STRATEGIES FOR PROFITABLE CHRONIC CARE MANAGEMENT

Amina Abubakar, PharmD AAHIVP
CEO, Rx Clinic Pharmacy
President, Avant Institute

Objective 1
1. Describe the importance of the CMS initiatives for the quadruple aim and how pharmacist-led clinical services meet and exceed the needs of innovative models of care, such as, value-based payment models, and the Quality Payment Program
2. Discuss strategies for sharing your value as a pharmacist to potential collaborators
3. Explain the rules for billing and documenting CCM encounters for a successful and sustainable CCM program

Quadruple Aim Goals of CMS

- Improving Patient Care
  - Patient Safety
  - Quality Patient Experience
- Efficient Care & Reducing Cost
  - Reduce Unnecessary Cost
- Improve Population Health
  - Decrease Disparities
  - Improve Community Health Status
- Satisfied Providers
  - Decrease burn out
  - Improved work-life experience


The Collaborative Relationship

Pharmacist Does the Work  Physician Bills for the Work  Shared Revenue

Speaker Disclosure Statement

Amina Abubakar has no actual or potential relevant conflict of interest that might bias and/or impact the content of the presentation.
How are pharmacist-led clinical services making an impact for Medicare providers?

- 271 Quality Measures
- Most: 6
- Groups: 15
- Medicare Annual Wellness Visit
- 30 measures addressed
- Chronic Care Management
- At least 7 linked to appropriate medication therapy management
- Transition of Care Management
- Osteoporosis Screening
- Urinary Incontinence Screening
- Adult MDD: Suicide Risk Assessment
- Colonoscopy Screening
- Breast Cancer Screening
- Medication Management
- STD screening
- Cognitive Assessment
- Fall Risk Assessment
- Tobacco cessation Counseling
- Osteoporosis Screening
- Urinary Incontinence Screening


Which aim of the quadruple aim would be addressed by the influenza vaccination?

A. Improving patient care
B. Efficient care and reducing cost
C. Improving population health
D. Satisfied providers

CMS Quality Performance: 2017 performance Data

Which aim of the quadruple aim would be addressed by the influenza vaccination?

A. Improving patient care
B. Efficient care and reducing cost
C. Improving population health
D. Satisfied providers

A Peek Into A Primary Care Practice
How can the clinic afford clinical pharmacy services?

Now that they have the "buy-in" How would you answer this question?

Creating Your Value Proposition

Pharmacist-Led Clinical Services

- Diversifying their clinical team
- Penalty Avoidance for Clinic Meeting MIPS & Incentives
- Quality & Engagement
- Increased Revenue
- Decreased Government Health Spending

A. Share the value of decreased government health spending
B. Share the value that can be produced through achievement of higher MIPS scores
C. Share the value of diversifying their clinical team
D. All of the above

Which of the following is an example of how to share your value to potential collaborators?

- Direct Supervision - physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Does NOT mean the physician must be present in the room.
- General Supervision - procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required

Types of Practitioner Support

- Incident-to regulations require direct supervision
- CCM is exempt from this regulation and can be provided under general supervision

Chronic Care Management (CCM)

- Non-face-to-face of clinical staff time directed by a physician or other qualified healthcare professional (QHP) per calendar month
- Must have at least 2 chronic conditions or episodic health conditions that are expected to last at least 12 months, or until death
- Chronic conditions place a significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive Care Plan and monthly log of activities
- Can be used for follow up on AVVs
- General Supervision
- Potentially coordinated with Med Sync Calls

Chronic Care Management: Other Requirements

- Certified EHR Technology
- Does the care plan need to be housed in a Certified CCM Technology?
- Medical Practice must have 24/7 “access to care”
- Only contracted time from clinical staff and providers counts
- Must document verbal consent from patient to enroll in CCM
- Welcome them to the program, explain details
- Explain copays
- Unenroll at anytime – must let the clinic know
**Chronic Care Management (CCM): Billing**

