NCQA PCMH 2014

CHRONIC CARE MANAGEMENT

Biz • Med

Medicare CCM
Cost-Effective Setup & Operations
Thursday, Jan. 29, 2015 - 5pm EDT
Overview

• What is Medicare Chronic Care Management?

• What does it have to do with a Medical Home?

• How do I start billing Medicare?

• Things to watch out for

• Q & A

Links to recording and materials will be emailed to all participants
What is CCM?

The ACO Value Proposition of Chronic Care Management

For the first time in its history, the Centers for Medicare and Medicaid Services has agreed to pay primary care and other physicians a whopping $2 per minute for remotely managing Medicare patients diagnosed with chronic illnesses.

Dr. Leonard McCoy, examining Medicare beneficiary William Shakespeare, on Thursday in his PCMH in Manhattan. Michael Moses for The New York Times

OP-ED | BEVERLY CRUSHER M.D.
When Patients Become Healthy
Why do commercial health insurers ignore the benefits of PCMH?
- Editorial: Chronic Care With a Smile
- Spock: Depression in the Air We Breathe?
- Wesley: Where the Rabbit Meets the Walrus
- Worf: Reagan, Obama and Health Care

DEANNA TROY PHD
On the Hook?
One admires the chutzpah of Patient-Centered Medical Homes expecting to be handsomely paid for their efforts to manage and coordinate care for the sickest patients.
- Mother Hubbard: Obama’s Economic Ideas
- Op-Docs: The Diabetes Epidemic, Revisited

Watching

Image is for illustration purposes only. This is not an authentic page of The New York Times.
Medicare Chronic Care Management (CCM)

The Patient

- Medicare FFS beneficiary
- 2 or more chronic conditions
- Expected to persist at least 12 months or until death
- Significant risk of death, acute exacerbation/decompensation, or functional decline

The Services

- Care management & planning
- Medications management
- Self-care management
- Care coordination
- Outreach for services
- Enhanced access

High-Risk, Complex, Frail-Elderly
## CCM Billing Prerequisites

### What you need to have

- Medicare FFS patients
- MU Certified EHR (any)
- Remotely accessible care plan (EHR or other tech)
- 24x7 access to a clinician  
  - Phone and/or Internet
- Reasonably accessible and flexible schedule
- Relationships  
  - Specialists, ER, Hospital, home care, LTC, community

### What you need to do

- Obtain patient consent
- Create individual care plan  
  - With patient/caregiver
- Do 20 minutes CCM per patient per month  
  - Not face to face  
  - One or multiple resources  
  - All at once or incremental  
  - Track the time
- Document activities in EHR
- Bill Medicare no more than once per month
Getting Paid for CCM

Who can do CCM

- Any physician, NP, PA can bill for CCM
- Any clinician can provide CCM (certified MA and up)
- CCM billing rights can be reassigned (outsourced)
- Only general supervision is required (new for CCM)
- Multiple clinicians can provide CCM for each patient (additive time)
- Computers cannot perform billable CCM (monitoring)

What does Medicare pay

- ~$40 per patient per month
- For minimum of 20 minutes CCM per month
- Only one provider can bill for each patient each month
- Things you cannot bill on months when CCM is billed:
  - TCM (CPT 99495, 99496)
  - Home health or hospice (HCPCS G0181, G0182)
  - Certain ESRD services (CPT 90951-90970)
So What Do I do Next?

Step 1: Estimate revenues and basic costs
Step 2: Assess your ability to provide the service
Step 3: Revise your cost projections
Step 4: Collect your tools and set it all up
Step 5: Do your own “pilot” experiment
Step 6: Assess the results and expand (hopefully)
Step 1: The Math of CPT 99490

Per Patient Per Month (PPPM)
• $40 – including co-pay ($8) and subject to deductible
• 20 minutes – clinical staff time under general supervision (certified MA, LPN, RN or higher)

Revenue per Year
Approximately $380 to $480 per patient/per year (PPPY)

How many patients per billing provider?
– Medicare FFS (for now), pretty sick ~200, of those ~150 will consent
– REALISTIC Potential Revenue - $60K to $72K

Expenses per Year
• 150 patients = 50 hours of CCM per month = ~1/3 FTE
• Low level FTE ~ $30K per year
• Payroll expense ~ $10K (or $67 PPPY)
• Setup & tools ~ $5K

Other expenses should be minimal or sunk costs (EHR, email, phone, etc.)

