Welcome to
Chronic Care Management:
Primary Care Practices Meeting
the Triple Aim and
Getting Paid For It

WEBINAR ETIQUETTE
• All attendees are in “Listen Only” mode
• Questions or comments?
  - Open “Questions” pane in dashboard
  - Type in comments or questions
  - Comments will be monitored throughout webinar.
  - Questions will be addressed at end of the webinar.
• This webinar will be recorded and posted for you to share with others on your team
• Handouts are available for download in the Handouts pane, and will also be emailed out to attendees after the webinar.

AGENDA
Intro & Welcome               Jennie Price, HTH
Program Overview             Nancy J. Kamp, HMA
  - Program Calendar
Next Steps & Registration   Kristy Thomson, HTH
  - Program Dashboard
Introduction & Welcome

Why Focused on Chronic Care Management?

- New requirements for physician practices, such as the CCM fee, Patient Centered Medical Home recognitions, and pay for performance/value-based payment models are requiring a transformation in the way a physician office practices.
- There may be more money on the table for physicians who move to new models, such as the new non-visit-based payment for chronic care management (CCM) of Medicare patients.

Introduction & Welcome

Why Focus on Chronic Care Management?

- Help move us all toward meeting the “Triple Aim” of new model of care:

  - Improving the experience of care,
  - Improving the health of populations,
  - Reducing the costs of health care

Partnering with Health Management Associates

- What it will take to put in place for our physician practices?
- What are the process and tools needed to meet the requirements?
- Why do it?
- Various Models and Costs
- Outline of the “CCM Solution” Program
Meet Nancy Jaeckels Kamp - Principal, HMA

Primary Care nurse with years of experience in:
- PCMH transformation
- Behavioral Health integration into primary care
- Lean methodology and training
- Complex Care management training and transitions of care models
- Leading regional and state-wide learning collaboratives

About HMA
• Our integrated delivery team includes
  – Practice Transformation Specialists and Certified PCMH trainers
  – Care management trainers
  – IT professionals
  – Experienced clinicians
  – Integrated Care Specialists
  – FQHC and Medicaid regulatory specialists
  – Data analysts
• We stay ahead of policy trends and changes, new initiatives, and business opportunities to keep our clients informed

Medicare CCM Payment
Opportunity and Dilemma
CPT Code 99490

“Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements; multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.”

(CMS Final Rule, October 31, 2014)

New Medicare Payment for Chronic Care Management (CCM)

• Potential for over $400 per year for each Medicare beneficiary in the practice with two or more chronic diseases (avg monthly pay was $42.35 in 2015)
• CCM payments reimburse providers for furnishing specified non-face-to-face care mgmt. services each calendar month
• A first step along the continuum of risk-based reimbursement
• A way to retain and grow Medicare

What is the benefit? Why Do it?

• Care Management (CM) is being developed, and implemented within practices, or outsourced by most PC practices already....and not regularly being reimbursed
• CM has been proven in the research to reduce total costs of care for chronic disease patients while improving their overall health
• Key part of Practice transformation if seeking PCMH recognition or some other type of accreditation
• If taking on any risk within plans/mgd care contracts, this approach to team care and management of “high utilizers” is critically important
• Builds a better model for care overall for complex Medicare patients
Who qualifies?

- Medicare beneficiary requirements
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until death
  - The chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Consent to services, co-pay and information sharing (does not qualify for co-pay exemption)

Does this make sense for you to do?

- Example Table:

<table>
<thead>
<tr>
<th>Medicare Beneficiary</th>
<th>1000</th>
<th>500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible for CCM (2 or more CDs—CMS says 40-60%)</td>
<td>400 – 600 (lets take an average of 50% = 500)</td>
<td>200 – 300 (lets take an average of 50% = 250)</td>
</tr>
<tr>
<td>Gain consent for program (conservative estimate of 70%)</td>
<td>350</td>
<td>175</td>
</tr>
<tr>
<td>Monthly billing at 2015 average of $42.64</td>
<td>Calculate on 6 month and 12 month</td>
<td>Calculate on 6 month and 12 month</td>
</tr>
<tr>
<td>Total amount ranges</td>
<td>$89,544 - $179,088</td>
<td>$44,772 - $89,544</td>
</tr>
</tbody>
</table>

- Take into account the number of providers in your practice and their average panel size (1800-2000) and the percent of Medicare you have to get your own estimate for the this calculation.