- **CY 2018 Codes**
  - 99490 – Non-complex CCM, 20 mins (2019 PFS $38.41-$44.17)
  - 99487 – Complex CCM, 60 mins (2019 PFS $84.11-$96.73)
  - 99489 – Additional Complex CCM, +30 mins (2019 PFS $42.06-$48.37)
- **New CY 2018 Code**
  - 99491 – CCM provided personally by a physician or QHP
    - PFS $76.97-$88.52
  - At least 30 mins of professional time per calendar month
  - May not be billed with the other CCM codes
  - Only one clinician can furnish during a calendar month
  - Usually PCP
  - Some specialist may be serving as the patient’s PCP
  - Must have had E&M, AWV or IPPE prior to billing a CCM
  - Copays and deductibles DO apply
    - Consider on the dual eligible or patients with supplemental plans

**Notes:**
- If time such as a phone call, leads to an office visit resulting in an E&M charge, that time would be included in the billed office visit, NOT the CCM time.

**Care Plan documentation is different than the monthly log documentation**

- Use templates in EHR or CCM software program
- Know the MUST 5 (next slide)

**Monthly log**

- WHO, when, how long and what activity
- EVERYONE logs in their non-face-to-face clinical staff time
- Document all patient education
- Prior Authorization
- Lab Call Backs
- Any coordination of care performed

**Chronic Care Management (CCM): Care Plan Documentation**

- Care Plan documentation is different than the monthly log documentation
- Use templates in EHR or CCM software program
- Know the MUST 5 (next slide)

**Monthly log**

- WHO, when, how long and what activity
- EVERYONE logs in their non-face-to-face clinical staff time
- Document all patient education
- Prior Authorization
- Lab Call Backs
- Any coordination of care performed

**Chronic Care Management (CCM): Care Plan Documentation**

- THE MUST 5

1. Needs Assessment (medical, functional, and psychosocial)
2. Preventive care services
   - List what and when services are due
   - E.g., Immunizations, routine labs, routine procedures
3. Medication reconciliation
   - Efficacy, adherence, ADR, DDI
4. Patient education including goals and expectations of therapy
5. Self-management Checklist (monitoring, diet, exercise, etc.)
6. Follow up plan for each disease state

**Clinical Integration for Effective CCM**

- Clinical staff
  - Aggregate time for the Care Team
  - Physician performs clinically necessary duties
  - Enhanced Senior Care Team
  - Clinical leadership dispensing

**CCM Care Plan Documentation: THE MUSTS**

- Five Basic Requirements for EACH Disease State
  1. Needs Assessment (medical, functional, and psychosocial)
  2. Preventive care services
     - List what and when services are due
     - E.g., Immunizations, routine labs, routine procedures
  3. Medication reconciliation
     - Efficacy, adherence, ADR, DDI
  4. Patient education including goals and expectations of therapy
  5. Self-management Checklist (monitoring, diet, exercise, etc.)
  6. Follow up plan for each disease state

**Chronic Care Management Billing Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Payment (PFS non-facility)</th>
<th>Clinical Staff</th>
<th>Care Planning Documentation</th>
<th>Billing Practitioner/Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Complex CCM (94900)</td>
<td>$43</td>
<td>20 minutes</td>
<td>Established, implemented, reviewed or monitored</td>
<td>Ongoing oversight, direction and management</td>
</tr>
<tr>
<td>Complex CCM (94875)</td>
<td>$94</td>
<td>60 minutes</td>
<td>Established or substantially reviewed</td>
<td>Ongoing oversight, direction and management + Medical decision making or care planning component</td>
</tr>
<tr>
<td>Complex CCM Add-on (94899)</td>
<td>$47</td>
<td>Additional 30 minutes</td>
<td>Established or substantially reviewed</td>
<td>Ongoing oversight, direction and management + Medical decision making or care planning component</td>
</tr>
<tr>
<td>Initiation of CCM during a visit (G0506)</td>
<td>$64</td>
<td>N/A</td>
<td>Established</td>
<td>Occasionally provided by an extensive assessment and CCM care planning beyond usual effort for the separately billable initiating visit</td>
</tr>
</tbody>
</table>
Determining Medical Decision Making (MDM)

