STROUDWATER

CRITICAL ACCESS HOSPITAL

FINANCIAL AND OPERATIONAL VIRTUAL CONFERENCE

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STROUDWATER

INTRODUCTION TO CHRONIC CARE MANAGEMENT

Amy Graham, Principal

Cameron Smith, Consultant

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OBJECTIVES

Learn about why the Chronic Care Management Program is important to patients and healthcare organizations

Understand the basic elements of Medicare's Chronic Care Management program

Understand the financial considerations of the Chronic Care Management program

OVERVIEW

CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

CHRONIC DISEASES IN AMERICA

6 IN 10

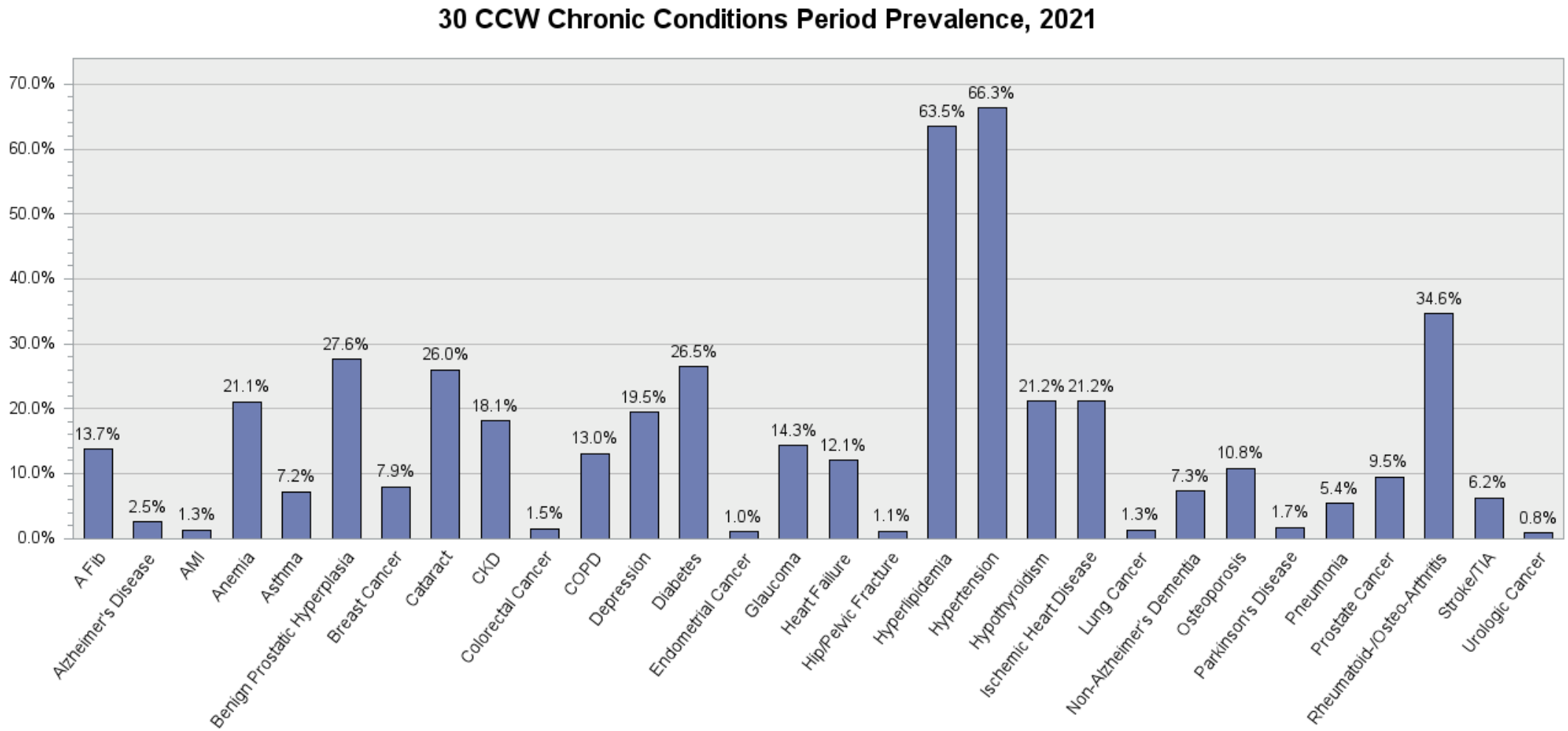
Adults in the US have a **chronic disease**

