COMPLETED GRANT SYNOPSIS

Toolkit Development and Evaluation of a Collaborative Pharmacy Practice Model for Community Pharmacist-Provided Chronic Care Management (CCM) Services

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Objectives

1. Create a model for integration of a community pharmacist into a prescriber's office
2. Develop and implement a collaborative pharmacy practice agreement (CPPA) and business associate agreement (BAA) between the community pharmacist and the prescriber to allow for the delivery of patient care services
3. Deliver Annual Wellness Visits (AWV) or Initial Preventive Physical Examinations (IPPE) to new patients or patients not seen within one year prior to Chronic Care Management (CCM) enrollment
4. Enroll existing patients in CCM
5. Deliver CCM to enrolled patients on a monthly basis
6. Create a detailed implementation guide for the Community Pharmacy Foundation (CPF) with tools and resources to assist community pharmacists in providing services through this model of care

Methods

Design

- **Study Design**
  - Proof of concept
- **Sample Size**
  - Provision of Annual Wellness Visits (AWV), Initial Preventive Physical Examinations (IPPE) or Chronic Care Management (CCM) services to 50 patients
- **Subject Characteristics/Identification**
  - Patients with insurance through traditional Medicare (with or without a supplement), including dual eligible patients, who were also eligible for AWV, IPPE, and/or CCM
    - **AWV eligibility (CPT code G0438 or G0439)**
      - Medicare beneficiaries who:
        - Are not within the first 12 months of their first Medicare Part B coverage period; and
        - Have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months.
    - **IPPE eligibility (CPT code G0402)**
      - Medicare pays for one IPPE per beneficiary per lifetime for beneficiaries within the first 12 months of the effective date of the beneficiary's first Medicare Part B coverage period.
    - **CCM eligibility (CPT code 99490)**
      - Medicare patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Subjects identified through the physician's Certified Electronic Health Record (CEHR)
- **Data collection**
  - Number of patients seen for face-to-face visits, number of patients enrolled in CCM, number of services billed for, and number of those corresponding services reimbursed
    - Sustainability of this model will be proven with successful reimbursement after billing "incident-to" the prescriber for these services

Study endpoints	• Formation of a Business Associate Agreement (BAA) • Implementation of a Collaborative Pharmacy Practice Agreement (CPPA) • Integration of a community pharmacist into a prescriber's office • Delivery of AWV, IPPE or CCM to 50 patients • Reimbursement for AWV, IPPE, or CCM services billed incident to a physician

Results

Pharmacist-Provided Medication Reconciliation and CCM Services

Insurance	Patients Seen	Enrolled	Declined	Enrollment %	Reimbursed
Medicare Only	24	3	21	12.50%	5
Medicare w/ Supplement	29	9	20	31.03%	15
Dual Eligible	100	1	99	1.00%	3
Total	153	13	140	8.50%	23

- The table above lists the three insurance types targeted (Medicare only, Medicare plus supplement, and Medicare plus Medicaid) with the corresponding number of patients seen for medication reconciliation services, the number enrolled in community pharmacist-provided CCM services, and the number of times the practice was reimbursed for community pharmacist-provided CCM services over a three month period. All services were billed incident to a physician and reimbursed based on the physician fee schedule (PFS). Reimbursement varies based on locality, but CPT 99490 (20 minutes of CCM) averages $40 ($32 from Medicare, $8 from patients based on 80/20 copay requirement).
- CCM services can be billed on a monthly basis only if enough time is spent providing patient care (e.g. 20 minutes for 99490). Thus, the number of reimbursed services reflects the number of enrolled patients who actually received CCM services over three months (i.e. some patients did not answer phone calls, dropped out, or no longer required the service).
- The Community Pharmacist-Provided Chronic Care Management Toolkit was created as a result this grant, and contains guidance, resources, and experiences to aid in the establishment and provision of CCM services by community pharmacists. Additional materials found at the end of the toolkit include a sample Business Associate Agreement (BAA), Collaborative Pharmacy Practice Agreement (CPPA), and a comprehensive care plan.