REALISTIC Net Revenue
• Between $45K and $60K per billing provider per year

~$100 PPPY
Step 2: CCM & the Medical Home

• If your practice is a NCQA Level 3 recognized PCMH and/or is operating in accordance to the full medical home model of care, you have everything you need to provide and bill for CCM services.

• If you are just beginning your PCMH journey, the NCQA 2014 PCMH Standards are a great fit for CCM, and you may want to start with CCM pertinent Standards/Elements/Factors.

• If you are “on paper” or use an EHR that is not certified by ONC, you cannot bill Medicare for CCM services regardless of PCMH status.

• If you are participating in the Comprehensive Primary Care (CPC) Initiative or the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, you can ONLY bill CCM for patients not attributed to you for the demonstration.

• In general, if your practice is a designated RHC or FQHC, you cannot bill for CCM services regardless of your PCMH status.
CCM & NCQA 2014 PCMH Crosswalk

• **Identify Patients** – PCMH 4A
  – Medicare FFS (age)
  – 2 or more chronic conditions (severity, risk)

• **Access** – PCMH 1A, 1B, 1C, 2A
  – 24x7 access to clinical advice by phone & electronic
  – Timely (same-day) appointments availability for acute and routine care
  – Continuity of care with personal clinician

• **Care Coordination** – PCMH 5A, 5B, 5C
  – Diagnostic tests & results (lab, imaging, etc.)
  – Specialists, including mental health
  – Care transitions (ER, hospital, other facilities, home)
  – Send electronic clinical summaries for transitions of care

• **Population Management** – PCMH 3D
  – Preventive care outreach
  – Chronic care services outreach
  – Medications monitoring outreach

No need to reinvent the wheel – the NCQA PCMH framework has everything you need for CCM
CCM & NCQA 2014 PCMH Crosswalk

• Care Planning – PCMH 3C, 4B, 4C, 4E
  – Comprehensive health assessment
  – Comprehensive care plans
  – Care plans provided to patient in writing/electronic
  – Self-management support
  – Medication management
  – Community resources

• Care Team – PCMH 2D, 1B
  – Train and assign members to care coordination
  – Train and assign members to population management
  – Train and assign members to self-efficacy support
  – 24x7 team access to medical record

• Certified EHR Technology – PCMH 3B, 6G
  – Problem lists
  – Medication lists
  – Test orders and results
  – Health information exchange

If you are not a recognized PCMH, this may be a good time to become one
CCM Workflow

Identify Eligible Patients and Define Sub-Groups → Outreach for Annual Wellness Exam → Create Care-Plan and Obtain CCM Consent → Define Monthly CCM Activities for Each Group → Define Care Team and Publish Care Plans

Identify Resource(s) and Assign Work → Perform and Document CCM Activities → Track Time Spent Up to 20 Minutes → Generate Claims → Drop Claims to Medicare

Notes:
- You may want to group patients by condition types
  - To facilitate starting small (minimizing your risk)
  - To allow creation of CCM protocols for each group
  - To track performance (sooner or later, someone is going to ask for this)
- Even if you already have care plans, it’s probably best to first bring patients in
- Care team MUST have access to care plan 24x7 (Internet is a must)
- Choose wisely – 20 minutes is all Medicare will pay for (test one out)
- Find an efficient way to document and track time across patients and resources
- Don’t forget to drop those claims
Technology for CCM