4 IN 10

Adults in the US have **two or more**

THE LEADING CAUSES OF DEATH AND DISABILITY
and Leading Drivers of the Nation's **$3.5 Trillion** in Annual Health Care Costs

CHRONIC CONDITION PREVALENCE



Source: https://www2.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts

WHAT IS CHRONIC CARE MANAGEMENT?

Chronic Care Management (CCM) services are designed to address the complex needs of Medicare beneficiaries suffering from multiple chronic conditions

In 2014, Medicare started paying for CCM services to patients with multiple chronic conditions under the Physician Fee Schedule

CCM allows healthcare professionals to be reimbursed for the time and resources used to manage Medicare patients' health between face-to-face appointments

CCM services may be furnished for Medicare patients with **two or more chronic conditions** who are at significant risk of death, acute exacerbation/decompensation, or functional decline

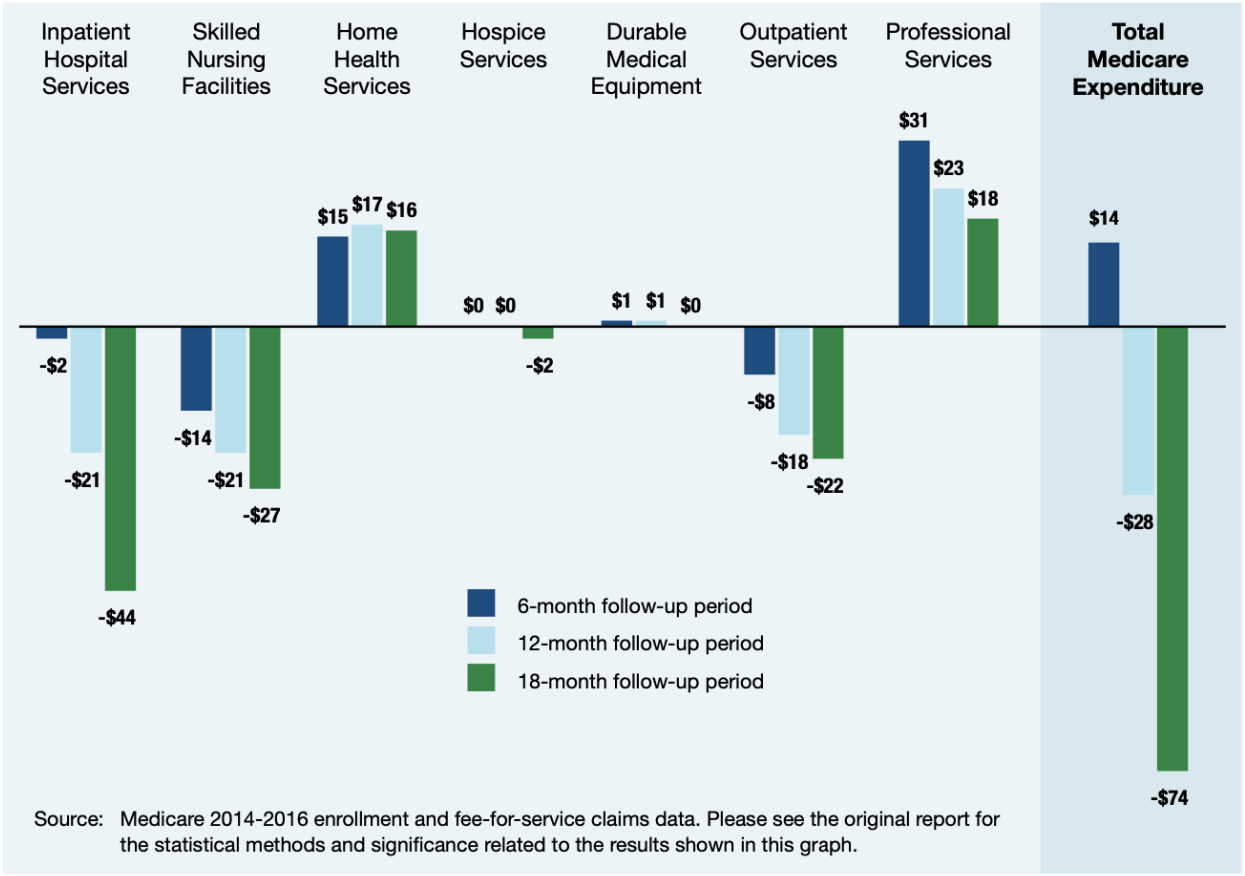
CCM services can be provided by FQHCs, RHCs, CAHs and can be a face-to-face encounter or non-face-to-face

