LPCA
Louisiana Primary Care Association Inc.
"Louisiana's Health Centers"

Chronic Care Management:

Helping Patients Live Healthier While Achieving Financial Success for Providers

March 3, 2021

Introduction

Randy McKinney, M.S., M.P.A.

Randy brings more than 25 years of healthcare and management experience to LPCA. Randy came to LPCA from the Louisiana Virtual Medicine Alliance, where he served as Chief Operations Officer. Prior to working with LVMA, Randy served as Rural Health Clinic Administrator at Bienville Family Clinic in Arcadia. He joined the Louisiana Department of Health and Hospital's Bureau of Primary Care and Rural Health in 2009 as a Practice Management Consultant, where he served until 2013. He is also a Louisiana Licensed Nursing Facility Administrator.

During Randy's tenure as Administrator at Bienville Family Clinic, the clinic, in collaboration with the Bienville Parish School Board, received the 2019 National Rural Health Association's Outstanding Program Award for their work in providing Telemedicine Services in Bienville Parish Schools. Randy also served as the President of the Louisiana Rural Health Association in 2019.

Randy holds a Bachelor of Business Administration Degree from Dallas Baptist University, and Masters' degrees in Public Administration from the University of North Texas, and Criminal Justice from Grambling State University. He also has 30 graduate hours in Adult Education (Northwestern State University).

About the Louisiana Primary Care Association

Established in 1982 as a non-profit organization, the Louisiana Primary Care Association, Inc. (LPCA) promotes accessible, affordable, quality primary healthcare services for the uninsured and medically underserved populations in Louisiana. It is a membership organization of Federally Qualified Health Centers (FQHCs) and supporters committed to the goal of achieving health care access for all.

Care Management Services

4 General Categories

- **Transitional Care Management**
- **General Behavioral Health Integration (BHI)**
- **Psychiatric Collaborative Care Model (CoCm*)***
- **Chronic Care Management (CCM)**
  - *All care management services are FQHC services*
  - *Care Management Services are IN ADDITION to any routine care coordination services already furnished as a part of an FQHC Visit*

Chronic Care Management

Why CCM?

- **Chronic care management (CCM) is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients.**
- **The Centers for Medicare & Medicaid Services (CMS) recognizes that providing CCM services takes provider time and effort.**
  - CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible (Medicare and Medicaid) patients need to stay on track with their treatments and plan for better health.

Chronic Care Management

What is CCM?

- **Care coordination that is outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient.**
- **Practitioners may now bill for CCM for a calendar month when:**
  - At least 20 minutes of **non-face-to-face clinical staff time** is spent on care coordination for a Medicare patient with multiple chronic conditions, and is Directed by a physician or other qualified provider
    - *This time may be spent on activities to manage and coordinate care for eligible Medicare and dual eligible beneficiaries*

Chronic Care Management

Who is eligible for CCM?

- **Patients eligible for separately payable CCM services are:**
  - Medicare fee-for-service and dual eligible (Medicare and Medicaid) beneficiaries
  - With two or more chronic conditions expected to last at least twelve months or until the death of the patient
  - When those conditions place the patient at significant risk of:
    - *death*
    - *acute exacerbation/decompensation*
    - *or functional decline*

Chronic Care Management

Chronic Conditions

Alcohol Abuse	Drug Abuse/ Substance Abuse
Alzheimer's Disease and Related Dementia	Heart Failure
Arthritis (Osteoarthritis and Rheumatoid)	Hepatitis (Chronic Viral B & C)
Asthma	HIV/AIDS
Atrial Fibrillation	Hyperlipidemia (High cholesterol)
Autism Spectrum Disorders	Hypertension (High blood pressure)
Cancer (Breast, Colorectal, Lung, and Prostate)	Ischemic Heart Disease
Chronic Kidney Disease	Osteoporosis
Chronic Obstructive Pulmonary Disease	Schizophrenia and Other Psychotic Disorders
Depression	Stroke
Diabetes	

Chronic Care Management

Who can bill for CCM?