Conclusion

With support from the Community Pharmacy Foundation (CPF) and assistance by the Tennessee Pharmacists Association (TPA), Seamless Healthcare PLLC explored the delivery of community pharmacist-provided chronic care management (CCM) services with an endocrinologist. Initially Seamless Healthcare and TPA strived to find a primary care physician to partner with, but after two unsuccessful attempts decided to move forward with an opportunity at a specialist's office. A business associate agreement (BAA) and collaborative pharmacy practice agreement (CPPA) were put into place to ensure the optimal delivery of pharmacist-provided CCM services.

When the grant was written, it was believed that pharmacists could bill for Initial Preventive Physical Examinations (IPPE) "incident to" the physician similar to initial Annual Wellness Visits (AWV). This proved to not be the case, but IPPEs can still be provided in a split billing fashion similar to other Evaluation and Management (E/M) codes. The endocrinologist was approached about the ability of the community pharmacist providing either AWVs autonomously or IPPEs in conjunction with the billing provider. Specialists have the ability to provide IPPE or AWVs, but typically do not since these services tend to be more preventive in nature and structured for primary care physicians. While there was much consideration, ultimately the physician was only comfortable implementing community pharmacist-provided CCM services. The inability of the pharmacist to provide AWVs, or be involved in IPPEs, did not hinder the initiation or provision of CCM services but did limit the number of possible billable services. This limitation resulted in only 23 services billed during the grant period instead of at least 50.

In-Office Care Delivery and CCM Enrollment

To ensure the formation of prescriber and patient relationships in-office without the provision of AWVs or involvement in IPPEs, the community pharmacist provided face-to-face medication reconciliation services with the patient prior to the scheduled visit with the prescriber. During the three months of care delivery, 153

patients received medication reconciliation services by the community pharmacist. The endocrinologist's patient population mainly consisted of Medicaid and Dual Eligible patients, explaining the high number of Dual Eligible patients seen compared to patients with Medicare or Medicare plus supplement. While medication reconciliation is not as financially sustainable as providing AWVs or being involved in IPPEs, face-to-face interaction with patients and providers created relationships, credibility, and trust that increased patient enrollment in CCM and continual pharmacist autonomy under the CPPA.

Total CCM enrollment was predicted to be around 10% on average, which was close to the actual total enrollment percentage of 8.5%. CCM enrollment rate was highest with patients that had a Medicare plus supplement plan (31.03%), followed by patients with Medicare only (12.50%) and patients that were Dual Eligible (1.00%). These outcomes were expected since supplement plans pay the required 20% copay (as long as deductibles are met) when CCM services are delivered, while Medicare by itself does not and copay coverage varies with Dual Eligible patients. The sole Dual Eligible patient that enrolled was a "Qualified Medicare Beneficiary," or QMB, which is a Dual Eligible status where the copay is either covered by the state plan or can be waived by the practice. No other Dual Eligible status (Non-QMB, SLMBs, QDWIs, QI-1, or QI-2) or traditional Medicare patients can have the copay waived by the practice.

New CCM rules do allow for CCM enrollment without an initial visit (AWV, IPPE, E/M, or TCM) to patients seen in the past year. The community pharmacist reached out to these patients to discuss enrolling in CCM. It was found that enrollment was non-existent when "cold calling" patients compared to meeting the community pharmacist in person during a face-to-face visit. Potential reasons why patients refused CCM over the phone included not knowing the pharmacist personally, feeling as though they are being sold something, or not recognizing the pharmacist's relationship with the providers in the office.

CCM Care Delivery

The community pharmacist had 24/7, remote access to the physician's certified electronic health record (CEHR) even though it was no longer a requirement starting in 2017. All providers, including the community pharmacist, thought remote access was crucial to the delivery of high quality CCM since documentation was such an important element. Remote access to pertinent information proved to be important during CCM calls, especially when modifying therapies and sending in new or refill prescriptions on the weekends. Even though it is not a requirement, community pharmacists should insist on having remote access to the CEHR when establishing CCM services.