WHY IS CHRONIC CARE MANAGEMENT IMPORTANT?

Patients benefit from CCM	Patients will gain a team of dedicated healthcare professionals who can help them plan for better health and stay on track for good health Patients will receive a comprehensive care plan CCM will give patients the support they need between visits
Benefits to your Practice	Improve care coordination practices Support patient compliance and help patients feel more connected Sustain and grow your practice Provide additional resources ($) to help your practice care for high-risk, high-needs patients

PBPM EXPENDITURES DECREASED BY $74 FOR CCM BENEFICIARIES

Estimated PBPM impact of CCM on total expenditures and by expenditure category: follow-up periods of 6,12, and 18 months



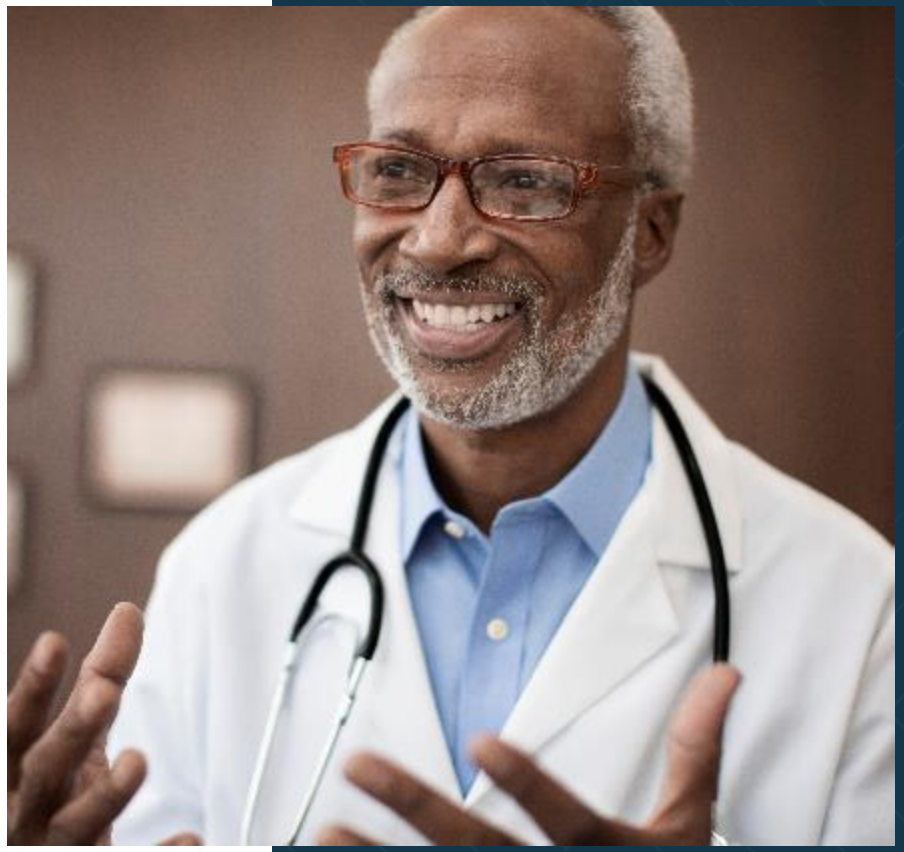
Source: https://www.pyapc.com/wp-content/uploads/2024/01/Providing-and-Billing-Medicare-for-CCM-PYA-010924.pdf

