The Chronic Care Management Team: In Practice and in Business
Target Audience: Pharmacists
ACPE#: 0202-0000-18-025-L04-P
Activity Type: Knowledge-Based
Disclosures

Amina Abubaker: None
Michelle Thomas: None
Cindy Warriner: None

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Learning Objectives

1. Explain the Centers for Medicare and Medicaid Services requirements for delivering Chronic Care Management (CCM) services.
2. Describe the roles of pharmacists in delivering CCM services as part of a coordinated care model.
3. Discuss examples and benefits of pharmacists practicing in community pharmacies and physician office practices delivering CCM.
4. Describe how CCM services can contribute to the business case for supporting pharmacists’ patient care services.
1. Assessment Question

A complete list of the key components necessary for delivering Chronic Care Management include:

A. Comprehensive care plan, transitional care management, comprehensive care management, 24/7 access to care, comprehensive billing plan

B. Transitional care management, comprehensive care management, comprehensive care plan, structured data recording, 24/7 access to care

C. Structured data recording, comprehensive care plan, 24/7 access to care, collaborative partnership, transitional care management

D. Comprehensive care plan, 24/7 access to care, structured data recording, transitional care management
2. Assessment Question

Which of the following is true concerning pharmacist involvement in delivery of CCM?

A. Pharmacists can provide CCM in a community pharmacy working under a physician or QHP’s general supervision
B. Pharmacists can provide CCM in a physician office working under a physician or QHP’s direct supervision
C. Patient counseling as part of dispensing counts toward the monthly time requirement for CCM
D. Medication management is not part of the care plan for CCM
3. Assessment Question

Which of the following is not a benefit of pharmacists collaborating with physician offices to provide CCM?

A. Diversifying the care team
B. Improvement of coordination of care, health and patient satisfaction
C. Increasing access to care for patients
D. Replacing the all of the roles of the qualified health professional
4. Assessment Question

In presenting a business case for addition of CCM services by a pharmacist, which of the following would be important to include:

A. Benefit of face to face time with the pharmacist
B. Provider income for the initial comprehensive assessment
C. Calculated provider time saved due to CCM calls
D. Expected income for coordinating care transitions
Description of Practice Setting
Who am I – How am I engaged in CCM?
Amina Abubakar, PharmD, AAHIVP

Owner of Rx Clinic Pharmacy of Charlotte, NC
President of Avant Institute of Clinicians
Co-founder of the Pharmacogenetics Center of Excellence
The Rx Clinic Pharmacy Team

- Independent Community Pharmacy in Charlotte, NC
- CPESN Luminary Pharmacy Owner
- Innovative and Expansive Community Clinical Services
  - Accredited Diabetes Self-Management Training (DSMT) Program
  - Point-of-Care Testing program
  - Diabetic Shoes & Compression
  - Durable Medical Equipment
  - Insulin Pump Training
  - Routine & Travel Health Immunizations (Yellow Fever Certified)
  - Pharmacogenetic Testing Program with MTM
  - Chronic Care Management via provider collaboration
The Rx Clinic Pharmacy Team

- Ambulatory Care Department via provider collaboration
  - Pharmacists embedded in the medical practice
  - Hybrid Community-Ambulatory Care Pharmacists
  - Management Services Organization
  - Federally Qualified Health Center (FQHC)
Our Collaborations for Chronic Care Management

- **Community Pharmacy Dept**
  - With EHR Access
  - CCM Secure Communication Platform (Care Plans)

- **Ambulatory Care Dept**
  - Pharmacist Embedded in Medical Practice
  - Primary Care / Outpatient

- **Hybrid Community-Am Care Pharmacists**
  - Assisted Living Facilities
  - Part-time at a Medical Practice

- **Federally Qualified Health Center (FQHC)**
  - Many services available under FQHC rules
  - Non-complex CCM ONLY
Michelle H Thomas, PharmD, BCACP, CDE
Community-Based Pharmacist Practitioner
Chickahominy Family Practice
Quinton, Virginia
Practice Setting: Family Practice

- New Kent, Va (~18,000 rural)- 2 locations
- Physician-owned
- Care Providers: 2 MDs, 4 Nurse Practitioners (NP), 1 Physician Assistant (PA), 1 PharmD
- Team: Medical Assistants, Medical Secretaries
Pharmacist Practitioner: Primary Care
Michelle H Thomas, PharmD, BCACP, CDE

