INTEGRATING CHRONIC CARE MANAGEMENT INTO COMMUNITY PHARMACY PRACTICE

ACPE UAN: 0107-9999-17-101-L04-P 0.1 CEU/1.0 hr

Activity Type: Knowledge-Based

Learning Objectives for Pharmacists: Upon completion of this CPE activity participants should be able to:
1. Define Chronic Care Management
2. Review how Chronic Care Management can fit into a community pharmacy practice site
3. Discuss established methods to identify and develop a prescriber partnership
4. List steps for how to complete a patient care appointment
5. Outline billing opportunities and appropriate chronic care management CPT code utilization

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Jonathan G. Marquess along with his Pharmacist wife, Pam are the owners of multiple Independent Community Pharmacies and one Long Term Care Pharmacy in Georgia. He is also the owner and diabetes educator in two American Association of Diabetes Educators (AADE)-recognized diabetes education centers in Atlanta, GA. Jonathan earned his doctor of pharmacy degree from Mercer University, School of Pharmacy in Atlanta. He also completed The International Health Care Course sponsored by the Royal Danish School of Pharmacy in Copenhagen, Denmark, the APhA’s Community Pharmacy Management Program, and is a Certified Diabetes Educator (CDE) and Certified Insulin Pump Trainer (CPT). Throughout his career, Dr. Marquess has been actively involved in local, state, and national professional organizations. He is currently serving his second term on the APCI Board of Directors. In March 2016, Dr. Marquess was awarded the Daniel B. Smith Practice Excellent Award at the APhA Annual Meeting. He is a Past President of the Georgia Pharmacy Association (GPhA) and recently completed a 3-year term on the APhA Board of Trustees. In 2012, Marquess was named Independent Pharmacist of the Year from GPhA in 2012 and the Innovative Pharmacist of the Year from GPhA in 2008.

Speaker Disclosure: Jonathan G. Marquess reports no actual or potential conflicts of interest in relation to this CPE activity. Off-label use of medications will not be discussed during this presentation.
Integrating Chronic Care Management into Community Pharmacy Practice
Jonathan G. Marquess, PharmD, CDE, FAPhA

Learning Objectives
- Upon successful completion of this activity, pharmacists and pharmacy technicians should be able to:
  1. Define Chronic Care Management
  2. Review how Chronic Care Management can fit into a community pharmacy practice site
  3. Discuss established methods to identify and develop a prescriber partnership
  4. List steps for how to complete a patient care appointment
  5. Outline billing opportunities and appropriate chronic care management CPT code utilization
Chronic Care Management (CCM)

- **The Opportunity**

  - $1.65 Trillion spent annually on patients in the US with Chronic Diseases
  - 35 million and growing Medicare patients eligible for $20B a year in untapped unmet REOCCURRING Chronic Care billing services in the United States alone
  - My pharmacy delivers chronic care management software and support services to local physician practices
  - “Chronic Care Management” has been our focus but without reimbursement outside of our dispensing revenues and diabetes education classes
  - Recently, with chronic care management as a core focus in my ten stores to grow business and improve patient outcome, we are billing and getting reimbursed by Medicare for CCM on a daily basis
Chronic Care Management (CCM)

A Few Facts

Senior Facts
• 43.1 million seniors in the U.S. – and growing
• 77% of seniors (33 million) have 2 or more chronic conditions
• Seniors account for 13% of population, consume 40% of medications
• Average senior takes 3.5 medications monthly – 42 medications, including refills, annually
• All of these patients potentially qualify for CCM services

Physician Facts
• 91 percent of physicians accept Medicare patients
• Medicare and Medicaid account for 49% of patients in the average physician practice

Improved Outcome in Proven CCM Services

• Combination of CCM & Monthly Med Sync-switching them from only dispensing to a total patient care model

• Improve trackable health measures at the same time, 10% to 90% adherence increase in our payer project in a study done by Samford University.

• Our combined CCM services is driving both maximum improved patient outcomes alongside minimum practice workflow
Chronic Care Management (CCM)

Revenue Potential

Medicare compensates $40.00 on average for monthly CCM interventions include; 8 dollars per co-pay

- Enroll 100 Medicare patients: $18,000 in new pharmacy annual revenues
- Enroll 5000 Medicare patients: $900,000 in new pharmacy annual revenues
- Enroll 20,000 Medicare patients: $3,600,000 in new pharmacy annual revenues

Chronic Care Management (CCM)

Collaborative Care Technology

- Interoperability platform
- A customized pharmacy Electronic Medical Record platform
- Integrated database
- Bi-directional data flow
- Appointment setting and real-time referral management
- Readily accessible metrics

How Patients Benefit

- Links providers regardless of EMR system
- Aggregates reporting
- Enhances communication among providers
- Provides a new level of care coordination
- Reduces conflict about reimbursement and quality measures
Chronic Care Management (CCM)

The Opportunity

• The Medicare CCM program requires 20-minute provider interventions monthly

• As a physician with a busy practice – and generally a large Medicare patient population – you may not be well equipped to provide ongoing CCM services on a monthly basis

• Community pharmacists are ideally positioned to provide monthly CCM services in support of physicians

• By partnering, physicians and pharmacists can enhance the chronic care management of seniors

• The technology facilitates this collaboration, including the documentation and billing of these services

How It Works

The physician

• Identifies potential Medicare patients for the program
• Enrolls the patients in the program
• Alerts the patient the pharmacy will follow up shortly to get them started

The pharmacy

• Provides monthly monitoring services on your behalf to enrolled patients
• Performs ongoing clinical assessments via patient surveys, medication reviews, and adherence monitoring
• We will administer regular surveys of these patients – surveys tailored to their disease state
• These services do not have to be face-to-face; surveys, other assessments can be provided by telephone by pharmacy staff
• We can also administer tests on your behalf and report the results to you
How It Works- Cont’d

The Custom EMR Software
- Is Medicare-certified
- Utilizes physician billing codes to document the services provided
- Documents the time allotted to the services to meet the 20-minute monthly requirement
- Reports the results of the services provided each month by the pharmacy to the physician

Chronic Care Management (CCM)

The Opportunity

- As of January 2015, Medicare launched a program to compensate providers for delivering chronic care management (CCM) services to seniors with two or more chronic conditions.