- **Physicians and certain Non-Physician Practitioners (Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives)**
- **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**
- **Hospitals, including Critical Access Hospitals (CAHs)**

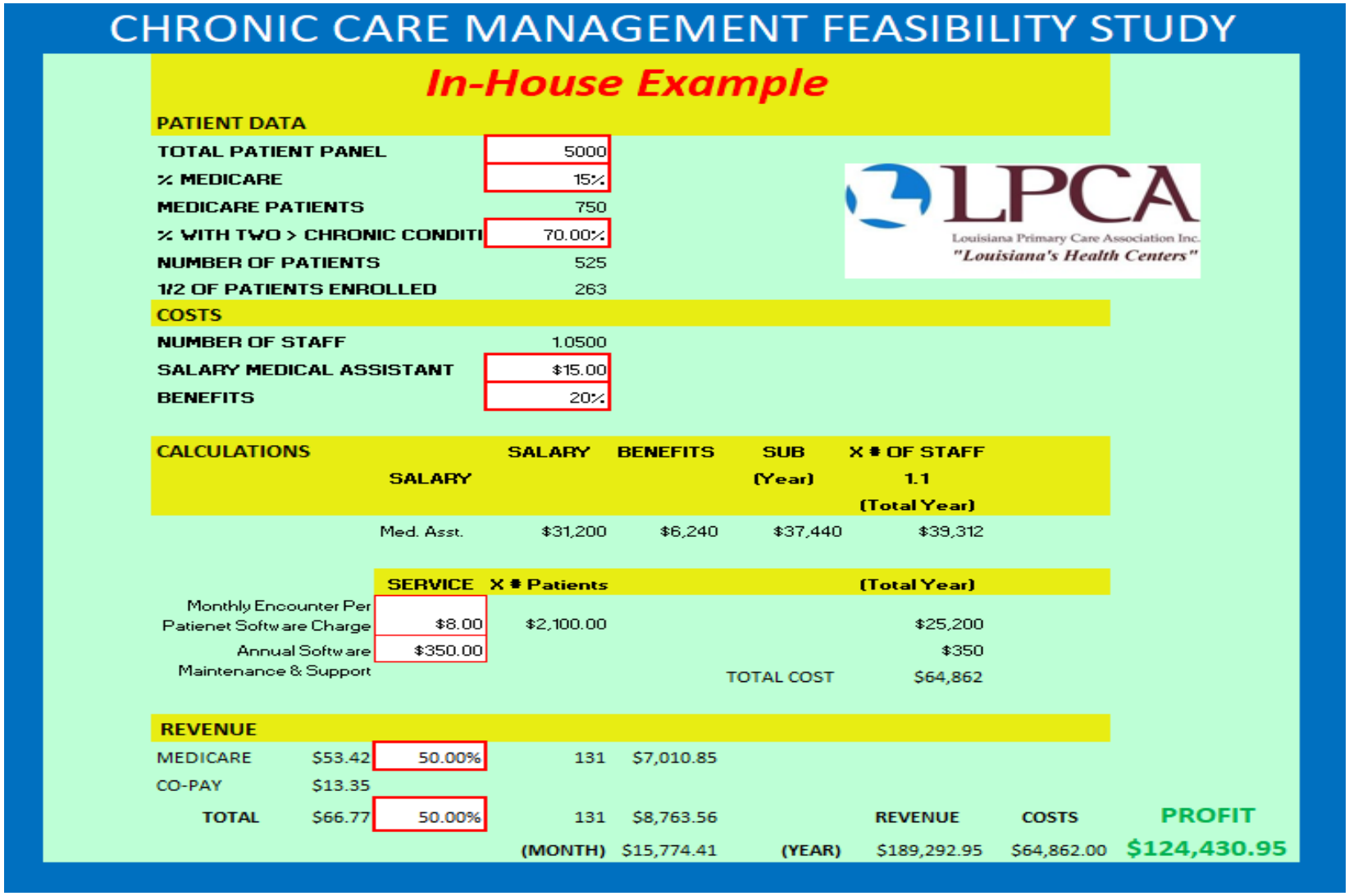
Chronic Care Management

To Provide In-House or to Contract Out?