Does this make sense for you to do?

- Costs table:

<table>
<thead>
<tr>
<th>Cost element</th>
<th>Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR build</td>
<td>Based on your gaps in electronic capabilities</td>
</tr>
<tr>
<td>Staff for care management</td>
<td>Salary differences in your area</td>
</tr>
<tr>
<td>- Medical assistant (RN or provider supervision)</td>
<td>FTE per caseload – if only doing CCM work, a CM with a mix of moderate and complex care need levels could average 250 - 350 patients</td>
</tr>
<tr>
<td>- LPN (some supervision)</td>
<td></td>
</tr>
<tr>
<td>- RN</td>
<td></td>
</tr>
<tr>
<td>Other?</td>
<td></td>
</tr>
</tbody>
</table>

- If your overall numbers are low, does it make sense to partner with a practice and share a care manager?
Billing Nuances

• CPT code for CCM
• 4 types of providers can bill for CCM:
  - Physician, PA, APN, clinical nurse specialists, and nurse mid-wife
• Only one CCM fee may be billed per patient per month
• If Care coordination/management is happening outside of the practice, documentation and coordination must be connected and the billing still generates from the billable provider within the practice
• If you are a part of a MSSP, you can still bill for CCM (your costs will go toward you total spend)
• Do not need to be PCMH recognized to bill for CCM
• CPT code for TCM – see later....

Poll Questions

Do you know your average panel size?

Poll Questions

Do you know the percentage of Medicare patients?
(If not, do you know how to obtain this information?)
**Poll Questions**
Do you already have methods for identifying patients with multiple chronic conditions in need of care management?

**What must be done?**
- Secure eligible beneficiary written consent
- Provide 20+ mins of non-F2F CM
- Make it all Work
  - Monitor and affect financial performance of the organization
  - Track CPT code used
  - Track patient outcomes and ED visits and readmissions
  - Build next levels of care, transitions of care, behavioral health integration, etc.

**Five Practice Capabilities**
1. Use a certified EHR for specified purposes
2. Maintain a comprehensive electronic care plan
3. Ensure beneficiary access to care
4. Facilitate transitions of care
5. Coordinate care
EHR Capabilities

- Store consent permanently and retrievable
- Document and retrieve non-visit notes
- Electronic capture of full assessment and care plan (may need to create templates to add to EHR)
- Must be able to transmit a care summary electronically for the purposes of coordination

Electronic Care Plan

- The provider must develop and regularly update an electronic care plan.
- Must be electronically accessible 24/7 to all care team members furnishing CCM services billed by the provider.
- This care plan includes:
  - A list of current practitioners and suppliers that are regularly involved in providing medical care
  - The assessment of functional status related to chronic health conditions
  - The assessment of whether cognitive limitations or mental health conditions that could impair self-management
  - An assessment of preventive healthcare needs
- The care plan should address all health issues (not just chronic conditions) and be compatible with the beneficiary's choices and values
- Provider paper or electronic availability of the care plan to the beneficiary/patient.

Access to Care

- 24/7 access to a member of the care team to address acute/urgent needs in a timely manner
- Continuity of successive appointments with designated provider or member of the care team
- Enhanced opportunities patient/provider communication by telephone and other alternative methods such as, patient portal and other secure messaging (offered and availability to the patient but not required to use these methods)
Transitions of Care
A provider must have the capability to:
• Follow-up after an ER visit
• Provide post-discharge transitional care management (TCM) services as necessary (cannot bill for TCM and CCM during the same month)
• Coordinate referrals to other clinicians
• Share information electronically with other clinicians as appropriate
• Coordinate with home and community-based clinical service providers to meet patients psychosocial needs/functional deficits

Care Coordination/Management
• 20+ minutes of non-face-to-face care management services
  – *Medication reconciliation and overseeing self-mgmt. of meds
  – *Ensuring receipt of all recommended preventive services
  – *Monitoring the patients condition (physician, mental, social)

• 20+ minutes of non-face-to-face care management services – ADDITIONAL types of services could include:
  – Education and addressing questions from the patient and family
  – Arranging and coordinating community resources needed
  – Communications and coordination with other providers the patient is also seeing
**FQHC/RHC eligibility in 2016**