- This new Medicare program presents physicians with the opportunity to partner with local health care providers, including pharmacists, to provide these CCM services.

- My pharmacy has launched this program and partnered with a local physician practice to bring in new revenues.
Billing Codes
• CPT code 99490 represents the first and core CCM billing code

• National average reimbursement for this code is $40 with some large urban locations paying as much as $45 and most of the rural areas paying $40

• Additional reimbursement of $68 to physician under G code G0506 is now available upon creation of the patient's care plan at the initiation of Chronic Care Management

• CPT code 99487 – Complex chronic care management services with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; Establishment or substantial revision of a comprehensive care plan; Moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. Reimbursement: +/- $94.00 per patient per month.

Billing Codes
• CPT code 99489 – Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month and must also involve complex or moderately complex decision making. (List separately in addition to code for primary procedure). Reimbursement: +/- $47.00 per patient, per month

• New Add-on G-Code –G0506 Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service).
What contracts are needed to implement CCM?

**Patient Consent Agreement**
- The patient needs to complete the consent agreement to be enrolled in the CCM Program

**Physician | Pharmacy Partnership Agreement**
- Details the specifics of the physician/pharmacy collaboration, including delineation of responsibilities, reporting, billing, etc.

**Physician | Pharmacy | Vendor Business Associate Agreement for HIPAA**
- Needs to be completed by all three parties to enable the sharing of information on patients

Chronic Care Management (CCM) Implementation follows Project Management Institute (PMI) Model:

- **Project Initiation**
  - Contract
  - Negotiations
  - Project Design
  - Project Kick Off Project Evaluation
  - Provide Monthly or other Reporting for assessing success
  - Determine what went well and what could be improved
  - Obtain User sign off after each phase
Chronic Care Management (CCM)

Implementation follows Project Management Institute (PMI) Model:

- **Project Planning**
  - Refine Project Schedule
  - Assess Best Fit Workflow
  - Collaborate with IT on electronic file specifications (Clinical and Billing)
    - *Initial load*
    - *Incremental Updates*
  - Refine Call Center Staffing Requirements
  - Assess Pharmacy Network Engagement Opportunities
  - Identify Phases for Go Live

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Chronic Care Management (CCM)

Implementation follows Project Management Institute (PMI) Model:

**Project Execution**

- Implement Electronic Files
- Implement Electronic Files
  - Spec sign off
  - Testing
  - Issue Resolution
  - Production Go live
- Implement Workflow and Process
- Adopt Change Management Processes
- Implement Continuous Feedback Loop for Improvements during Implementation
  - Monitor Project Performance and Adjust if Needed
  - Execute Phased Implementation Approach
  - Provide Go Live Support
Chronic Care Management (CCM)

Implementation follows Project Management Institute (PMI) Model:

• **Project Evaluation**
  • Provide Monthly or other Reporting for assessing success
  • Determine what went well and what could be improved
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We Focus On Quality
Chronic Care Management (CCM)

2017 Quality MACRA MIPS Measures Improved By Our CCM Program

WHAT IS MACRA?
• The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan federal legislation signed into law on April 16, 2015.

Chronic Care Management (CCM)

Utilizing Clinical Local Pharmacy Chronic Care Management to improve MIPS quality scores and performance:

• New measures that will phase into MACRA pay-for-performance for the 2017 reporting year.

• These specific services and measures are not obligated nor limited to every patient, rather an example of what a majority of Chronic Care Management services may look like
What does MIPS stand for in healthcare?

• The Merit-Based Incentive Payment System (MIPS) is a new payment mechanism that will provide annual updates to physicians starting in 2019, based on performance in four categories: quality, resource use, clinical practice improvement activities and meaningful use of an electronic health record system.

• Can affect 4% of a doctor’s total 2017 Medicare reimbursements all the way up to 9% in later years

Chronic Care Management (CCM)

Pharmacy CCM Services Example Overview

• Pharmacy CCM Services Example Overview
• Pharmacies perform comprehensive medication reconciliation of patient’s medications
• Pharmacies help enroll patient in a monthly chronic care management program, including telephonic patient surveys and medication compliance monitoring & face-to-face meetings.
• Pharmacy provide monthly chronic care management interventions with enrolled patients, with emphasis on COPD and asthma medications compliance.
• Pharmacy conduct monthly telephonic patient surveys, including queries on COPD and asthma medication compliance, including use of maintenance and/or rescue inhalers.
### Chronic Care Management (CCM)

#### Pharmacy CCM Services Example Overview (Cont’d)

- Pharmacy provide monthly chronic care management interventions with enrolled patients, with emphasis on cardiovascular medication compliance.
- Pharmacy administer quarterly in-store high blood pressure readings.
- Pharmacy conducts monthly telephonic patient surveys, including queries on cardiovascular medication compliance and blood pressure.

#### Blood Sugar Monitoring

- Pharmacy provide monthly chronic care management interventions with enrolled patients, with emphasis on diabetes medication compliance and regular blood sugar monitoring.

- Pharmacy encourages regular blood sugar checks (fasting/non-fasting) through monthly, pharmacy-initiated telephonic patient surveys.
- Pharmacy also encourages physician appointment every three months to check A1c levels if not controlled.