Implementing a Chronic Care Management (CCM) program is a critical component to **improving the health and wellness** of primary care patients, in addition to **capturing additional revenue** for the management of eligible beneficiaries within primary care practices, including RHCs.

BASIC ELEMENTS OF A CHRONIC CARE MANAGEMENT PROGRAM

CHRONIC CARE MANAGEMENT PRACTITIONERS

- Physicians
- Certified Nurse Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
  - Only one physician, APP, RHC or FQHC, and one hospital can bill for CCM for a patient during a calendar month
- Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, registered dieticians, social workers, pharmacists) cannot bill for CCM
  - These practitioners, however, can participate in CCM delivery as “clinical staff”



PATIENT ELIGIBILITY

Eligible CCM patients will have multiple (2 or more) chronic conditions expected to last at least 12 months or until the patient's death and/or that place them at significant risk of death, acute exacerbation and or decompensation, or functional decline

Examples of chronic conditions include, but aren't limited to:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Hypertension
- Infectious diseases like HIV and AIDS

IDENTIFYING PATIENTS

Identify Medicare Part B patients with two or more chronic conditions expected to last at least 12 months or until the death of the patient

Prioritize patients at the **highest risk of hospitalization** or who have recently been/are **regularly seen in the ED**

Start with patients who **regularly call the clinic** to manage symptoms or with medical questions

Identify patients who may be most likely to benefit from care management based on the **number of specialists involved in their care** or who have **limited social or local family support**

Identify patients **dually eligible for traditional Medicare and Medicaid** (not managed Medicaid)

SERVICES INCLUDE

- Conducting an initial face-to-face visit
- Utilizing EHR to record patient health information
- Development of a comprehensive care plan
- Access to care and care continuity (24/7)
- Care coordination
- Transitional care management (TCM)

INITIAL VISIT

Before CCM services can start, an initiating visit for new patients or patients whom the billing practitioner hasn't seen within 1 year is required

Initiating visit can occur during a comprehensive face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE)

If the practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit

Face-to-face initiating visit isn't part of CCM and can be separately billed

Practitioners who furnish extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes may also bill:

HCPCS code G0506 — Comprehensive assessment of and care planning by the physician or other qualified health care practitioner for patients requiring CCM services

Billing practitioners can bill G0506 only once, as part of initiating visit

PATIENT CONSENT

- Patients must give consent to receive CCM services
- This can be given in written form or verbally and documented in the medical record
- This documentation in the medical record must include:
  - The patient's consent to participate in CCM
  - The patient was informed that she/he can stop receiving CCM services at any time
  - That only one healthcare professional or hospital can provide CCM in a calendar month
  - Information about applicable cost sharing
- Patients need to provide informed consent only once unless they switch to a different CCM practitioner

RECORDING HEALTH INFORMATION

- Documentation of time and furnished services are essential for billing
- Record the following into the EHR:
  - Patient demographics
  - Patient consent
  - Comprehensive care plan
- At least 20 minutes of non-face-to-face clinical staff time per month

COMPREHENSIVE CARE PLAN

Person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and inventory of resources and supports

Comprehensive care plan for all health issues with a focus on managing chronic conditions

