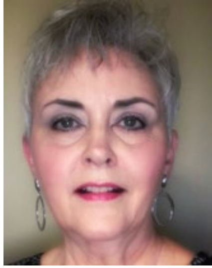
CCM for Patient Centered Medical Homes



The information and advice outlined in this document has been developed in cooperation with Linda J. Pepper, Ph.D., Founder and CEO of Pepper Consulting Services, LLC.

Dr. Linda Pepper has over 25 years of experience in corporate strategic planning, marketing and business development at the federal, state and private levels. Over the last 14 years, Dr. Pepper has worked exclusively in healthcare with Federally Qualified Health Centers, Patient-Centered Medical Homes, and healthcare technology companies. In 2013, she received her designation as a NCQA PCMH Certified Content Expert and has led 100% of her clients to a Level III recognition. Dr. Pepper has developed PCMH programs and business strategies leading to some of the highest NCQA pre-validation auto credit scores in the industry.

OPPORTUNITY IS FINALLY HERE!

The Patient-Centered Medical Home (PCMH) is one of two foundational models for the Affordable Care Act and health reform. Even though there has been solid documentation on the benefits of becoming a PCMH, the up front and maintenance cost of the model is one of the biggest obstacles for primary care practices. Sources have application estimates ranging from $50,000 to $100,000 or more per physician[1] and general operating costs being well over $200,000 a year per FTE.[2] Regardless of the associated costs, thousands of primary care practices across the nation have invested their time and money to implement the PCMH model and are sustaining their practices on fees-for-service that do not support chronic care coordination and management. Now, PCMHs finally have a way to get the reimbursements they've needed to make all their struggles worthwhile – the Centers for Medicaid and Medicare Services (CMS) Chronic Care Management (CCM) payment model.

1 http://www.uchospitals.edu/news/2012/20120624-pcmh.html; https://www.communitycarenc.org/media/files/pcmh-article-nc-physician-sept-2012.pdf

2 http://www.physicianspractice.com/practice-models/aco-vs-pcmh-which-best-your-practice

A year ago, on January 1, 2015, physicians who provided CCM services to qualifying Medicare patients under CPT Code 99490 could bill for those services and receive a payment of approximately $43 per patient per month. The majority of Medicare patients have two or more chronic diseases and are eligible for these CCM services. If you billed for one patient at $43 per month, that would be $516 a year. One provider caring for even just 200 of these qualifying patients could be making an additional $103,200 a year – certainly a significant increase in revenue. Then, multiply that amount by the number of providers in your practice. You can easily see how quickly the additional revenue could add up. Practices can continue to get their Per Member/Per Month payments from other payers but the CCM payment amount is also substantially more than that.[3] Most experts believe that commercial payers will follow CMS' lead and begin paying for CCM as well.

Initial reviews of the new payment from Medicare have certainly been favorable, but faced with complying with even more regulations, PCMHs may be uncertain as to whether or not participation is a good thing. Electronic Health Records requirements may be the biggest source of concern and definitely a trouble spot. Documentation in the EHR and billing are typically tied to face-to-face encounters, but the CCM code pays for activities outside the normal in-office patient visit. EHRs are not coded for care plan development and lack of functionality may cause concerns.

Millions of dollars have been spent on reorganizing practices to provide care management activities and PCMHs have been waiting patiently for some incentive for these changes. Initial reviews from practices participating in the new payment from Medicare have certainly been favorable. These new chronic care payments will go a long way to recoup the investments made along the way.

3 https://www.cga.ct.gov/2011/rpt/2011-R-0394.htm

CMS initially patterned this program specifically for PCMHs because they are uniquely prepared to embrace and succeed with the CCM payment. So, if you are a PCMH, what are you waiting for?

BARRIERS TO CHANGE

The National Chronic Care Management Survey that came out in October 2015[4] and was conducted by PYA (a national consulting firm) and ENLI Health Intelligence (a population health management solutions company. According to this survey, the adoption rates for CCM payments have been surprisingly slow. Only 25% of the 309 respondents included in the final survey analysis said they had launched a CCM program for their Medicare patients and less than half of those (49.2%) said they had successfully submitted a claim and received payment for CCM.

