billing. In Ohio, one of our managed Medicaid plans contracts with OutcomesMTM, which has been a great opportunity for our pharmacists to seek reimbursement for our services. We proactively identify patients from the clinic schedule that are eligible for comprehensive medication reviews (CMR) or targeted interventions so that we are able to offer these services to patients when they are already in the office.

Requirements unique to the use of the MTM billing portals in an FQHC:

Billing requirements for these services do not differ in the FQHC setting compared to other settings. The billing is done through the OutcomesMTM portal, which allows the pharmacist to bill for services rather than utilizing the billing department. This is a great opportunity for an initial service because of this benefit.

Clinical Pearls:

Consider what workflow is going to work best for your environment. Our patient population has a high no show rate, so we knew that investing the time to contact patients and schedule patients to come in for this service might not be the best method for recruiting patients. Offering the service at the time of their provider appointment created a lot of efficiencies for implementing the service. We are often able to complete a CMR with a patient, identify medication-related problems, discuss them with the provider, and get them resolved all within the same amount of time that the patient would have spent in the clinic anyways. The providers appreciate that we take the time to review medications with the patients in detail and this allows them to focus on other issues during their time with the patient.

Roadblocks:

Finalizing the contract was the most time-consuming process for us. I would recommend setting up a face-to-face meeting with decision makers to describe the service and why it is beneficial to the practice and the patients. Include the lawyers or other decision makers who will be reviewing the contract in this meeting so if they have concerns, they can be addressed up front.

Role of Resident and Students:

We have a PGY2 Ambulatory Care resident at PrimaryOne Health, as well as IPPE and APPE students. All trainees are trained on our EHR system and the OutcomesMTM system. IPPE and APPE students are responsible for identifying eligible patients for that clinic day and reviewing patient information in the EHR and OutcomesMTM portal to prepare for the CMR. The resident and/or clinical pharmacist preceptor will review the student's work-up prior to seeing the patient and the visits are led by the student or pharmacist depending on where students are within their rotation month. Utilizing the students to identify these billing opportunities frees up resident and pharmacist time to work on other clinical activities.

Recommended Resources:

American Pharmacists Association MTM Resource Library: http://www.pharmacist.com/mtm_library

340B Pharmacy

AxessPointe

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How is this service being used in your practice?

One pharmacy serves all five clinics, with plans to add two new pharmacies in two different clinics. Having the pharmacy within the clinic ensures that the clinic has access to pharmacists' expertise.

Does this service support the sustainability of other pharmacy services?

Over 90% of the revenue generated by the pharmacy department comes from the 340B pharmacy program. The savings created by the 340B pharmacy is used to support the pharmacy department's clinical services, without the savings the other services would not be supported.

Clinical Pearls:

Making sure that management understands that the 340B program is not just another revenue source and that the savings generated by the 340B program are needed to expand other clinical services including pharmacy services. Explaining to management that these expanded clinical services can improve patient outcomes, improve provider satisfaction and help with provider recruitment is critical. Also, the improved pharmacy clinical services have the potential to increase patient capture rate. For the 340B pharmacy to produce a healthy stream of revenue, the pharmacy needs to retain the insured patients who can fill their medications at traditional community pharmacies. These patients see the value in the pharmacy services offered and are willing to overlook the fact that the 340B pharmacy has only one location with limited hours of operation. Since the 340B pharmacy is located inside the clinic, we have access to the clinic's electronic medical record (EMR), which allows for us to better capitalize on our existing standing relationships with the other providers in the clinic. The EMR and existing relationships are competitive advantages that we have which allow for us to take better care of our patients. Some clinics like to impose a clinic formulary. Often, providers do not like this restricted formulary and it may hinder them from seeing pharmacy as a helpful resource. At our site, we provide monthly, hour-long in-services with the other providers to explain the medication use process and why certain medications are preferred. These in-services additionally assist the pharmacists when they are looking to make therapeutic interchanges due to cost. They have made significant changes to the clinic's prescribing patterns, increased savings seen by the clinic, while also improving patient outcomes.

Roadblocks:

There were no major roadblocks when implementing this service. There are numerous tools available to assist in opening a 340B pharmacy. However, if you establish the 340B pharmacy without existing clinical pharmacy services, it may be more difficult to implement them afterwards. Since I was already a clinical pharmacist, I was able to connect the 340B pharmacy and other clinical services together, both helping to support each other.

Role of Residents and Students:

Within the first four months of residency, residents are heavily involved with the 340B pharmacy. The residents have helped expand the 340B program and other pharmacy services offered. They currently staff one day a week, which helps to stretch the limited resources of the pharmacy. The residents benefit from the experience, however you need to be able to provide the precepting, structure and support to help the resident succeed. We also currently have 3rd or 4th year students on rotations, but due to our limited hours, we are not able to hire interns.