Provide patients and or caregivers with a copy of the care plan

Make electronic care plan available and shared promptly both within and outside the billing practice with individuals involved in patient's care

Comprehensive Care Plan

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

ACCESS AND CARE CONTINUITY

- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified practitioners or clinical staff
- Provide patients or caregivers with a way to contact health care practitioners in the practice to discuss urgent needs no matter the time of day or day of the week
- Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments
- Provide patients and caregivers opportunities to communicate with their practitioners about their care:
  - Phone
  - Secure messaging
  - Secure web
  - Email
  - Secure electronic patient portal

CARE COORDINATION

Coordinate with home and community-based clinical service providers, including:

- Home health and hospice
- Outpatient therapies
- Durable medical equipment
- Transportation services
- Nutrition services

Communication with these service providers must be documented in the beneficiary's medical record

CARE TRANSITIONS

Manage care transitions between and among health care providers and settings, including:

- Referrals to other clinicians
- Follow-up after an emergency department visit
- After discharges from hospitals, skilled nursing facilities, or other healthcare facilities

Create and exchange or share continuity of care document(s) promptly with other practitioners

PRINCIPAL CARE MANAGEMENT

Beginning CY 2020, CMS introduced Principal Care Management (PCM) services to furnish CCM for patients with a single chronic condition or with multiple chronic conditions but focused on a single high-risk condition

- PCM services may be expected to last 6 months–1 year or until patient's death
- PCM services require 30 minutes before billing

FINANCIAL CONSIDERATIONS

CPT CODES FOR CCM – CLINICAL STAFF TIME

99490

First 20 minutes of *clinical staff time* directed by a physician or other qualified health care professional, per calendar month

- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Comprehensive care plan established, implemented, revised or monitored

99439*

Each additional 20 minutes of ***clinical staff time*** directed by a physician or other qualified health care professional, per calendar month (limit 2); **in 2022 this code replaced G0588*

- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Comprehensive care plan established, implemented, revised or monitored

CPT CODES FOR CCM – CLINICAL STAFF TIME, CONT.

99487

First 60 minutes of ***clinical staff*** time directed by a physician or other qualified health care professional, per calendar month

- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Establishment or substantial revision of comprehensive care plan, ***moderate or high complexity medical decision making***

99489

Each additional 30 minutes of ***clinical staff time*** directed by a physician or other qualified health care professional, per calendar month (no limit)

- Listed separately in addition to code for primary procedure
- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Establishment or substantial revision of comprehensive care plan, ***moderate or high complexity medical decision-making***

CPT CODES FOR CCM – PHYSICIAN & RHC

99491

At least 30 minutes of ***physician*** or other qualified healthcare professional time, per calendar month

- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Comprehensive care plan established, implemented, revised or monitored

99437

Each additional 30 minutes by a ***physician*** or other qualified health care professional, per calendar month

- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Comprehensive care plan established, implemented, revised or monitored

G0511

20 minutes or more at RHC/FQHC, per calendar month

- Required Elements: Multiple (two or more) chronic conditions,
  - Multiple (two or more) chronic conditions,
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
  - Comprehensive care plan established, implemented, revised or monitored

ADDITIONAL CLARIFICATION

For CCM services the billing practitioner doesn't personally furnish, **the clinical staff furnish them under the direction of the billing practitioner on an incident-to basis** (as an integral part of services furnished by the billing practitioner), subject to applicable state law, licensure, and scope of practice. Clinical staff are employees or working under contract with the billing practitioner and payors directly pay that practitioner for CCM services.

- CPT code 99491 — Time only the ***billing practitioner spends***. Clinical staff time doesn't count toward the required reporting time threshold code.
- CPT codes 99487, 99489, and 99490 — Time spent directly by ***clinical staff***. Time spent by the billing practitioner may also count toward the time threshold if not used to report in 99491.