The Survey found three key concerns among most participants:

- Insufficient reimbursement for the time and effort required (47%)
- Lack of awareness regarding the opportunity (43%)
- Compliance concerns (39%)[1]

And these other concerns were also cited by survey respondents:

- Patient involvement is difficult and time consuming
- Copayments create patient concerns and dissatisfaction
- Electronic health records may not effectively support CCM requirements
- CCM services may require an investment[2]

4 The National Chronic Care Management Survey 2015. PYA and ENLI Health Intelligence 2015.

The concerns and hesitancy to participate are understandable due to the hard work it takes a PCMH to achieve recognition and sustain the effort at significant costs.

However, this CCM payment represents one of the best opportunities PCMHs have had in the last 50 years to realize significant revenue for your hard work.

Assessment, education and planning were integral parts of your journey toward becoming a PCMH. As an NCQA PCMH Certified Content Expert, I would encourage you to take the same approach with this new CMS CCM payment program. Learn all you can about the requirements. Assess your current situation with staff and technology to see if you can be compliant. Look for vendor partners that understand the PCMH model and the CMS payment system. Understanding the program and knowing your capabilities are your keys to building a successful foundation for your CCM program.

CMS REQUIREMENTS FOR THE CCM PROGRAM

CMS has very detailed program requirements for the CCM program from the types of patients that are eligible to the services you need to provide and how you will need to bill. You will find a comprehensive list of all of the CCM payment requirements at https://

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

To bill CMS under the CPT 99490 code, your practice will need to provide the following:

- 24/7 access to clinical staff to address urgent chronic care needs.
- Continuity of care through access to an established care team for successive routine appointments.
- Ongoing care management for all chronic conditions, including medication reconciliation and regular assessment of the patient's medical, functional and psychosocial needs.
- A comprehensive, patient-centered health summary and care plan that includes all current patient records from all providers.
- Coordination with home and community-based clinical service providers.

- Patient and caregiver access, allowing all relevant caregivers the opportunity to communicate about the patient's needs and appropriate care.
- Track a minimum of 20 minutes of non-face-to face CCM services per month.

You can see from these requirements that the PCMH model certainly influenced CMS in their development of this program. Following along with the PCMH care model, CMS originally planned for primary care providers to coordinate this program for the patients, but the CPT 99490 code actually allows several different types of providers to perform the chronic care management services. Primary care providers, specialists, advanced practice registered nurses, physician's assistants, clinical nurse specialists, and certified nurse midwives are all eligible to bill Medicare under this new CCM payment model. Non-physicians and limited-license practitioners – clinical psychologists and social workers – are not eligible to bill for CCM.

The provider that bills for the services must be prepared to have oversight of the CCM program; however, they are not required to be present for the work to be done. This means any clinically licensed staff member, such as a Medical Assistant (MA), can provide the program services.

PATIENT ELIGIBILITY AND CHRONIC CONDITIONS

CMS has given the practice guidelines about which Medicare patients with chronic conditions may participate but also allows the provider to use their own discretion in making decisions about which chronic diseases. The CMS guidelines say the following about patient eligibility and chronic conditions:

- The patient must have two or more chronic conditions expected to last at least 12 months, or until the death of the patient.
- The chronic conditions are those that would place the patient at significant risk of death, or acute exacerbation/decomposition.

- CMS does not provide an exhaustive list of chronic conditions that would be required but does point practices to their Chronic Condition Warehouse (CCW)[5] that has 22 conditions listed to assist researchers with beneficiary, claims, and assessment data, but cautions that this resource is not meant to be an exhaustive list.

OTHER IMPORTANT REQUIREMENTS FOR PARTICIPATION IN THE PROGRAM

If you are planning to participate in this new CMS CCM payment model, then you will need to know that CMS requires you to use 2015 technology that includes and satisfies the 2011 or 2014 criteria for the EHR Incentive Program. Attesting to meaningful use is not required, but most PCMHs do this.

CMS requires providers to develop, maintain and regularly update an electronic care plan based on the needs of the patient. This care plan needs to cover all of the patient's health conditions, not just those that are chronic. It should be developed in concert with the patient, aligned with their choices and values, and reference care provided by the patient's other healthcare providers. As the billing practice, you must be able to electronically share this care plan electronically with other providers who are caring for the patient. As a PCMH, your practice is very familiar with developing care plans for complex and high need patients as one of the many requirements for recognition. CMS has additional recommendations for what the care plan should include may be found on the CMS website in their CMS CCM information document.