• Certified 2011 or 2014 Edition EHR capable of and used for:
  – Structured recording of demographics, problems, medications, and medication allergies
  – Creation AND transmittal of summary care record (any way EXCEPT fax or paper)
  – Store beneficiary consent forms
  – Recording that care plan was given to beneficiary
  – Recording of care coordination activities
• “Something” that allows electronic sharing of care plans
  – 24x7 to all CCM team
  – Electronic transmission to other providers
The CCM Care Plan

• CMS does not provide an exact definition
• Electronic (not necessarily created in/by EHR)
• Updated as needed
• Based on comprehensive health assessment (PCMH 3C)
• A care plan considers and/or specifies (PCMH 4B):
  – Current problems (may include historical problems).
  – Current medications.
  – Medication allergies.
  – Patient preferences and functional/lifestyle goals.
  – Treatment goals.
  – Assessment of potential barriers to meeting goals.
  – Strategies for addressing potential barriers to meeting goals.
  – A self-care plan.
  – Care team members (internal and external to the practice)
• Provided in writing/electronic form to the patient/caregiver
• Electronically accessible to CCM care team (24x7)
• Electronically transmittable to other care providers
CCM Service Definition

• CMS does not provide a definitive definition
• It does however provide some guidance:
  – performing medication reconciliation and overseeing the beneficiary’s self-management of medications
  – ensuring receipt of all recommended preventive services
  – monitoring the beneficiary’s condition - physical, mental, social

• The third bullet above is probably where most time will be spent
  – Answer questions and provide education (patient, caregivers, etc.)
  – Arrange for community resources
  – Coordinate with agencies, other providers
    • home health and hospice, outpatient therapies, durable medical equipment, transportation services, nutrition services

• Things that look like CCM but CANNOT be counted towards CCM time
  – Care plan creation (?)
  – Face to face visits or electronic billable encounters
  – TCM if billed separately (coordination after inpatient discharge)
  – Home health or hospice supervision (if billed separately)
  – Computerized monitoring of patients
Performing CCM

Question: What monthly services do patients with chronic disease require?

• Your CCM eligible population will be diverse
• You should stratify – for example:
  – People with cancer & Alzheimer's need services different than people with diabetes and hypertension
  – People serviced by home-care or hospice need services different than people still in the workforce
• Examine the (unpaid) things you do today
  – What would qualify for CCM billing?
  – What triggers your (reactive) actions?
  – Try to bill for things you already do for free, before adding new ones
• Get your staff together for this analysis
  – Do they call often to remind people of due/overdue services?
  – Do they get lots of questions on the phone? (Do you have a phone log?)
  – Do they help people with specialty appointment making?
  – Do they spend time chasing down consult notes?
  – Do they spend time reconciling med lists?
  – Do they spend time arranging for community resources?
  – How much of this can be proactively done when the patient is not here?
### Documenting CCM

<table>
<thead>
<tr>
<th>MUST document in EHR (for CMS)</th>
<th>MUST document somewhere (for your practice &amp; audits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Copy of consent form</td>
<td>• List of CCM patients</td>
</tr>
<tr>
<td>• That care plan was given</td>
<td>• CCM protocols for staff</td>
</tr>
<tr>
<td>• Communications with other agencies, providers, resources</td>
<td>• For each service instance</td>
</tr>
<tr>
<td>• <em>Clinical advice</em></td>
<td>– What it is</td>
</tr>
<tr>
<td>• <em>Demographics, problems, medications, medication allergies</em></td>
<td>– Who provided it</td>
</tr>
<tr>
<td></td>
<td>– When it was provided</td>
</tr>
<tr>
<td></td>
<td>– How long it took</td>
</tr>
<tr>
<td></td>
<td>• For billing</td>
</tr>
<tr>
<td></td>
<td>– Calculated total time</td>
</tr>
<tr>
<td></td>
<td>– <em>Almost ready for billing</em></td>
</tr>
<tr>
<td></td>
<td>– Ready for billing (=&gt;20 min)</td>
</tr>
<tr>
<td></td>
<td>– Billed status</td>
</tr>
</tbody>
</table>