Four levels of MDM
- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity

Level of Complexity is based on:
- Nature and number of clinical problems
- Amount and complexity of data reviewed by clinician
- Risk of morbidity and mortality to the patient

Overview for Utilizing Technicians

Technician works up 10 patients
Pharmacist Reviews 10 Cases (~1-2 hours)
Pharmacist Aggregates Team Time and Completes

Chronic Care Management (CCM): Maximizing Your Processes

Within the Pharmacy
- Run reports to find eligible patients and their provider
- Obtain a CSA with provider
- Integrated CCM process into pharmacy workflow
  - CCM group or tab in your dispensing software
  - Sync CCM calls with Med Sync Calls
- Enhanced Services Team
  - Med Sync Technician coordination with pharmacist
  - MUST document in clinic’s EMR on integrate or send care plans and logs into EMR

Within the Clinic
- Identify patients
- Run reports
- Ask clinical staff
- Enroll patients
  - Verbally over the phone and document in EHR
  - During AWV ( billed )
- Develop a process to capture all time used from all team members
- Document and bill before the end of the month

Chronic Care Management: Strategic Planning

- Create an arrangement with a Supervising Medical Provider
- Best Practice to set up a Collaborative Practice Agreement with supervising medical provider
- General Supervision
- Documented verbal confirmation from the patient is required (i.e. EHR documentation)
- Be transparent regarding Copay/Deductibles
- Consider starting service with dual eligible patients with secondary insurance coverage
- Copay ~ $8.00 / Deductible not met ~ $42
- Strategize how to capture time spent from all qualified medical staff involved in patient’s care
- Be an expert on EHR capabilities
- Templates
- Communication tracking
- Time tracking

Strategies for Profitable CCM

- Focus pharmacist’s time on complex CCM
- Utilize CCM for face to face visits

Chronic Care Management (CCM): Challenges with Implementation

- Patient engagement
- Balancing time for documentation to justify the pharmacist or technician’s time
- Identifying high risk or high touch patients in the EMR to maximize the time spent on CCMs
- Developing a system that captures time spent on patient from the provider, nurses, medical staff, clinical pharmacist, etc.
Which of the following is not a requirement of the chronic care management care plan for each chronic disease state?

A. List of specialists seen for each chronic condition  
B. Medication reconciliation  
C. Needs assessment  
D. Self-management checklist

Impact of Pharmacists in Improving Quality Measures that Affect Physician Payment

Impact of Quality Measures Performed through Pharmacist Collaboration with a Primary Care Clinic

Chronic Care Management Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Access to EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Pharmacy</td>
<td>With EHR Access</td>
</tr>
<tr>
<td>Pharmacy Embedded in the Clinic</td>
<td>Without EHR Access</td>
</tr>
<tr>
<td>Assisted Living</td>
<td></td>
</tr>
<tr>
<td>Outpatient/ Ambulatory Care</td>
<td></td>
</tr>
<tr>
<td>Independent Living</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>Non-complex CCM ONLY</td>
</tr>
</tbody>
</table>

CMS Quality Performance: A Practice we started with in 2017

In 2017, the primary care practice satisfied all six quality measure benchmarks, earning a MIPS Quality Performance Score of 60 out of 60 points.

The MIPS Quality Performance Score contributed to a Final Score of 100 out of 100 points and a total MIPS payment adjustment of +1.88% for all Medicare Part B claims submitted in 2019.

During 2018, the practice billed an average of $75,000 per month in Medicare Part B claims; extrapolating this same volume to 2019, an additional $16,920 in annual reimbursement is expected.
Potential Revenue Generated from CCM

- Clinic has 200 patients enrolled into the CCM program
- Pharmacist has 2 other days per week to work on CCMs
- Non-face-to-face 20 mins of care
- $42 per CCM
- 40 patients per week = 1,920 patients per year

Additional Resources