Before you can bill CMS for these CCM services, you will need to get the patient's consent to participate in the program. To gain the patient's consent, CMS expects you to:

- Give your patients an overview of the CCM program,
- Explain how your CCM services may be accessed,
- Let the patient know their information will be shared among all of the patient's providers,
- Let your patient know that only one provider may bill for the CCM services at a time,
- Let your patient know they are responsible for any associated copayment or deductibles,
- Let your patient know they may stop their participation in the program at any time with written notification.

Consent to participate is not a part of the PCMH care model but many of the other CMS CCM payment program requirements are very similar to those required for PCMH recognition. Even though there are strong similarities between PCMH and the CMS CCM program, you will still need to think carefully about how your practice will comply with all of the CMS program requirements to ensure you can successfully bill for your time. The revenue stream this program can provide your practice may be significant but the primary reason you want to ensure your success is to improved patient health benefits and outcomes.

Non-face-to-face monitoring of chronic care patients has been shown to be both efficient and effective for all chronic conditions and diseases.

Studies show monitoring patients through e-visits or other types of health monitoring devices improve health outcomes and reduce unnecessary health costs such as hospital re-admissions. Non-face-to-face monitoring and visits are especially beneficial to the underserved and rural residents. PCMHs serving rural patient populations know large portions of healthcare spending go toward managing conditions like diabetes, congestive heart failure, hypertension, asthma and obesity. Until now, we have never had the true capability and capacity to provide this type of enhanced access and engagement for our patients with the advancement of technologies that support such non-face-to-face monitoring.[6]

5 https://www.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts

6 http://www.healthcarereformmagazine.com/healthcare-reform/chronic-disease-and-improved-healthcare/

SETTING UP A SUCCESSFUL CCM PAYMENT PROGRAM

After educating your PCMH practice about the CMS requirements and doing a thoughtful assessment of your current situation, you can begin to formulate your plan to access this new revenue stream given your ability to comply. As a PCMH, you are already faced with many complex rules and regulations to maintain your recognition status. Your staff is most likely already overworked and your fee-for-service based budget may not be able to sustain another hit for new technologies. What can you do to capture this opportunity, keep your practice on stable financial ground, and your staff happy?

Even your certified EHR system most likely does not have a care plan function and you've struggled with interoperability issues that prevent secure sharing of patient information securely across multiple platforms. EHRs were not designed to handle non-face-to-face visits and patient visit protocols and forms are for in-office visits only. In fact, the official documentation of EHR guidelines in the Federal Register as of 2015 listed the words "chronic care" only once in 195 pages of documentation.[7] EHRs simply were not designed to perform the work necessary for tracking non-face-to-face chronic care management.

Providers are faced with so many changes and new requirements just to comply with health reform and many are frustrated and would just like to get back to the real reason they got into medicine – treating patients and helping them get well.[8]

You may think you can manage this new program by setting up a spreadsheet to track the time that is spent with each patient, but that is simply not a solution that benefits anyone – least of all your staff.

The best solution is to look for a vendor partner that has a solid CCM solution and understands the PCMH practice model.

So how do you sort through all the vendor choices in the market right now and find the right solution for your practice? How can you tell which vendor will stick with you and make sure your organization is successful? Which vendor has a simple to use, easy to operate application that won't require a lot of changes to your current workflow or cost you a lot of money?

As an NCQA certified PCMH content expert and long-long time healthcare business consultant, I truly understand the issues practices are facing when trying to make good business decisions about program implementation and vendor evaluation. This new CMS CCM payment strategy can mean significant income for practices that really need some relief. I know it is possible for PCMHs to participate in the CCM program at a scale that makes it significantly worthwhile both financially and in terms of patient care. Based on my research on CCM strategies, features, products and vendors, here are some important things to consider before you make your business decisions about implementing this new payment program.

7 https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25595.pdf
8 http://healthcarehacks.com/doctors-are-frustrated-and-dismayed-by-health-care-reform

1. ALIGNMENT. First, do an accurate and honest assessment of your requirements and current situation. The solution you choose for this CCM payment model should always be aligned with your practice business goals and the needs of your patients.

