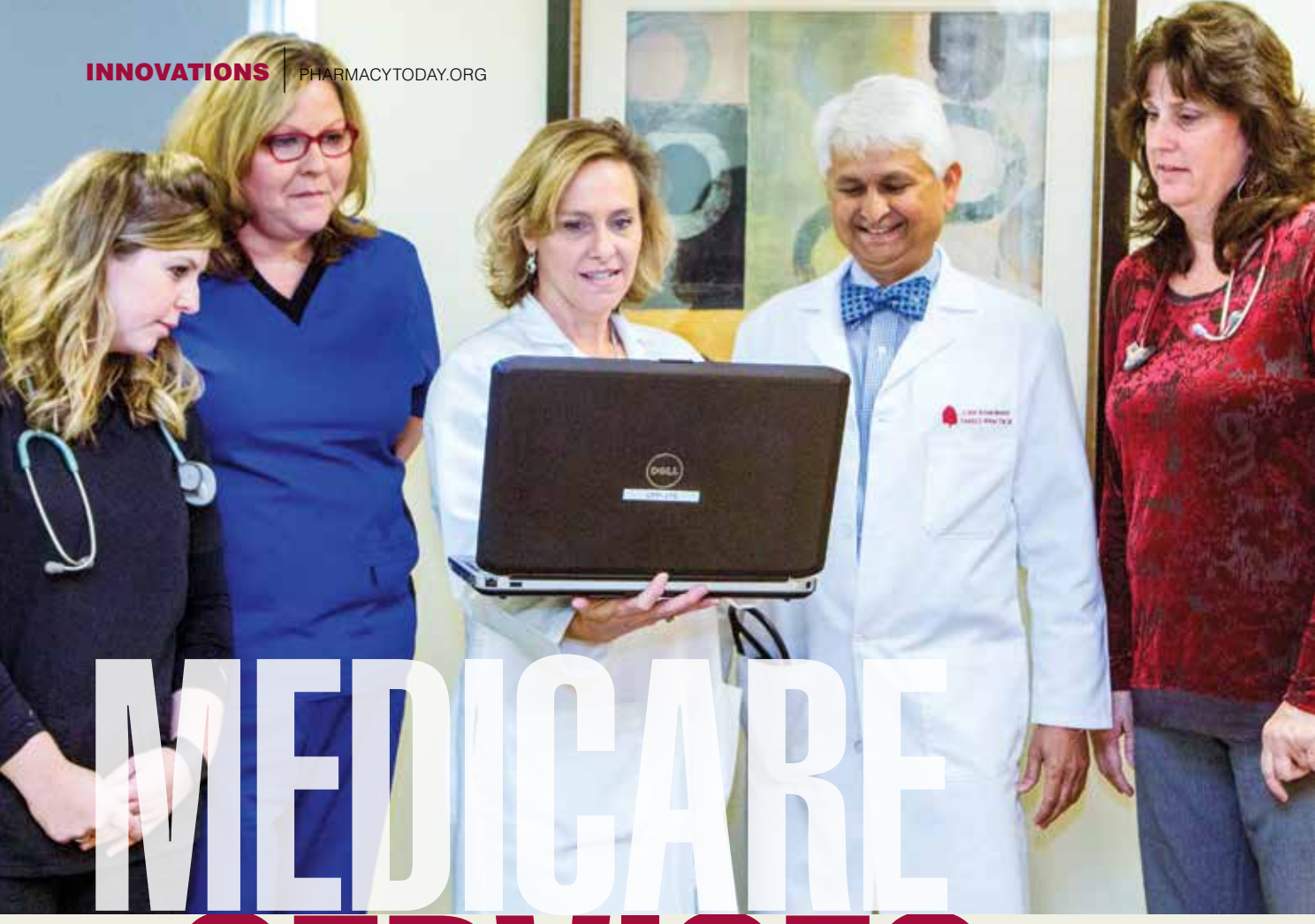


MEDICARE SERVICES

position pharmacists in new revenue-generating models

Certain patients at Chickahominy Family Physicians in Quinton, VA, know they can expect a call from pharmacist Michelle Thomas every month. During the call, she goes over their medications and asks questions about their chronic conditions.