The average time spent providing CCM clinical services was roughly 25 minutes per patient each month. Even though some patients required over 40 minutes of time, 99490 cannot be billed multiple times (i.e. billing two 99490 codes for 40 minutes of time) and 99489 (30 minute modifier code) can only be utilized with moderate or high complexity patients. This presents an issue when patients are not moderate or high complexity but utilize the service more than 20 minutes per month (e.g. patient is hard of hearing, slow to understand concepts, or talks about non-health related issues). If patients utilized CCM services over 20 minute per month because of worsening health conditions or it was felt that the patient needed more face-to-face interaction, the community pharmacists scheduled the patient an office visit.

The retention rate for patients who enrolled in CCM was less than 100%, which is reflected by the reimbursed number being lower than the enrollment number multiplied by three months. Some patients never answered their phone or reached out to the community pharmacist after enrolling in CCM. Other patients participated for the first month, but then either did not return phone calls or expressed their perception of feeling fine and not needing the service anymore. This was difficult, as a patient's perceived health status can be different from their actual health status (i.e. 100% better after average blood glucose lowered from ~300 to ~200). The patients who did utilize the service each month enjoyed the community pharmacist's accessibility and ability to modify therapies.

Billing and Reimbursement

All CCM services rendered by the community pharmacist (i.e. 99490 only) were successfully billed for incident to the physician. The prescriber successfully received reimbursement based on which insurance the patient had.

- **Medicare – 80% covered by Medicare, 20% covered by patient.** Patients were charged 20% by the practice (i.e. roughly $8).
- **Medicare plus supplement – 80% covered by Medicare, 20% covered by supplement if patient had reached deductible.** Patients who had not reach their deductible were charged 20% by the practice.
- Medicare/Medicaid – **80% covered by Medicare, 20% covered by Medicaid (for "Qualified Medicare Beneficiaries") based on the State Plan.** Since the Tennessee State Plan does not cover CCM services, and federal statute permits the "lesser-of" Medicaid or Medicare reimbursement for cost sharing, the practice had to absorb the 20% cost.

Final Thoughts

Successful delivery and reimbursement of pharmacist-provided CCM proved that a community pharmacist could consider providing this service in their area. Community pharmacists should consider a hybrid model of care, where the community pharmacist can spend at least one day per week in the physician's office. As stated earlier, patient and prescriber relationships were formed in the office that enhanced CCM enrollment and pharmacist-provided care delivery. It was found that a hybrid model also made the physician and nurse practitioners more comfortable with the pharmacist's authority under the CPPA and remote access to the CEHR.

In a hybrid model, community pharmacists must ensure their ability to provide billable services at the physician office. This will most likely be either MTM or AWVs (if the practice doesn't already deliver AWV), because split billing can be difficult since it cuts into the practices bottom line (split billing will only work if the community pharmacist improves workflow efficiency enough to increase the number of visits that can be billed). It is unsustainable for a pharmacist to provide a non-reimbursable service in the physician's office, like medication reconciliation, with the hopes of enrolling patients in CCM. The number of CCM eligible patients seen in a day may already be less than optimal, and is exacerbated when patients cancel, reschedule or skip their appointments altogether. The revenue generated from MTM or AWV can compensate, to some extent, for the unexpected nature of an appointment-based model and for the patients who decline CCM services.

Community pharmacists should also focus on providing CCM services with primary care practices instead of specialists. While CCM is beneficial for patients seeing specialists, the overall requirements are much easier to achieve when patients are seeing only their primary care physician. Specialists also bill for in-office services that provide higher reimbursement than primary care physicians, thus making CCM a small amount of reimbursement that potentially lowers the necessity of in-office visits.

With regards to compensation from CCM billing, community pharmacists should insist on receiving at least the amount paid for by Medicare (i.e. 80% of the billable code) and let the practice manage copay collection. The community pharmacist should stress the effects of CCM on the practice's bottom line, including increasing office visit referrals and CCM impact on quality payment programs. Seamless Healthcare allowed the practice to keep all billable items during the grant period, but the physician agreed that an 80/20 split would be fair based on the work provided by the community pharmacist.