2. DON'T OUTSOURCE. Providing care to your patients with chronic diseases is your core business. Outsourcing your "core business" to a third party is not recommended by management professionals for multiple reasons:

A. RISK MANAGEMENT. Medicare fraud violations cost between $5,500 and $11,000 per incident.[9] By outsourcing your CCM services, you are accepting that the vendor is performing "incident to" your supervision which makes you actively responsible for multiple risk factors:

- Is the person performing the work appropriately credentialed to work in your state (especially nursing-staffed call centers)?
- Were all of the services billed for on claims actually performed?
- Have you periodically verified that the documentation you received is actually legitimate?
- Are your patients' privacy and HIPAA rights being protected?
- Are you provided audit logs? How often do you receive audit logs? Have you reviewed and verified the audit logs coming from a third party in the event of an audit?
- You are bearing 100% of the risk. The vendor you outsource to is paid by volume but bears none of the risk.

B. COSTS. Third party vendors may take from half up to two-thirds of the CCM reimbursement, leaving you with the expense of collecting the deductible. When these added expenses are taken out of your payment, you may only make $7 to $12 per patient. In addition to paying the third party, you also have the labor cost of filing the claim, paying the clearinghouse and your biller, and collecting an $8 co-pay. Is this slim margin worth the risk?

C. ADDED VALUE OR NOT. Carefully consider the impact of the outsourced product. Does it deliver added value or not? Most outsourcing vendors just track time - the 20 minutes of non-face-to-face time required by the code - but they don't add any value for true care management.

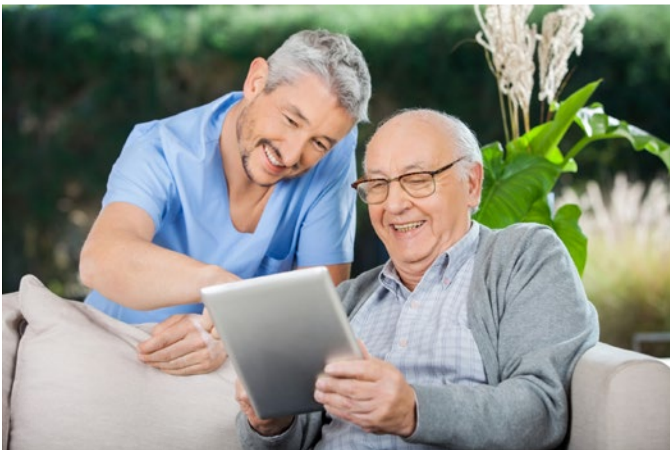
The market is full of apps that pose as third party Chronic Care Management vendors that only track your time and do not do true care management.

Medicare will eventually clamp down on this. Ensure the CCM services your practice provides add value that can be measured in improved patient engagement, care and outcomes.

3. LOOK BEYOND YOUR EHR. Research indicates that more than 80% of providers are seeking to replace their EHR because it isn't interoperable and doesn't integrate or interface with other EHRs or software programs.[9] EHR vendors core business focus has been the federally

9 http://openhealthnews.com/news-clipping/2013-09-03/great-ehr-market-shakeout

mandated MU program, but less than one third of all providers have actually completed MU Phase 2. The continued pressure put on EHR vendors to help their providers meet MU requirements means they are not focused on on changing or building new software to meet the new CCM care coordination requirements. More likely than not, EHR vendors will make a few "lightweight" modifications so their sales force can "check the box" when asked about the CCM payment program. To achieve CCM at scale, you will need a robust management system that provides a lot more than "lightweight" changes or add-ons to an EHR.



4. GET HELP WITH ALL OF CCM. The CMS CCM program requires some activities your practice is probably not familiar with. How do you 'enroll' a patient? What are the best practices for obtaining their consent? What kind of legal language needs to go into a consent? Which patients do we target first? To help with these new activities, look for a CCM product and company that does the following:

- Has prepared materials designed to help the patient understand the value your CCM program and how it adds value for their health.
- Automates care-coordination by alerting members of the care team when the plan changes and including a secure link to it.
- Provides scripts and educational materials that help your providers clearly and quickly explain the benefits to patients in just a few words.
- Gives you samples of the consent form your patients will have to sign.
- Provides reports identifying whether or not patients are eligible for reimbursement each month.
- Enables you to track your patient Transitional Care Management (TCM) program and make sure you don't bill TCM in the same month as CCM.
- Shares "best practices," and workflows on everything from enrolling patients to getting reimbursed from non-Medicare payers.
- Provides supporting information such as sample denial letters, patient consent and stop forms, and CCM brochures and fliers that explain the program value to the patient.