REIMBURSEMENT

CPT/HCPCS	Description	National Reimbursement
99490	First 20 minutes of clinical staff time	$61.56
99439	Each additional 20 minutes of clinical staff time	$47.15
99487	First 60 minutes of clinical staff time – Moderate/High complexity	$131.96
99489	Each additional 30 minutes of clinical staff time – Moderate/High Complexity	$71.06
99491	At least 30 minutes of physician time	$83.17
99437	Each additional 30 minutes of physician time	$58.61
G0511	20 minutes or more at RHC/FQHC	$71.68

RHC BILLING FOR CCM

Beginning CY 2022, RHCs and FQHCs can bill CCM and TCM services for the same patient during the same time period

CCM services can be billed using G code G0511 either alone or with other payable services

RHC Payments for G0511 are not factored in the RHC AIR

Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, and 99491

2024 rate is $71.68

Four new buckets of care management added in 2024

Remote Physiological Monitoring(RPM); Remote Therapeutic Monitoring(RTM); Community Health Integration (CHI); Principal Illness Navigation(PIN)

New rules allow for multiple G0511 per patient per month

FINANCIAL PROJECTION

Assumptions

- CCM enrollment is assumed at 10% (model 1) and 35% (model 2) of the Medicare patient panel, with a ramp-up period of 4 years in 25% increments
  - Medicare patient panel size was estimated by taking the Medicare total clinic visits and dividing by an assumed 3 visits per year based on the National Library of Medicine's Study
  - Payment per member per month is assumed at $75

5-year financial benefit

- Model 1: $414k
- Model 2: $1.45M

Model 1

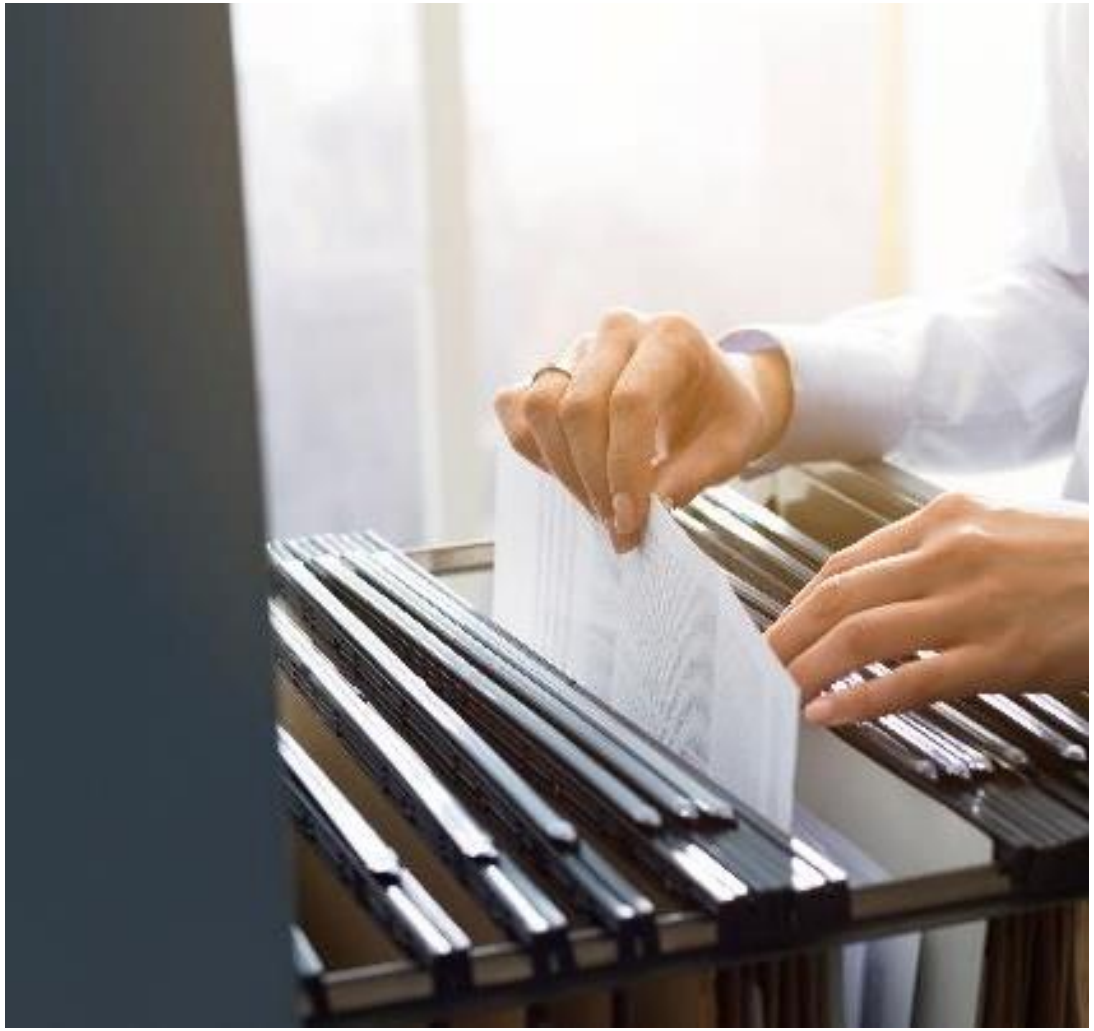
	Chronic Care Management				
	YR 1	YR 2	YR 3	YR 4	YR 5
Medicare Patients	1,170	1,224	1,280	1,339	1,401
% Participation	10%	10%	10%	10%	10%
Revenue PMPM	$ 75.00	$ 75.00	$ 75.00	$ 75.00	$ 75.00
Months	12	12	12	12	12
Ramp Up	25%	50%	75%	100%	100%
Annual Impact	$ 26,325	$ 55,072	$ 86,408	$ 120,510	$ 126,054