Practice Innovation Timeline

2011
- DM visits
- DSMES classes
- Annual Wellness Visits
- Transitional Care

2018
- CCM
- ACO lead
Cindy Warriner, BS, RPh, CDE
Health Quality Innovators (HQI)
Nonprofit health care consulting company
Richmond, Virginia
Pharmacist Consultant: Quality Improvement Organization

- QI consultant supporting the Medicare Quality Improvement Organization tasked with:
  - Decreasing Adverse Drug Events (ADEs) among the Maryland and Virginia Medicare population
  - Providing free resources to support improvement interventions and trials
  - Developing ideas for tracking and analyzing data
  - Incorporating successes into sustainable processes to assist providers
  - Spreading successes to improve the quality of patient care
Overview of CMS Requirements for Delivering CCM
What is CCM?

- Medicare Part B fee-for-service program that pays providers for furnishing management and coordination services for chronic conditions each month.
  - Often provided telephonically
  - May be provided in person

CCM Key Components

Structured Data Recording  Comprehensive Care Plan  24/7 Access to Care

Comprehensive Care Management  Transitional Care Management

Care Plan Basics – Suggested Elements

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Symptom Management
- Planned interventions and who is responsible
- Medication management
- Community services ordered
- Description of how services outside the practice will be coordinated
- Periodic review of the care plan

CCM Eligible Patients

Medicare beneficiaries who reside in the community setting that meet the following requirements:

- 2+ significant chronic conditions expected to last 12+ months or until death
- Significant risk of death, acute exacerbation/decompensation, or functional decline (e.g. diabetes, heart failure)
- Comprehensive care plan is established, implemented, revised, or monitored

For Complex CCM, beneficiaries also require:

- Moderate or high complexity medical decision making
- Establishment or substantial revision of a comprehensive care plan
- 60 minutes of clinical staff time directed by a physician or qualified health professional per calendar month

# Types of CCM

<table>
<thead>
<tr>
<th>CCM Service</th>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Assessment (G0506)</td>
<td>N/A</td>
<td>Extensive assessment &amp; care planning during CCM enrollment (add-on to primary service)</td>
</tr>
<tr>
<td>CCM (CPT 99490)</td>
<td>20+ minutes</td>
<td>5 core CCM services</td>
</tr>
<tr>
<td>Complex CCM (CPT 99487)</td>
<td>60+ minutes</td>
<td>5 core CCM services plus: • Moderate or high complexity clinical decision making • Establishment or substantial revision of care plan</td>
</tr>
<tr>
<td>Additional CCM Time (CPT 99489)</td>
<td>30 minute increments</td>
<td>For Complex CCM, added onto when time required exceeds the 60 minute baseline rate (e.g. 90 or 120 minutes)</td>
</tr>
</tbody>
</table>
The Care Team

- CCM care team members can be classified into three categories based on their profession and role on the team:
  - Qualified Healthcare Professionals (QHP)
  - Clinical Staff (e.g. pharmacists)
  - Non-clinical Staff

Location of the Care Team

- QHPs and clinical staff do not need to be co-located when CCM services are provided
  - General Supervision: QHP needs to be generally available (e.g. via phone) to the clinical staff when services are delivered
- There are no restrictions on where non-clinical staff can be located

Types of Supervision

**Direct**

The QHP must be present in the office suite and immediately available to furnish assistance and direction. The QHP does not need to be present in the room when the procedure is performed.

**General**

Services are furnished under the QHP’s overall direction and control, but the QHP’s presence is not required during the performance of the procedure.

CCM is provided under general supervision.

# Care Team Roles and Responsibilities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Qualified Healthcare Professional (e.g. Physician, NP, PA)</th>
<th>Clinical Staff (e.g. Pharmacist)</th>
<th>Non-clinical Staff (e.g. Pharmacy Staff, Office Manager)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Patient</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect Structured Data</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Develop Comprehensive Care Plan</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain/Inform Updates for Care Plan</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Manage Care</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provide 24/7 Access to Care</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Document CCM Services</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bill for CCM Services</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Provide Support Services to Facilitate CCM</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Billing Basics and Contractual Relationships

• QHPs bill for CCM services provided
• All CCM team members must be contracted, leased, or employed by QHP
• Only one practitioner may be paid for CCM monthly
• Billing only once per calendar month