Thomas has been employed with the small family practice since 2011. Part of what she does there is deliver chronic care management (CCM) services to patients who qualify. Along with other services she provides, CCM services generate added revenue for the practice. Physicians at Chickahominy can bill for them and get reimbursed by Medicare.

"On a quarterly basis, they give me—along with all the other providers—a report of my revenue, and we look to see if it's at least breaking even, and it's never been less. It has actually steadily increased over the years to a significant gain," Thomas, PharmD, CDE, BCACP, told ***Pharmacy Today***.

Thomas spends most of her time seeing patients alongside physicians in the practice. CCM services are non–face-to-face visits, but Thomas sees patients in person for transitional care management (TCM) services and annual wellness visits (AWV), which also are reimbursed by Medicare.

Thomas isn't alone working in such a model. Pharmacists across the country are generating revenue through the delivery of various Medicare services in collaboration with physicians to leverage a sustainable position not only for pharmacy but for physician practices as well, especially as physicians try to meet outcomes required by new value-based payment models. Many pharmacists, like Thomas, are directly employed with a physician practice as a full-time employee, often sharing in the revenue from these services. Other pharmacists in the community might

PHOTO CREDIT: JULIA RENDLEMAN/ICDA

contract with one or more physician practices to provide services.

"My role here is only one potential model that a pharmacist could follow to make an impact in this type of care," said Thomas. "Across the board, our providers are very receptive to the recommendations of pharmacists. They are interested in getting a different perspective on things, and I think sometimes we underestimate what we can offer to a family practice group, whether within or outside the group."

Many opportunities exist within CCM

"It was pretty exciting when the CCM codes came out," Kelli Barnes, PharmD, BCACP, assistant professor at Ohio State University (OSU) College of Pharmacy, told ***Today***. "It let our practice track and bill for care we were already providing outside of typical office visits."

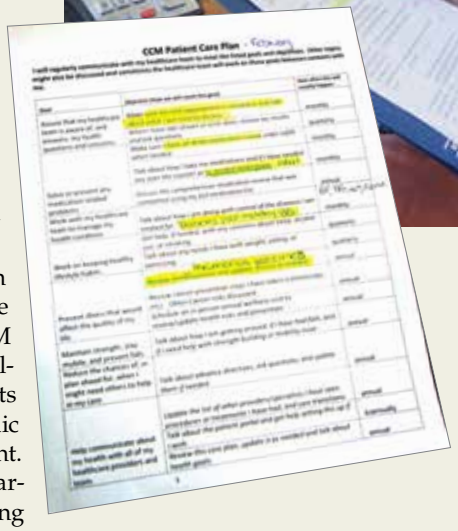
Barnes is also employed with OSU's General Internal Medicine clinics. Before the advent of CCM codes, Barnes and her pharmacist colleagues were always calling patients to follow up with them about chronic disease and medication management. Now the practice can bill for the pharmacists' non–face-to-face time using CCM codes. The OSU clinics have hired more pharmacists for their six practice sites in the Columbus area in part on the basis of these expanding care models.

CCM, TCM, and AWVs each have their own requirements and billing codes. Physicians bill for the pharmacist's services through billing rules for incident-to physician services. The type of supervision varies with the different services. For CCM services and parts of TCM services, CMS does not require direct supervision. In other words, pharmacists do not have to be physically located in the office-based practice. Thomas said this opens up the opportunity for community pharmacists to provide CCM services through a collaboration with a physician practice.

Sandra Leal, PharmD, MPH, FAPhA, CDE, vice president for innovation at SinfoníaRx, said that right now, CCM codes are underutilized. "Providers might know about the codes, but they are not really using them," she said. "It's an opportunity for pharmacy to step in and help bring in revenue for the practice that they are essentially leaving on the table," she said.