- Identify the eligible population
- Initiate and **obtain consent** during an Annual Wellness Visit to include an HRA At least 20 minutes of certified clinical staff time per calendar month that includes establishing, implementing, revising or monitoring care plan
- Care management must occur within the practice and under the supervision of the provider (cannot have outside or centralized care mgmt. model)

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**Transitions Care Management**

**What's TCM and how does it relate to CCM?**

- 30 day post-discharge transition focus
- New TCM codes – 99495 and 99496
- Patients need to be at moderate or high risk for these services and codes to be used
- Cannot code in same month as CCM unless the 30 day post-discharge date concludes in the same month as the CCM begins
- Build CCM first and then can add TCM capabilities

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**Additional Benefits**

- Increase focus on Medicare
- Begin steps towards eventual risk-based payments
- Builds a complex care management program and begins steps towards additional models such as TCM, BHI
- Retain patients with more intense customer service
- Improve negotiating position with MCOs for business and better reimbursement contracts
Practices sign up for the program and receive:
- Access to an on-line CCM readiness assessment
- Two, 90 minute webinars giving technical guidance, tools, and steps to building the internal processes
- One, full-day care management training
- Two, follow-up practice specific coaching calls for additional support and personalized assistance
- Collaborative networking calls with all practices working on CCM; share stories, tools, successes and lessons learned

Readiness Assessment
- Electronic assessment to guide your practice in understanding gaps in care, processes and staff
- Easy to complete guide specific to CCM requirements
- Assessment will be a key guide to working with your practice both individually and collaboratively and prioritizing your biggest needs
- Re-assess at conclusion of program to see where there are still needs and aid in creating an ongoing action plan

Webinars
- Two, 90 minute webinars will provide the technical requirements for CCM and the steps towards building the solution
- First webinar will concentrate on familiarizing your practices with CCM overall and reviewing your assessment and critical gap areas, the steps to getting started, identifying your eligible population, ongoing data collection
- Second webinar will focus on the technical aspects for electronic requirements, documentation and billing as well as building communication and coordination bridges
Day-long CM Training

- Building CCM workflows from patient identification to ongoing management and billing
- Reviewing tool kit with such things as: care plan templates, consent forms, and care management tools
- Build care management skills and competencies:
  - Self-management goal setting
  - Patient engagement/Motivational Interviewing
  - Shared decision making
  - Care guides for disease-specific care management

Coaching Calls, Collaborative Sharing, and Tool Kit

- Practices may participate in individual coaching calls with someone on the HMA CCM Solution Team to help guide your team on any questions, gaps, additional resources needed for successful implementation
- Practices may participate in collaborative sharing calls facilitated by HMA coaches with invitees from all practices working within the CCM Solution. Sharing lessons, tools, and successes

Tips for decision-making

- You can easily obtain data on your patient Medicare panel
- You have an adequate pool of eligible Medicare patients
- You are already working on or planning on care management and care transitions models
- You are already in or thinking about risk-based contracts?
- You are looking for reimbursement for work you are already doing for best patient care that is not traditional FFS
- Building the CCM program seems a doable thing with some help – leadership and clinicians are bought in
Poll Question
Do you think your organization would benefit from taking on the CCM Solution and Medicare payment?

Kristy Thomson, COO
HomeTown Health

What makes this program different?

• The CCM Solution is a unique program built to guide the practice team in building and implementing your own model of care and work redesign.

• Our philosophy and approach is to provide technical assistance and training for staff in order to grow your own capacity and competency within the practice for long-term sustainability of the model long after the program is completed.
NEXT STEPS
Registration and Resources

PROGRAM INFO DASHBOARD:
www.hthu.net/CCMsolution/

NEXT STEPS
Registration and Resources

PROGRAM OVERVIEW & CALENDAR FOR PROGRAM
Located on the CCM Solution Webpage:
www.hthu.net/CCMsolution
or
In the Handouts Section of this Webinar for
download now!

NEXT STEPS
Registration and Resources

PROGRAM REGISTRATION FORM
Please submit registration forms ASAP
(by April 1st)

The CCM Team will reach out to you,
give you access to the Participant
Dashboard, and get you started on the
Readiness Assessment.
QUESTIONS?
Type your Questions in the Q&A Pane!

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