Considerations for CCM Collaboration

- Desired outcomes of CCM collaboration
- Care team members and division of responsibilities
- Processes for identifying, consenting, onboarding, and withdrawing patients
- Use of and access to a certified EHR
- Procedures to document services and time spent providing care
- Mechanism and format for communicating health information
CCM Value Proposition

- Opportunity to improve patient outcomes and quality metrics – linked to value-based payment models
- Improved coordination of and access to care for patients
- Enhanced collaboration between physicians and pharmacists
- Optimizing clinicians’ time using a team-based care model
- Additional revenue for participating clinicians
How do you get started, including who to target?
Getting Started with CCM

Considerations for patient selection

Insurance coverage (secondary)
Diseases (must have ≥2 chronic conditions)
List of Medications

Collaboration with physicians and other QHPs
What are important factors to consider in getting patients enrolled and started in a CCM service?
Enrollment: Consent

Describe the service and how patient can access
How information will be shared
Cost of the service
That only one QHP can provide this service monthly
How to stop the service
Enrollment

Communications process/phone calls
Marketing
Collaborative practice agreements
How are CCM Services delivered in your practice?
Delivery of CCM Services

Workflow
Pharmacist unique role
Elements of medical decision making
Support staff usage
Provider involvement
### Chronic Care Management (CCM): Billing Practitioner Responsibility

<table>
<thead>
<tr>
<th>Code</th>
<th>Care Planning Documentation</th>
<th>Billing Practitioner Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Complex CCM (99490)</td>
<td>Established, implemented, revised or monitored</td>
<td>Ongoing oversight, direction and management</td>
</tr>
<tr>
<td>Complex CCM (99487)</td>
<td>Established or substantially revised</td>
<td>Ongoing oversight, direction and management + <strong>Medical Decision-making of mod-high complexity</strong></td>
</tr>
<tr>
<td>Complex CCM Add-on (99489)</td>
<td>Established or substantially revised</td>
<td>Ongoing oversight, direction and management + <strong>Medical Decision-making of mod-high complexity</strong></td>
</tr>
<tr>
<td>Initiation of CCM during a visit (G0506)</td>
<td>Established</td>
<td>Personally performs extensive assessment and CCM care planning <strong>beyond usual effort</strong> for the separately billable initiating visit</td>
</tr>
</tbody>
</table>
### Elements for Each Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Significant Complications, Morbidity and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>
What are the requirements for billing; How does it work in the practice?
Billing

ICD 10 codes
CPT coding
Logistics
Overlap services – cannot concurrently bill
  Transitional Care Management (CPT 99495, 99496)
  Home Health Supervision (HCPCS G0181)
  Hospice Care Supervision (HCPCS G9182)
  Certain ESRD Services (CPT 90951-90970)
  Patient Monitoring Services (CPT 99090, 99091)
What is the value proposition and business case for pharmacist involvement in CCM?
Value Proposition: Improved Patient Care

- Improved coordination of care
- Improved access
- More attention to patient needs
- Improved health and satisfaction
Value Proposition: Improve Revenue

- CCM billing $40-$100+/month per patient ($500+ annually)
- Provider billing for initial comprehensive assessment
- Improved quality metrics can lead to incentive payments (e.g. MACRA/MIPS)
- Increased timely follow up when appointments due
- Improved practice reputation, new patient draw
Value Proposition: Quality Measures

- Potential to improve key quality metrics and patient outcomes

- Sample measures of interest:
  - Patients with A1C > 9.0%
  - Medication reconciliation post discharge
  - Influenza/Pneumococcal immunization
  - Tobacco screening and counseling
  - Blood pressure screening and control
Value Proposition: Saving Provider Time

- Patient phone calls for refills
- Care coordination - specialist notes, communication
- Home Health collaboration - supplies, feedback
- Referral follow-through
- Screen/triage less serious patient issues
Impact of the CCM program from the Rx Clinic Pharmacy Clinical Team