- **Chronic Care Management (CCM) services may be provided:**
  - ***In-house OR***
  - ***Contracted with outside entity***

Chronic Care Management

Feasibility Study: In House Example



CHRONIC CARE MANAGEMENT FEASIBILITY STUDY

In-House Example

PATIENT DATA	
TOTAL PATIENT PANEL	5000
% MEDICARE	15%
MEDICARE PATIENTS	750
% WITH TWO > CHRONIC CONDITI	70.00%
NUMBER OF PATIENTS	525
1/2 OF PATIENTS ENROLLED	263

LPCA
Louisiana Primary Care Association Inc.
"Louisiana's Health Centers"

COSTS	
NUMBER OF STAFF	1.0500
SALARY MEDICAL ASSISTANT	$15.00
BENEFITS	20%

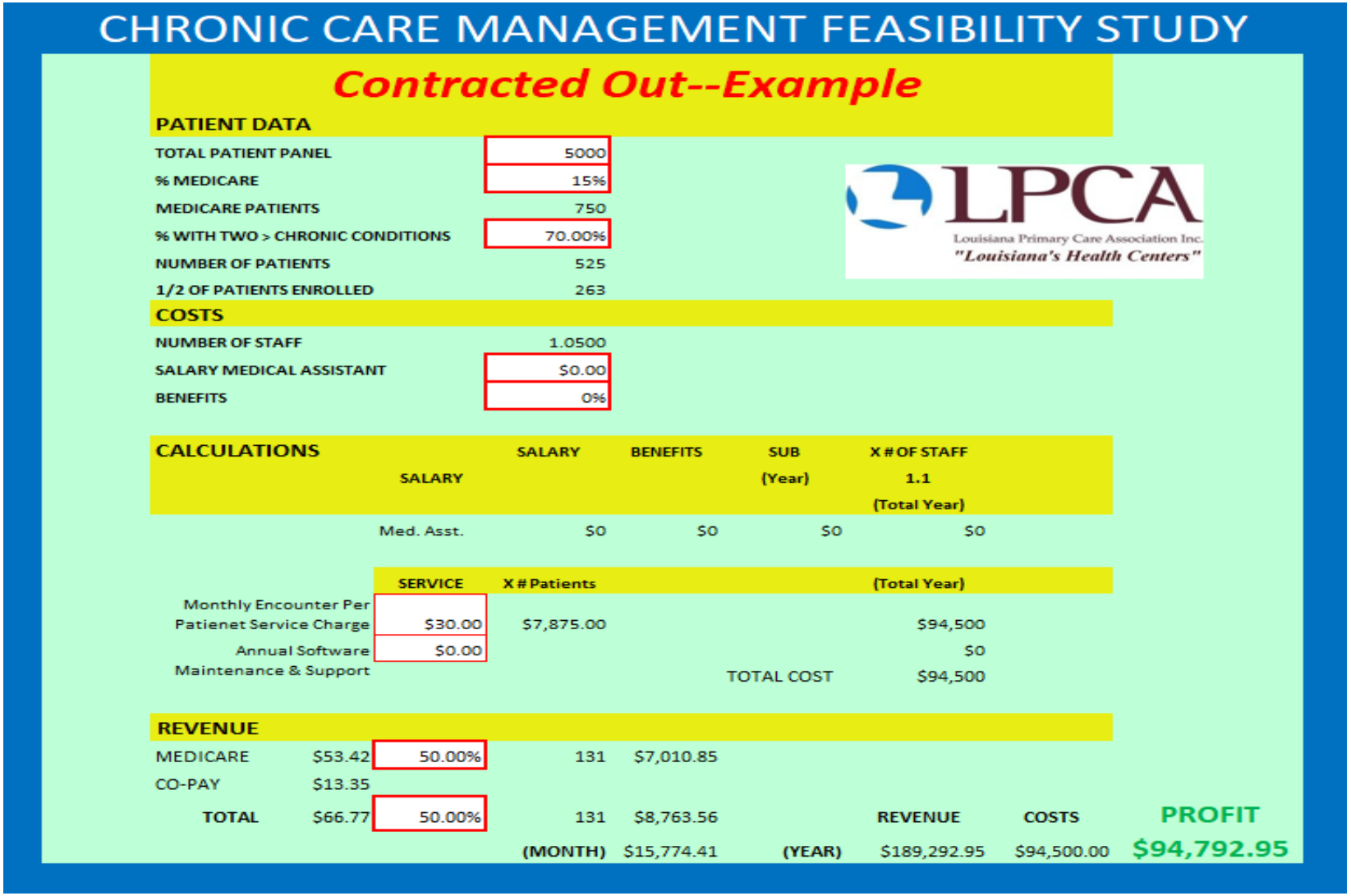
CALCULATIONS	SALARY	SALARY	BENEFITS	SUB (Year)	X # OF STAFF 1.1 (Total Year)
	Med. Asst.	$31,200	$6,240	$37,440	$39,312