Of course, this is coupled with the benefits of care coordination. Through CCM services, Leal said, pharmacists can also address gaps in care, such as getting patients up to date on immunizations, which helps with overall outcomes that physicians need for other contracts they might be working under.

TCM services and AWVs also can be a way to identify potential patients for CCM. Thomas said there are three different ways patients at Chickahominy are normally enrolled in CCM: After an AWV, she will flag the potential patient and notify the physician so that the CCM service can be offered. She will identify potential patients whom she sees for TCM visits; often they are the


CCM Patient Care Plan - Today

ADDITIONAL READING

- Medicare Learning Network: http://apha.us/2inOs6Q
- Fact sheet on complex CCM services: http://apha.us/2j8dusS
- More information about TCM: http://apha.us/2jfKtgE

Previous page: Hillary Lapace, RT; Angie Stewart; Michelle Thomas, PharmD; Anup Gokli, MD, MBA; Margaret Mountcastle, DNP (left to right).
Above: Thomas speaks by phone to a new patient who is receiving chronic care management (CCM) services. Upon enrollment and annually, she helps develop the patient's individualized care plan.
Right: The sample form contains a list of topics the patient's plan might include. Some topics are discussed on every call, and other targeted topics are scheduled less often; pneumonia vaccine records are reviewed annually, while home blood glucose results might be reviewed every month.

Above: Thomas and Stewart, the practice's medical secretary, work closely together. Here they are discussing upcoming CCM appointments for the week. **Below right:** Thomas and Gokli discuss a medication regimen for a patient who was seen for an annual wellness visit.

most complicated patients. Or the physician or other health care provider will offer the service directly to the patient.

"Basically, CCM just dovetailed into TCM and annual wellness," said Thomas.

CMS defines CCM services as non–face-to-face care management or coordination services for certain Medicare beneficiaries having multiple (two or more) chronic conditions. CCM visits often have copayments associated with them, although not for dual-eligible beneficiaries. Some Medicare supplemental plans may cover the copayment as well.

Medication management is part of TCM services

TCM codes came out in 2013; CCM codes are more recent. TCM services help to ensure that patients, through the course of chronic or acute illness, are smoothly transitioned from an inpatient hospital setting to a community setting. TCM services are delivered over a 30-day window postdischarge from the inpatient setting. The three primary components of TCM services are an initial contact with the patient within 2 days of discharge, certain non–face-to-face services, and a face-to-face visit within a required time frame.

At Chickahominy, an external system will tell providers if one of their patients was discharged from the hospital. Thomas performs all of the services for TCM visits in collaboration with the physician provider. After the patient visit is scheduled with Thomas—CMS requires a 7- or 14-day window, depending on the complexity of the patient—a nurse calls the patient within 2 days of discharge to make sure the patient has everything needed until he or she is scheduled to come in. Thomas also receives a copy of the patient's discharge summary.

"Before they come in, I reconcile their medications with their discharge document to see what changes might have been made. Many times they need labs or a follow-up, and I get all that organized before they come in," said Thomas.

The appointment lasts 30 minutes. During that time, the pharmacist and the patient go over what happened in the hospital and what changes were made to the patient's medication. Thomas asks patients to bring in all their medications to clarify the regimen and changes.

"Almost always, there is some confusion over what medications they should still be taking or the changes," said Thomas.

CMS requires pharmacists and other providers to perform the face-to-face visit requirement for TCM services under direct supervision of the physician provider, and the patient needs to have direct contact with the physician at some point during the visit. For Thomas, this is done at the completion of her TCM visit, when the physician meets with the patient for 5 minutes. Non–face-to-face TCM services delivered during the 30-day window may be performed under general supervision.