Model 2

	Chronic Care Management				
	YR 1	YR 2	YR 3	YR 4	YR 5
Medicare Patients	1,170	1,224	1,280	1,339	1,401
% Participation	35%	35%	35%	35%	35%
Revenue PMPM	$ 75.00	$ 75.00	$ 75.00	$ 75.00	$ 75.00
Months	12	12	12	12	12
Ramp Up	25%	50%	75%	100%	100%
Annual Impact	$ 92,138	$ 192,752	$ 302,427	$ 421,785	$ 441,187

DOCUMENTATION & CARE PLAN

THE IMPORTANCE OF GOOD DOCUMENTATION:



- Improving the accuracy and completeness of clinical documentation can reduce compliance risks, minimize a healthcare facility's vulnerability during external audits, and provide insight into quality of care and patient safety issues
- Strong clinical documentation that appropriately captures the patient's medical status including comorbidities, along with efficient coding, can improve revenue capture

DOCUMENTATION & COMPONENTS – CONSENT

CCM - Chronic Care Management
Patient Consent Form

A message from your doctor

Your health is very important to me and my staff.
Our goals are to:
- Keep you as healthy as possible
- Provide you with the best care
- Keep you out of the hospital
- Minimize the costs and inconvenience of unnecessary visits to doctors, labs, or urgent care facilities.

I encourage you to participate in the Chronic Care Management (CCM) program.

What are CCM Services?

Chronic Care Management (CCM) services help manage your health between office visits. The program provides a series of non-face-to-face activities and additional services especially for our CCM patients. For example:

- You will have a dedicated Care Team that is familiar with your conditions
- We actively help you manage all your medications
- We help coordinate your care with your other doctors
- We share your health information only with other authorized providers

Your Care Plan

Your Care Plan includes valuable information that will help you understand your medical conditions. Your Care Plan will help you to be as healthy as possible. Your caregivers and other authorized providers can access your Care Plan 24/7 using our secure medical portal in the event you require care when we are not available.

How much does this cost?