	SERVICE	X # Patients		(Total Year)
Monthly Encounter Per Patienet Software Charge	$8.00	$2,100.00		$25,200
Annual Software Maintenance & Support	$350.00			$350
			TOTAL COST	$64,862

REVENUE								
MEDICARE	$53.42	50.00%	131	$7,010.85				
CO-PAY	$13.35							
TOTAL	$66.77	50.00%	131	$8,763.56		REVENUE	COSTS	PROFIT
			(MONTH)	$15,774.41	(YEAR)	$189,292.95	$64,862.00	$124,430.95

Chronic Care Management

Feasibility Study: Contracted Out Example



CHRONIC CARE MANAGEMENT FEASIBILITY STUDY

Contracted Out--Example

PATIENT DATA	
TOTAL PATIENT PANEL	5000
% MEDICARE	15%
MEDICARE PATIENTS	750
% WITH TWO > CHRONIC CONDITIONS	70.00%
NUMBER OF PATIENTS	525
1/2 OF PATIENTS ENROLLED	263

COSTS	
NUMBER OF STAFF	1.0500
SALARY MEDICAL ASSISTANT	$0.00
BENEFITS	0%

CALCULATIONS	SALARY	SALARY	BENEFITS	SUB (Year)	X # OF STAFF 1.1 (Total Year)
	Med. Asst.	$0	$0	$0	$0

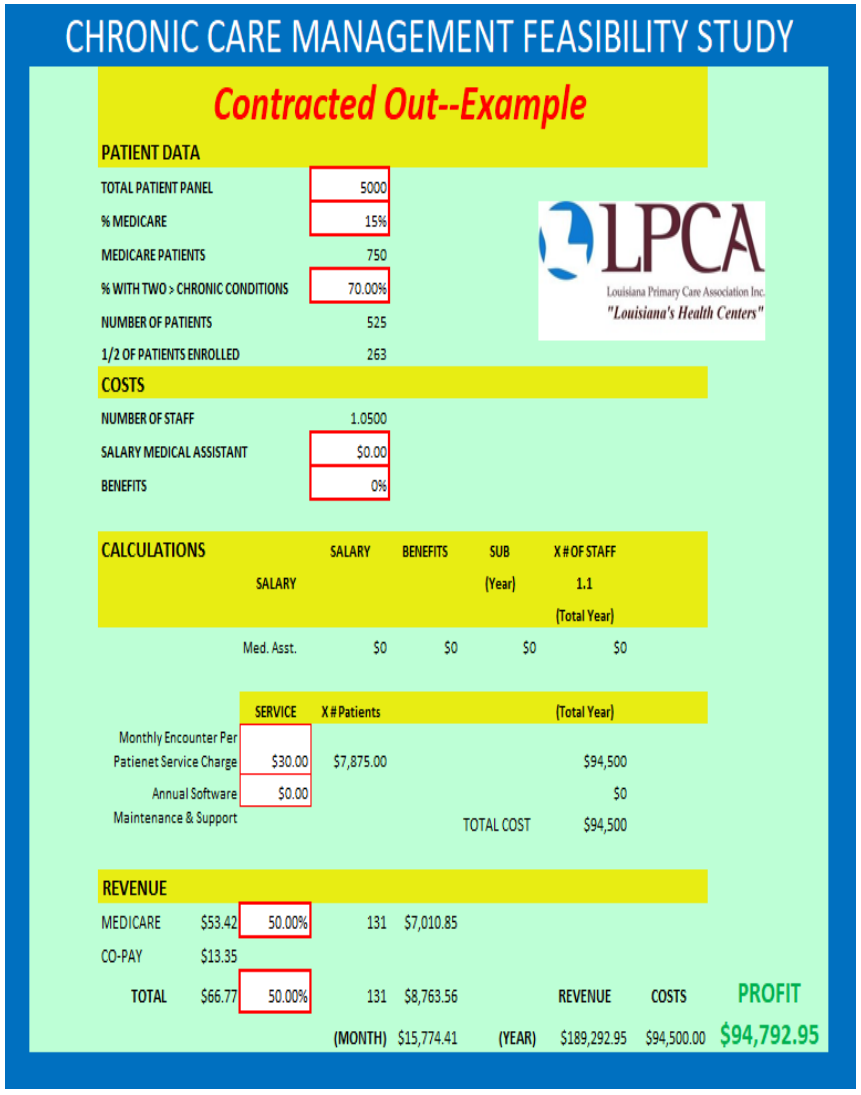
	SERVICE	X # Patients		(Total Year)
Monthly Encounter Per Patienet Service Charge	$30.00	$7,875.00		$94,500
Annual Software Maintenance & Support	$0.00			$0
			TOTAL COST	$94,500

