CHAPTER 7

Generating Revenue Through Healthcare Reimbursement

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INTRODUCTION

Ambulatory care pharmacists have more opportunities to build successful and sustainable practices than ever before. Healthcare reform has highlighted the need for accountable care and pharmacists across the country are responding through integration into healthcare teams. Interdisciplinary teams with pharmacists have demonstrated improved health outcomes, increased patient safety, and measurable quality interventions all resulting in decreased healthcare costs.[1] Many payers are quickly adopting outcomes-based reimbursement in the place of traditional fee-for-service. Despite these successful practices and potentially positive shifts in reimbursement models, reimbursement and sustainability continue to pose a significant barrier to ambulatory pharmacists' delivery of care. Knowledge of healthcare billing and pharmacist ability to generate revenue from their services are critical to creating a successful practice.

Chapter Objectives

- Compare reimbursement opportunities for ambulatory pharmacists based on practice setting, including physician-owned, hospital-based, community and Federally Qualified Health Centers (FQHCs).
- Review the most common revenue generating models for ambulatory pharmacist services, including incident-to, facility fee, medication therapy management (MTM), and employer-sponsored wellness programs.
- Explain how alternative routes of revenue generation, such as grants, demonstration projects, and relative value units (RVUs), can be used when creating a pharmacist service.

PAYERS IN HEALTHCARE

To understand pharmacist revenue generation potential for patient care services, first it is important to recognize who are the payers and what the payer mix is for the patient population receiving your services. In the United States, healthcare payers may be categorized into four major groups:

1. Commercial
2. Federal government
3. State government
4. Self-pay

Although self-pay is possible, it is not common or conducive for sustainability in most situations and will not be discussed in this chapter. Based on 2016 data obtained from the American Medical Association (AMA), the typical payer mix for primary care and multispecialty clinics is 43.4% commercial, 29.4% Medicare, 16.9% state Medicaid, and the remaining composed of smaller healthcare payers, such as worker's compensation, self-pay, etc.[2] With that said, the payer mix may differ based on your practice site location. If the patients receiving your service are from a low-income urban or rural community, Medicaid may have a greater presence. For services provided in an upscale location with a younger population, commercial payers may dominate the payer mix. In most clinics, Medicare is the single largest payer and a reason Medicare processes dominate healthcare billing.

COMMERCIAL PAYERS

Although commercial payers are lumped into one category they are comprised of multiple separate entities with numerous and differing benefit plans that vary within individual states and across the nation. Because of variability in reimbursable services within the many benefit plans, it is difficult to give specific guidance other than to encourage you to work with your organization to identify the plans that predominate as insurers for patients you serve. Commercial payers may develop and use any billing model they wish; however, most use the Medicare billing model as a standard. Organizations and providers may negotiate specific contracts with commercial payers to cover the services provided with agreed-upon service billing codes or use a more general process where providers are credentialed by the payer to submit billing codes for their services. If your organization has a large non–Medicare-insured population, the compliance officer in your organization is responsible for understanding the billing process of the payers with which your organization does business. This is a good reason for you to get to know your compliance officer. Of note, business models differ between commercial and government payers in that commercial payers are risk adverse in the management of their plans, whereas government payers exist to manage high-risk patients such as seniors and those who are medically disabled. To manage risk, benefit coverage varies across the types of payers based on the risk of populations they insure. The common types of commercial health insurances are listed in **Table 7-1**.