Recommended Resources:

- Peer to Peer - <http://www.hrsa.gov/opa/peertopeer/index.html>
- Apexus 340B University - <https://www.apexus.com/>

340B Pharmacy

Health Partners of Western Ohio (HPWO)

Jenny Clark, PharmD

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How is this service being used in your practice?

We currently operate four in-house pharmacies and manage five contract pharmacy arrangements.

Does this service support the sustainability of other pharmacy services?

We use the savings generated from the 340B pharmacy to help support our clinical pharmacy services.

Clinical Pearls:

The 340B program is vital to the organization and the health of our patients. Patients must have access to affordable medications. Even though Ohio is a Medicaid expansion state, there are still a great number of patients that fall thru the cracks of healthcare coverage. Our patients receive a tremendous discount on medications based on household size and income. Without this program, many of our services at HPWO would not be viable.

Roadblocks:

The biggest roadblock is getting the program started on a firm foundation of support for quality and integrity. There are specific regulations with the 340B program and it is important that the entity is responsible for the integrity of their 340B program. The responsibility of a good program should not be outsourced.

Role of Residents and Students:

Students come through rotations but we do not depend on them for sustainability.

Recommended Resources:

- HRSA's Peer to Peer Program - <http://www.hrsa.gov/opa/peertopeer/index.html>
- Apexus - <https://www.340bpvp.com/controller.html>
- LinkedIn - The 340B Resource Network
- HRSA Office of Pharmacy Affairs - <http://www.hrsa.gov/opa/index.html>

340B Pharmacy

Penobscot Community Health Care
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How is this service being used in your practice?

We operate 340B pharmacies, which generate revenue to pay for all our clinical pharmacy services.

Requirements unique to 340b pharmacy in an FQHC:

As an FQHC, we are less restricted than the hospitals, because FQHCs are not restricted by the group purchasing organization (GPO) or Orphan Drug exclusions.

Clinical Pearls:

Taking ownership of the 340B program operations and compliance was a large undertaking, but it allows for the C-suite to see a direct line between resources generated by the 340B program and the pharmacy department. This makes it an easier sell when requesting that the 340B resources be allocated to the pharmacy department.

Role of Residents and Students:

PGY1 residents are involved in the 340B program through their staffing and administrative rotations. The PGY2 Health-System Pharmacy Administration (HSPA) residents are involved as well longitudinally.

Recommended Resources:

- Apexus: 340BUniversity, 340BU On Demand, 340BPVP.com
- APhA Peer to Peer Mentor program

Spirometry

Community Health Centers of Greater Dayton

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How is this service being used in your practice?

Codes being used to bill Spirometry	
Code	Definition
94375	Respiratory Flow Volume Loop
94060	Pre and Post Spirometry: Bronchodilation responsiveness, pre-and post-bronchodilator administration

Requirements unique to the use of these codes in an FQHC:

None that I am aware of.

Clinical Pearls:

In hindsight, a better model may be combining the pharmacy visits with other provider visits to allow for a higher level of billing and reimbursement. However, this would be difficult at our clinic because we work closely with medical residents. The procedure codes for spirometry do not require another provider in the room and can be completed by medical assistants or LPNs. The difference with a pharmacist providing this service is that, as a pharmacist, you can make a recommendation to the provider about the plan while also providing asthma, COPD, and smoking cessation counseling depending on what is indicated. If there is counseling involved with a documented assessment and plan, billing a 99211 in addition to the procedure codes may be justified.

Roadblocks:

The biggest roadblocks are often getting everyone to agree on the interpretation of billing rules. This challenge is often overcome by trying to come to terms with what the laws and/or rules actually mean. Specific to spirometry, I do not think there were really any roadblocks while implementing this service because the procedure codes for spirometry are pretty straightforward.

Role of Residents and Students:

Residents and students often see the patients and present them to me.

Recommended Resources:

The following link takes you to a 2016 CPT® and ICD-10-CM code and reimbursement information FAQ sheet. This document lists out the different CPT® codes related to spirometry, when to use what code, and the description of the service.

- <http://www.midmark.com/docs/default-source/marketing-collateral/007-1120-00.pdf?sfvrsn=2>
- http://www.jonesmedical.com/pdf/Jones_Spirometry_Reimbursement_Guide_2015.pdf

Chronic Care Management (CCM) Codes

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How is this service being used in your practice?

We are working on the implementation process now. Currently, we are looking at having a documentation log for all health care providers to track time spent outside of visits, including pharmacists, to accumulate to the 20 minutes required for the code billing. After the requirements have been met, the designated billing staff member will submit the code.

Requirements unique to the use of these codes in an FQHC:

These codes were not eligible to be billed by FQHCs until January 1st, 2016.