REVENUE								
MEDICARE	$53.42	50.00%	131	$7,010.85				
CO-PAY	$13.35							
TOTAL	$66.77	50.00%	131	$8,763.56		REVENUE	COSTS	PROFIT
			(MONTH)	$15,774.41	(YEAR)	$189,292.95	$94,500.00	$94,792.95

LPCA
Louisiana Primary Care Association Inc.
"Louisiana's Health Centers"

Chronic Care Management

Feasibility Study: Side-by-Side Examples:



CHRONIC CARE MANAGEMENT FEASIBILITY STUDY

Contracted Out--Example

PATIENT DATA	
TOTAL PATIENT PANEL	5000
% MEDICARE	15%
MEDICARE PATIENTS	750
% WITH TWO > CHRONIC CONDITIONS	70.00%
NUMBER OF PATIENTS	525
1/2 OF PATIENTS ENROLLED	263

LPCA Louisiana Primary Care Association Inc. "Louisiana's Health Centers"

COSTS	
NUMBER OF STAFF	1.0500
SALARY MEDICAL ASSISTANT	$0.00
BENEFITS	0%

CALCULATIONS	SALARY	BENEFITS	SUB (Year)	X # OF STAFF 1.1 (Total Year)
	SALARY			
Med. Asst.	$0	$0	$0	$0

	SERVICE	X # Patients	(Total Year)
Monthly Encounter Per Patienet Service Charge	$30.00	$7,875.00	$94,500
Annual Software Maintenance & Support	$0.00		$0
		TOTAL COST	$94,500

REVENUE								
MEDICARE	$53.42	50.00%	131	$7,010.85				
CO-PAY	$13.35							
TOTAL	$66.77	50.00%	131	$8,763.56		REVENUE	COSTS	PROFIT
			(MONTH)	$15,774.41	(YEAR)	$189,292.95	$94,500.00	$94,792.95

CHRONIC CARE MANAGEMENT FEASIBILITY STUDY

In-House Example

PATIENT DATA	
TOTAL PATIENT PANEL	5000
% MEDICARE	15%
MEDICARE PATIENTS	750
% WITH TWO > CHRONIC CONDITI	70.00%
NUMBER OF PATIENTS	525
1/2 OF PATIENTS ENROLLED	263

LPCA Louisiana Primary Care Association Inc. "Louisiana's Health Centers"

COSTS	
NUMBER OF STAFF	1.0500
SALARY MEDICAL ASSISTANT	$15.00
BENEFITS	20%

CALCULATIONS	SALARY	BENEFITS	SUB (Year)	X # OF STAFF 1.1 (Total Year)
	SALARY			
Med. Asst.	$31,200	$6,240	$37,440	$39,312

	SERVICE	X # Patients	(Total Year)
Monthly Encounter Per Patienet Software Charge	$8.00	$2,100.00	$25,200
Annual Software Maintenance & Support	$350.00		$350
		TOTAL COST	$64,862

REVENUE								
MEDICARE	$53.42	50.00%	131	$7,010.85				
CO-PAY	$13.35							
TOTAL	$66.77	50.00%	131	$8,763.56		REVENUE	COSTS	PROFIT
			(MONTH)	$15,774.41	(YEAR)	$189,292.95	$64,862.00	$124,430.95