- Number of CCMs completed in a month: 490
- Impact on quality measures
  - Mammogram screenings leading to positive breast cancer findings
  - Reduced A1C to goal for diabetes
  - Chronic Kidney Disease patient not on epoetin alfa injections because PCP said that nephrology does them but they didn’t
  - Congestive heart failure patients missing appropriate medications like statins that reduce the risk of morbidity and mortality
  - Patient refusing colonoscopy but had success with recommendation of Stool DNA testing which is more sensitive and accurate than Fecal Occult Blood Testing
  - Educating patients on proper use of emergency rooms – decrease in ER care and increase PCP care to lower overall healthcare cost
Impact of the CCM program from the Rx Clinic Pharmacy Clinical Team

- Cost-effective solutions for medications
  - Enrolled patients into patient assistance programs
  - Provider accepted recommended lower-cost alternative
- Identified patients with poor kidney function and medications were never adjusted
# Rural Primary Physician Practice CCM Trial

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Data</th>
<th>Quarter 3 2017</th>
<th>Quarter 4 2017 Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI Screening and Follow-up</strong></td>
<td>CMS 69</td>
<td>Objective: 5%</td>
<td>Performance Rate: 47.50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 69</td>
<td>CMS 69</td>
</tr>
<tr>
<td><strong>BP Screening and Follow-up</strong></td>
<td>CMS 22</td>
<td>Objective: 10%</td>
<td>Performance Rate: 32%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 22</td>
<td>CMS 22</td>
</tr>
<tr>
<td><strong>Hemoglobin A1C Control</strong></td>
<td>CMS 122</td>
<td>Reduce by 5%</td>
<td>Performance Rate: 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 122</td>
<td>CMS 122</td>
</tr>
<tr>
<td><strong>Colorectal Cancer Screening</strong></td>
<td>CMS 130</td>
<td>Objective: 5%</td>
<td>Performance Rate: 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 130</td>
<td>CMS 130</td>
</tr>
<tr>
<td><strong>Tobacco Cessation Intervention</strong></td>
<td>CMS 138</td>
<td>Objective: 5%</td>
<td>Performance Rate: 69%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 138</td>
<td>CMS 138</td>
</tr>
<tr>
<td><strong>Control Blood Pressure</strong></td>
<td>CMS 165</td>
<td>Objective: 5%</td>
<td>Performance Rate: 42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMS 165</td>
<td>CMS 165</td>
</tr>
<tr>
<td><strong>Annual Wellness Visits</strong></td>
<td>Improvement</td>
<td>10 Patients</td>
<td>Performance Rate: 0 Billed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement</td>
<td>CMS 165</td>
</tr>
<tr>
<td><strong>Chronic Care Visits</strong></td>
<td>Improvement</td>
<td>5 Patients</td>
<td>Performance Rate: 0 Billed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement</td>
<td>CMS 138</td>
</tr>
</tbody>
</table>
What tips do you have to help audience members engage in CCM?
1. Assessment Question

A complete list of the key components necessary for delivering Chronic Care Management include:

A. Comprehensive care plan, transitional care management, comprehensive care management, 24/7 access to care, comprehensive billing plan
B. Transitional care management, comprehensive care management, comprehensive care plan, structured data recording, 24/7 access to care
C. Structured data recording, comprehensive care plan, 24/7 access to care, collaborative partnership, transitional care management
D. Comprehensive care plan, 24/7 access to care, structured data recording, transitional care management
2. Assessment Question

Which of the following is true concerning pharmacist involvement in delivery of CCM?

A. Pharmacists can provide CCM in a community pharmacy working under a physician or QHP’s general supervision
B. Pharmacists can provide CCM in a physician office working under a physician or QHP’s direct supervision
C. Patient counseling as part of dispensing counts toward the monthly time requirement for CCM
D. Medication management is not part of the care plan for CCM
3. Assessment Question

Which of the following is not a benefit of pharmacists collaborating with physician offices to provide CCM?

A. Diversifying the care team
B. Improvement of coordination of care, health and patient satisfaction
C. Increasing access to care for patients
D. Replacing the all of the roles of the qualified health professional
4. Assessment Question

In presenting a business case for addition of CCM services by a pharmacist, which of the following would be important to include:

A. Benefit of face to face time with the pharmacist
B. Provider income for the initial comprehensive assessment
C. Calculated provider time saved due to CCM calls
D. Expected income for coordinating care transitions
Contact Information

- Amina Abubakar: amina@rxclinicpharmacy.com
- Michelle Thomas: michellethomasrx@gmail.com
- Cindy Warriner: cwarriner@hqisolutions