At the OSU clinic where Barnes works, there is a similar system in which pharmacists are responsible for providing TCM services and work with physicians to optimize the patient's care plan.

Pharmacists might also work solely on the non–face-to-face components of TCM, since that's where a lot of medication management services are delivered.

Eric Dietrich, PharmD, BCPS, CPC-A, clinical assistant professor at University of Florida (UF) College of Pharmacy, has been instrumental in establishing transitional care management at UF, especially in his former role in making postdischarge follow-up calls for patients being seen across six different outpatient clinics.

In that position, he reviewed all medications the discharged patient was on and made sure there were no gaps, drug interactions, or duplications.

"Another goal of the phone call was to help try to get people into the clinic to see the physician," Dietrich told *Today*.

Any non–face-to-face TCM services are important not only in getting the service started in a timely manner but also in identifying any issues the patient is having to avoid a hospital readmission.

Annual wellness is a good place to start

AWVs must be provided under direct supervision in the physician's office.

As a community pharmacist, Olivia Bentley, PharmD, director of clinical services at Rx Clinic Pharmacy in North Carolina, provides these services and other billable Medicare services in the physician's office—and is paid for them—without being directly employed by a physician. Some clinics pay her by the hour or per service, and sometimes she gets paid as a percentage of what's received from the insurance company.

She does AWVs in the clinic setting and has also been able to conduct them in federally qualified health centers and assisted living centers.

According to Leal, AWVs are a viable way for pharmacists to break into doing CCM, TCM, and other Medicare services.

"It's a pretty nicely compensated code from Medicare that the pharmacist can do, and then that can lead into identifying patients who would qualify for chronic care management," said Leal.

AWVs are conducted once a year, and they incorporate many preventive components, like making sure the patient has completed any required screening tests based on age.

In fact, through AWVs, Bentley was able to establish what she calls a "collaborative physician service." She now provides billable Medicare services for several clinics and has other pharmacists working with her.

Her model originally grew out of an established relationship her pharmacy had with a physician in the community. She approached the physician in 2013 when meaningful use, PQRS, and quality measures were being discussed and asked about working together.

"We shared about how pharmacies are getting rated, too, with star ratings. We shared how we're also trying to avoid getting bought out by chains, just like independent providers are trying not to get bought by big hospital systems," said Bentley.

With much in common, they began their collaboration as a pilot program where Bentley would see a few patients in an afternoon for AWVs to help the physician meet meaningful use, PQRS, and other quality measures. The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) starting in 2017 represents additional new opportunities to help physicians.

"The doctor reviewed my notes, and he was so impressed by my documentation that he said he wanted me to see all of his patients," said Bentley.

Before Bentley starts working with a physician's office, she performs an assessment, equivalent to a physician's report card. Using electronic health record data, they can discuss quality measures for the year. Then, at the end of the year, Bentley runs the same report card to show the value she was able to add.

"We're getting doctors to understand that by utilizing pharmacists, they're adding another clinician on their team who can focus specifically on quality measures and value-based care," said Bentley.

2017 and beyond

As value-based care evolves, Thomas said she is finding that the level of complexity of the patient is becoming more important.

"Providers get brief visits with patients and don't tend to have the time to do what I do," said Thomas.

Thomas was happy to hear about the changes coming to CCM codes in 2017, which will include coverage for complex chronic care management services. "If it takes 60 minutes per month to visit, you can bill a higher complexity level," said Thomas.

Above: Thomas and Gokli review hospital discharge medication-related issues with a patient.

Some changes might even make it easier for more pharmacists to get involved with CCM.

"One of the nicest things coming in 2017 [for CCM services] is they are going to be more flexible and easier to implement," said Leal. "I think that will increase CCM use."

Leal said pharmacists should look at the ambulatory care physician fee schedule from CMS to stay informed about yearly changes as well as new codes that could potentially be leveraged by pharmacists. The Medicare Learning Network has brief summaries of each existing code as well.

Loren Bonner, senior editor