LPCA
Louisiana Primary Care Association Inc.
"Louisiana's Health Centers"

CONTRACTING CCM SERVICES OUT TO A VENDOR

Contracting Out CCM Services:

- If Contracted out:
  - Locate and evaluate vendors who provide contracted CCM services
    - How is provision of services achieved?
    - How do they communicate with your providers and staff?
    - How do you ensure required “general supervision” in order to bill?
    - How do they provide documentation to you so that you can bill
      - Through interface? $$$
      - PDF that can be “scanned” into a document folder in your EHR
    - How much $$$ will your clinic or center be charged?
    - How much revenue does your clinic or center receive?

LPCA
Louisiana Primary Care Association Inc.
"Louisiana's Health Centers"

PROVIDING CCM SERVICES IN-HOUSE WITH YOUR STAFF

In House CCM Services:

- If in house:
  - Evaluate software to “guide” your providers and staff in ensuring that services are provided
    - Software might be available in your EHR
    - Other software is available
  - Evaluate staff needed to “ramp up”
    - Do you have sufficient staff to begin the “ramping up” process?
    - Will you immediately hire a new staff member?

Identify your CLINIC or CENTER'S CCM CHAMPION!

- **CCM delivery has been slow to be adopted and difficult to sustain.**
- **Program viability varies widely**
  - Clinician and other staff acceptance can explain much of the variation in uptake, expansion and sustainability of CCM services

CCM “Champions”

- **CCM “champions” are enthusiastic individuals who initiate and promote the uptake of CCM services. “Champions” can have 3 main roles:**
  - Enthusiastic promotion of CCM
  - Acting as legitimators, and
  - Relationship building/sustaining

CCM "Champion"

Provider Champion

- **A "Provider Champion" for your center's CCM program could act as:**
  - an "internal" advocate for your center's program, by facilitating internal "buy in" to your Center's program
  - as an "external" advocate who could act as a liaison in developing relationships with patients and with others who are stakeholders in your patients' care

CCM "Champions"
Non-Provider/Staff Champions

- **Non-Provider Staff CCM Champions can assume the following roles:**
  - Explain CCM services to patients
  - Ensure that the patient is comfortable with CCM, and that they understand the entire process
  - Patient retention
    - Call patients who have expressed a desire to be removed from the CCM program
      - Facilitate addressing their concerns or needs that are not being met
      - Find out the "real reason" that they don't want to continue receiving CCM services
        - Help patients to overcome objections or reluctance to continue use of program by reviewing program benefits

LPCA
Louisiana Primary Care Association Inc.
"Louisiana's Health Centers"

STEPS TO IMPLEMENT CCM FOR YOUR PATIENTS

Steps to Implement CCM in Your Facility

Step 1: Identify the Patients

- Use your EHR to search for patients with 2 or more chronic conditions.
- Run reports sorted by provider
  - Provider can review his/her report and remove anyone that he/she does not think is a good fit for the CCM program
- At first, it might be workable to focus on a small number of specific diagnoses, such as diabetes, hypertension or COPD
- Create a LOG of participating CCM patients

Steps to Implement CCM in Your Facility

Step 2: Designate Staff for Each Identified Patient

- Primary care clinician
- Nurse/Medical Assistant
- Other staff helping with
  - Enrollment
  - Consents
  - Scheduling
- The patient should be able to access “successive routine telephone appointments” with the designated clinician
- Other clinical staff can provide services “incident to” the primary clinician
  - The primary provider is providing GENERAL SUPERVISION

Steps to Implement CCM in Your Facility

Step 3: Design a CCM Process & Schedule

- Set up appointments for new visits and assessment calls as needed
- As enrollment increases, consider designating time frames for clinician visits and nurse calls
  - New and subsequent (monthly)
- Assign CCM nurses and staff to assist with:
  - Enrollment
  - Consents
  - Scheduling
  - Other related activities
- Ensure that an after-hours clinician is available to receive and respond to patient calls

Steps to Implement CCM in Your Facility

Step 4: Inform the Patient

- Invite patients to participate in CCM:
  - Through a written invitation accompanied by a written consent form; or
  - by initiating a telephone call where consent can be obtained and documented.
    - This invitation could work best by contacting an involved family member (or other individual, such as a neighbor) to help to facilitate getting the patient started on the program
      - ***But the PATIENT must consent and agree to participate***
- Explain how the program works, and that they can decline, transfer or terminate the program at any time.