Clinical Pearls:

Start planning early. We found out late in 2015 that we were not eligible to begin billing January 1st 2016. However, if we had been eligible, we would not have been ready to start this service. The enrollment requirement of patients for the service is time consuming and we will be ramping up in the months leading up to our go-live in 2017.

Role of Residents and Students:

Yes, residents will be incorporated into the service with the documentation of their time. We provide numerous consults to the other providers each week. The time spent on these consults will contribute to the time needed for CCM billing.

Diabetes Self-Management Training (DSMT)

El Rio Community Health Center

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Code	Definition
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes

How is this service being used in your practice?

Advanced practice pharmacists conduct 30-60 minute appointments for diabetes management in a one-on-one setting. After seeing the patient, the pharmacist will submit the code.

Requirements unique to the use of these codes in an FQHC:

To bill for these codes, you must have Medicare accreditation to administer Diabetes Self-Management Training (DSMT). Accreditation can be obtained through either the American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE). In an FQHC, only services provided to individuals (as opposed to a group setting) are reimbursed. The pharmacists billing for these encounters must receive 15.0 units of diabetes-specific continuing education annually.

Clinical Pearls:

Our organization has both AADE and ADA accreditation, but only one is needed to receive reimbursement from Medicare. We recommend having a template built within your electronic health record for documentation purposes. This can house your referrals into the program, patient self-assessment, patient readiness to learn, your assessment, goals, barriers to care (social, financial, etc.) and your annual quality improvement project. We also recommend having a designated program coordinator to keep the program in compliance and utilizing a data analyst who can pull and build reports for annual review.

Reimbursement for DSMT services are provided for a continuous 12 month period or less. A maximum of 2 hours is reimbursed each additional calendar year.

Role of Residents and Students:

Residents and students complete the DSMT assessments needed for compliance. Residents can also be used in development and implementation of your annual quality improvement project.

How Billing Differs from Other Practices:

An FQHC cannot bill for group visits. There must also be a reason for one-on-one visits in an FQHC, which may relate to a language barrier, need in an underserved population, physical disability, etc.

Recommended Resources:

The following link takes you to a document designed by the Indian Health Service to assist programs in setting up DSMT services.

- https://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Resources/InstantDownloads/DSMT_Guidebook_508c.pdf

Diabetes Self-Management Training (DSMT)

Primary Health Care Inc. East Side Clinic

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Practice Site Information:

Primary Health Care Inc. consists of five FQHC clinics in the central Iowa area. The East Side Clinic is a Level 2 Patient-Centered Medical Home. Currently, working on payment through quality-based measures.

How is this service being used in your practice?

Clinical pharmacist and IPPE/APPE students conduct 30-60 minute appointments for diabetes management in a one-on-one setting. Data is tracked on all patients that finish DSME/S in the clinic.

Clinical Pearls:

Quality-based payments are in their infancy stages; we are still working out a formula to assess how much of the quality-based payment comes to the clinical pharmacy/diabetes education office. For example: Our A1C quality indicator is to have HbA1C at <9% in 75% of our population. Our current quarterly data, we have seen an uptake in providers utilizing quality guidelines that we have built and our quality indicator is at 63%. This has increased from the 2015 data. The negative with quality-based payment is that it is SLOW and retrospective. The positive is that we are seeing better control of our diabetes population as a whole, they are receiving education on a regular basis and we have had better adherence to standards of medical care.

Role of Residents and Students:

IPPE students are given the opportunity to direct interviews with preceptor overview. APPE complete the DSMT assessments needed for compliance. We do not have residents at this time.

Recommended Resources:

- <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html>
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>

Other Potential Opportunities for Pharmacists and Billing

1. Complex Care Management (add on codes to CCM, approved 1/1/17)
 - a. Initial 60 minutes CPT 99487
 - b. Additional 30 minute increments CPT 99489
2. Annual Wellness Visits (AWV)
 - a. Initial AWV G0438
 - b. Subsequent AWV G0439
3. Transitional Care Management (TCM)
 - a. Moderate medical decision complexity – visit within 14 days of discharge CPT 99495
 - b. High medical decision complexity – visit within 7 days of discharge CPT 99496
4. Shared savings or risk reduction contracting
5. Pharmacists and FQHC can negotiate payment with any commercial plan directly for pharmacy services
6. FQHC contracting pharmacist services with self-insured groups or Indian tribes that are not participating with Indian Health Service (IHS)
7. Opportunities for pharmacists to bill patients directly or work on quality improvement programs to sustain a pharmacist in that practice (Ex. FQHCs part of an ACO or PCMH that require quality improvement projects)

If you are participating in any of the identified opportunities above and willing to contribute to this document, please contact _____.

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