5. LIGHTEN THE LOAD ON IT. The new CMS CCM payment model does require sharing care plans with external care team members and the extended medical neighborhood. Your EHR is most likely not interoperable with other systems making it very difficult to share patient information securely. The good news is there are simple and easy ways to meet these requirements without the frustrations, challenges and costs of implementing new systems or paying for another interface. Make sure your CCM vendor meets simple interoperability requirements without asking you purchase new technology or pay for expensive interfaces.

6. BE PATIENT CENTRIC. The new CCM program is all about the patient and improved outcomes. CMS requires patient information and care plans be accessible by not only your internal care teams but also external specialists and physicians, family members and patient advocates supporting true patient care coordination. Make sure any new CCM application you are considering supports true team-based patient care and coordination, engaging patients, providers and all members of the care team regardless of where they are located.

7. AUTOMATE, AUTOMATE, AUTOMATE. Today, gas stations, grocery stores, movie theatres, even hardware stores enable you to self-serve. Why not enable your patients to do the same? There is CCM technology that enables patients to provide key health information like blood pressure, glucose, weight changes in energy levels, increased swelling, or mood swings. Your CCM technology should be able to automate the process for patients to input information and provide alerts to you the provider about clinical thresholds or negative trends. CCM technology should be able to send automatic updates to all parties when care plans change, not just those within your EHR. To be effective, true care coordination and management requires automation at multiple levels.

8. ENGAGE THE PATIENT. Your success with CCM depends on patient engagement and so you too should have a patient engagement strategy.

The best CCM tool in the market achieves patient responses that average between 85% to 90% weekly.

With patients providing health condition information at these levels, the practice now has a much better chance of preventing adverse events, keeping the patient well, easily meeting CCM requirements, but also fully demonstrating better outcomes.

9. PRACTICE AT THE TOP OF YOUR LICENSE. Medicare indicates about 68% of all its beneficiaries are eligible for CCM services, but it isn't feasible for your physician to actively manage and interact with that large a percentage of her panel.

Good CCM applications maximize practice staff members efficiently and keep the doctor in front of the patients that really need her. Be sure your CCM product supports the PCMH team model of care and allows everyone to practice at the top of their license.

With the right CCM technology, an MA should be able to easily triage CCM patients who need additional attention and forward them to a nurse, advanced practitioner, or doctor.

10. **INVEST IN SUCCESS.** CCM requires scale. Scale requires eliminating barriers, not training around them. The CCM product you purchase should be an Investment in your success. Your practice training, patient engagement products and strategies, billing reports, even advice on how to handle denials should all be easy and designed to make your CCM initiative successful as well as lucrative. The company should have all inclusive, “done-for-you” resources, materials and best practices to support your success without a never-ending list of products and services you have to buy after the fact.

11. BUY FOR THE FUTURE. Will the vendor support you after the sale? Will they be a true partner and stay with you for the long haul continuing to guarantee your success in the future? How do they update their system? Is it cloud-based to make it easy to install and use? If the system isn't working for you even though you have closely followed all of the vendor guidelines, are you locked in?

Choosing the right vendor and application to help you set up your CCM payment program will be critical to ensure your success. Using these questions along with the assessment of your practice needs will go along way in helping you narrow the field of vendors in the market and make sure you identify the best one to work with your practice. Finding that unique mix of innovative technology, turnkey services and a true care coordination solution will certainly set you up for success for both improving chronic care patient outcomes and enhancing your practice revenues.

ChronicCareIQ has designed a CCM solution that can ensure your success with the new Medicare billing program. Getting started with the ChronicCareIQ system is simple and easy to implement. We don't ask you to purchase any new technology or disrupt your current practice workflow. ChronicCareIQ can provide you with a true care coordination and patient management system that will meet all of your practice's needs and CMS' program requirements. Get started quickly and efficiently with a system that finally allows you to manage your chronic care patients and begin capturing that additional revenue for your practice.

To request a demo or get more information about ChronicCareIQ's unique program, please visit www.choniccareiq.com or call 855.999.8089

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