Steps to Implement CCM in Your Facility

Step 4: Inform the Patient (continued)

- Provide information on how to terminate or transfer CCM services
- Receive authorization of electronic communication of medical information with other clinicians (as per state and local rules and regulations)
- Provide designated provider's name, as well as the CCM nurse or other clinical staff member who will be communicating with the patient via phone.
- Explain the monthly scheduled clinical assessment telephone visit, which will be treated as though it was a regular visit, even though it will occur over the phone
- Explain how the services are billed, and what the patient's obligation is
  - Copays
  - Deductibles

Steps to Implement CCM in Your Facility

Step 4: Inform the Patient (continued)

- Review the participation agreement with patients to ensure that they understand.
  - This can be done in person, or via telephone
- Record in the patient's electronic record:
  - That CCM was explained
  - That written or oral consent was obtained to accept or decline services
  - The name of clinician to provide services
  - That an electronic care plan will be initiated
  - That the patient has the right to stop receiving CCM services at any time

Steps to Implement CCM in Your Facility

Step 5: Create and Document a Comprehensive Care Plan

- Care management for chronic conditions should include:
  - A systematic assessment of the patient's needs:
    - Medical
    - Functional
    - Psychosocial
  - A system-based approach to ensure timely receipt of all recommended preventive care services
  - Medication reconciliation with review and adherence and potential interactions
  - A review to ensure proper self-management of medications

Steps to Implement CCM in Your Facility

Step 5: Create and Document a Comprehensive Care Plan (Continued)

- **Create a patient-centered care plan based on ASSESSMENT and RE-Assessment:**
  - **Physical**
  - **Mental**
  - **Cognitive**
  - **Psychosocial**
  - **Functional**
  - **Environmental**
- **As appropriate, the care plan should be shared with other clinicians and providers**

Steps to Implement CCM in Your Facility

Step 6: Provide the Patient with a Copy of the Care Plan

- Written
  - Mail
  - Electronic through the portal
    - This is a good time to encourage patients to become familiar with using the portal
- During every monthly call to the patient, a portion of the care plan can be reviewed with the patient
  - Diet
  - Weight
  - Taking medications
  - Smoking cessation
  - Exercise
  - Patient education

Steps to Implement CCM in Your Facility

Step 7: Document Time Spent

- Set up a system to keep track of time spent on non-face-to-face services provided, including:
    - Phone calls and e-mails with the patient
    - Time spent coordinating care
        - By phone or other electronic communication
            - With other
                - Clinicians
                - Facilities
                - Community resources (patient transportation)
                - Caregivers
                - Family members
- Time spent on prescription management or medication reconciliation

Steps to Implement CCM in Your Facility

Step 8: Termination from the Program

- **Termination from the program:**
  - **Document:**
    - **Death**
    - **Transfer of patient to another provider**
    - **Termination from CCM plan for any reason**

Integrating Behavioral Health into CCM Call

- **While there may be several appropriate approaches to integrate behavioral health into a telemedicine visit, integrating the PHQ 2 and the PHQ 9 are widely accepted depression tools that can be used.**
  - Both incorporate widely accepted depression criteria with other leading major depressive symptoms into a brief self-report instruments that are commonly used for screening and diagnosis, as well as selecting and monitoring treatment. *(https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health)*

Integrating Behavioral Health into CCM Call

Patient Health Questionnaire-2 (PHQ-2)

Share

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is to screen for depression in a "first-step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	+1	+2	+3
2. Feeling down, depressed or hopeless	0	+1	+2	+3

PHQ-2 score obtained by adding score for each question (total points)

Interpretation:

- A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cutpoint when using the PHQ-2 to screen for depression.
- If the score is 3 or greater, major depressive disorder is likely.
- Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.