The answer depends on your insurance. Each month, after we provide you with a minimum of 20 minutes of non-face-to-face services, we will bill your insurer(s). Either you or your supplementary

What if I change my mind?

You may stop this service at any time, for any reason. If you choose to stop the service we will provide it only through the last day of the calendar month of your decision. Your signature is required to end Chronic Care Management services, so please ask my staff for the CCM revocation form.

You can only give CCM consent to one provider at a time. If another physician has offered to provide CCM, you will have to choose which physician is best able to treat and manage all your conditions. Please let me or my staff know if you change your mind, or if you have any questions.

How do I get started?

Signing this Chronic Care Management - Patient Consent Form allows me to begin immediately providing you with CCM services.

Again, I encourage you to sign up for this service.

Your Consent
I agree to participate in the Chronic Care Management program. Yes ____ No_____

_____ _____
Patient Signature/Date (Beneficiary's Representative)
Copy must be given to Patient and retained by Provider

_____ _____
Print patient name (Beneficiary's Representative)

DOCUMENTATION & COMPONENTS – CARE PLAN

HQIN Health Quality Innovation Network

Comprehensive Care Plan Template

Date of Establishment _____ or Date of Revision _____

Patient Information	
Name	
Date of Birth	
PCP	
Date Care Plan initiated	

Problem list	
Chronic Care Problems	
Surgeries	
Tests/Procedures	

Current Medications (Scheduled/PRN/Complementary or Alternative Medications)		
Medication	Dose	Frequency

Preventive Care		
Flu Vaccine:	Cancer Screenings	AWV:
Pneumonia Vaccine:	Breast:	
Tetanus:	Colon:	

Psychosocial	
Psychological and Neuropsychological testing (i.e. assessment /PHQ-2):	
Work/activities participation:	

HQIN Health Quality Innovation Network

Chronic Condition #1 - Goals and Interventions	
Chronic Condition #1:	
Prognosis:	
Symptom Management:	
Action Plan: Treatment Goals:	
Action Plan: Planned Interventions:	
Action Plan: Coordination of Care:	

Chronic Condition #2 - Goals and Interventions	
Chronic Condition #2:	
Prognosis:	
Symptom Management:	
Action Plan: Treatment Goals:	
Action Plan: Planned Interventions:	
Action Plan: Coordination of Care:	

Care Plan Reviewed with Patient ☐ **Care Plan Shared with Patient** ☐

Care Management Follow-up Activities	
Activity/Task description	Time Spent (in minutes)

DOCUMENTATION TIPS

Establish process to periodically audit documentation to support decisions regarding care

Attend the coding training to improve knowledge of documentation needs

Make sure all documentation is available to the team (physicians, nurses, therapists)

Additional information on Clinical Documentation Improvement (CDI) is available online at:

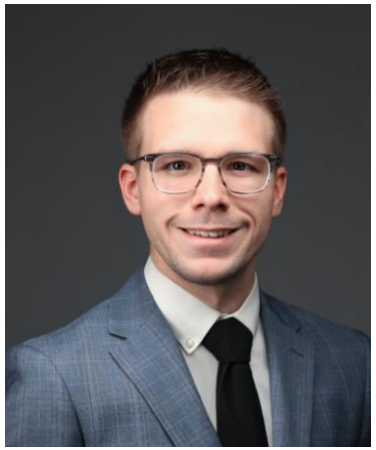
- http://www.ahima.org/topics/cdi
- https://en.wikipedia.org/wiki/Clinical_documentation_improvement

Q&A

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



Cameron Smith, Consultant
csmith@stroudwater.com
(T) 207.221.8253
(M) 309.337.3695

Amy Graham, Principal
agraham@stroudwater.com
(T) 207.221.8283
(M) 561.628.0066

USEFUL LINKS

- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralChart.pdf
- http://www.ahima.org/topics/cdi
- https://en.wikipedia.org/wiki/Clinical_documentation_improvement

PHYSICIAN TESTIMONIAL

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