Care Management Services

Chronic Care Management: Getting Paid

- **Care management services are paid IN ADDITION TO FQHC ENCOUNTERS**

Care Management Services

Chronic Care Management: Getting Paid

- **G0511 with revenue code 052X**
  - Add the general care management G code (G0511) to an FQHC Claim
    - G0511 can be submitted:
      - Alone OR
      - With other payable services
        - Payment rate adjusted annually

G0511 PAYMENT 2021-LOUISIANA (NOT NEW ORLEANS AREA)

Fee Schedule for G0511

Sources: 2021 National Physician Fee Schedule Relative Value File, GPCI21, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2021, MCR-MUE-PractitionerServices

Publisher: CMS

Effective: January 01, 2021

Medicare Carrier/Locality:

REST OF LOUISIANA 99-07202

Conversion Factor: 34.8931

Make it default

Calculate

Note 1: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

CMS has valued this code, but the Relative Value Unit (RVU) is not used for Medicare payment. For more information, check the code's status.

Code Status	X

Medicare Fees

	National	Adjusted	26	TC	53
Facility	$65.25	$62.10	$0.00	$0.00	$0.00
Non Facility	$65.25	$62.10	$0.00	$0.00	$0.00

G0511 PAYMENT 2021-NEW ORLEANS AREA

Fee Schedule for G0511

Sources: 2021 National Physician Fee Schedule Relative Value File, GPCI21, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2021, MCR-MUE-PractitionerServices

Publisher: CMS

Effective: January 01, 2021

Medicare Carrier/Locality:

NEW ORLEANS 01-07202

Conversion Factor: 34.8931

☑ Make it default

Calculate

Note 1: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

CMS has valued this code, but the Relative Value Unit (RVU) is not used for Medicare payment. For more information, check the code's status.

Code Status	X

Medicare Fees

	National	Adjusted	26	TC	53
Facility	$65.25	$64.19	$0.00	$0.00	$0.00
Non Facility	$65.25	$64.19	$0.00	$0.00	$0.00

Care Management Services

Coinsurance & Deductibles

- FQHCs
  - Only coinsurance applies
- Coinsurance for care management services CANNOT BE WAIVED
  - *FQHCs may offer financial assistance for patients who qualify (Sliding Fee Scale for deductibles/co-pays)*
- Coinsurance is the LESSER of the submitted charge or the payment rate

Care Management Services

Date of Service

- The service period for care management services is the CALENDAR MONTH
  - The date of service can be:
    - The date that the requirements to bill for the service have been met for that month OR
    - Any date after that, but on or before the last day of the month

Care Management Services

Diagnosis Code

- **All claims must include a diagnosis code and providers should use the most appropriate diagnosis code for the patient**

Care Management Services

Diagnosis Code: Cost Reporting

- **Any cost incurred in providing care management services is a reportable cost and must be included on the Medicare cost report**
  - **Costs are reported in the "*Other than FQHC Services*" section of the cost report**
  - **Costs are not used in determining the FQHC PPS Rate**

Care Management Services

Some Billing Rules

- FQHCs can only bill one care management service for a patient per month
- There is no additional payment if more time is spent
- No billing for overlapping dates of services when another entity is billing for care management services
- No billing during a Medicare Part A skilled nursing facility (SNF) stay
- FQHC can bill in a nursing home or an assisted living facility that is not furnishing care management services, and if the FQHC provides services required to bill
- No billing when person is under home health or hospice care supervision

Care Management Services

Some Billing Rules

- Billing is for time spent ONLY during the same calendar month.
- If 2 or more providers or staff discuss a patient's care, only one person's time will count toward the 20 minutes of care services
- FQHC may contract for "out of 4 walls of facility" services provided by another entity, provided that the care services provided are under the "general supervision" of the FQHC provider
  - This does not require the provider to be in the same physical location or immediately available.
    - Services must be under provider's overall supervision and control

Care Management Services

Some Billing Rules

- **Contact with patient every month is NOT necessary to bill for care management services**
  - **CMS does expect that FQHCs will want to keep the patient informed about their care management**

Care Management Services

Medicare Advantage Plans

- **FQHCs should consult with the Medicare Advantage Plan for billing information**

Sources Used for Presentation Material:

- **American College of Physicians Chronic Care Management Toolkit**
  - **https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf**
- **Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions December 2019**
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

QUESTIONS?

Contact

Randy McKinney

Telehealth Project Manager

(318) 547-8328

RMcKinney@LPCA.Net