* Nice to have tickler list to make sure the 20 minutes limit is achieved and month is billable
Billing for CCM

- Make sure your Medicare fee schedule is updated for 2015 and that includes CPT 99490
- At this time there is no guidance from CMS on how to bill – watch for MAC notifications (or call yours)
- Suggestion:
  - Create separate claims with one charge line only
  - ICD9: Use at least the two major chronic conditions (more is better)
  - DOS: Use the 1st of the month in the From field and the end of the month (or a predefined date towards the end of the month) in the To field
  - CPT: 99490
  - Description: Should auto-populate from your fee schedule
  - Charge Amount: Should auto-populate from fee schedule
  - All other fields as you usually bill E&M
- Depending on EHR/PMS you may have to manually create and drop these claims every month for each patient
- You may want to do this before you run your month-end reports
- Important to define a precise workflow here, or revenue will be lost
- Imperative to have billing office know exactly who they need to bill for & when
Step 3: Cost Revisions

Our baseline assumption was:

- 1/3 FTE for 150 patients ~ $10,000 per year
- Onboarding, setup & tools ~ $5,000 per year
- Total cost per year ~ $15,000 or $100 per patient per year

• How many of these things are you consistently and systematically doing now?
  - Is it “just” a matter of documenting your efforts?
    • You will be tempted to say Yes here – think hard & get data
  - Nobody tracks time – how are you going to do that?
    • In a way that translates into generating claims….

• Will you need additional staff?
  - Can you get qualified staff for the salary we assumed?
  - Can you set everything up within budget?
    • Including your time & opportunity costs

• Are the revised numbers still “worth it”?
  - If so, let’s continue…..
Step 4: Collect Your Tools

- Practice policies & procedures
- Patient stratification tools (reports)
- Care plan forms
- CCM standing orders (protocols)
- Administrative monthly workflow
- Patient consent for CCM form
- Recording & Tracking tools

If you are a Medical Home – You know how to create, or already have, these tools.
Step 5: Your Very Own Pilot

A few ideas to consider…..

• Keep it very simple at the start
• Example:
  – Pick a specific group of patients
  – Call the patient twice each month
    • Two sub-groups: first and third week and second and fourth week
    • Assign a few (~15) to each day of the week (make schedule)
    • Assign people to people – build relationships
  – Have a short checklist of what to ask and what to do
  – Assign work to staff and allow specific time to do this
  – Monitor time spent during the month and adjust
    • Note additional (ad-hoc) activities done for these patients
  – If 20 minutes is regularly exceeded:
    • Maybe one call is enough, if it triggers many more tasks or takes too long
    • Maybe email is more efficient
  – If 20 minutes is regularly not reached (not likely)
    • Maybe add weekly email to ask for status
    • Ask more and better questions
    • Maybe add contact with caregiver, pharmacy, specialists
  – Iterate and adjust the model
Our Pilot: Help us Help you

Sign up at: www.bizmedtoolbox.com

What we have for you

- CCM Tracking Toolkit
  - Getting started guide
  - Patient consent forms
  - Excel CCM tracker
    - CCM registry
    - Monthly time recording
    - Calculated monthly rollup
    - Alerts for billing
    - Year totals rollup

What we need from you

- Use the toolkit
  - Set up your CCM program
  - Record your activities
  - Analyze your process

- Feedback
  - What works
  - What doesn’t work
  - What else you need/want

What we want to build for you

- PCMH/CCM workflow platform
  - Web based & user friendly
  - Configurable CCM workflow
  - Automated tracking & admin
  - Captures reportable metrics
  - Reduces your cost & effort
  - “Talks” to your EMR

Sign up at: www.bizmedtoolbox.com
Things to Watch

- Medicare FFS is the only insurer certain to pay for CCM at this time. Medicare Advantage plans are not clear.
- Qualified chronic conditions not specified by CMS – choose wisely (this is a new program and audits are likely)
- This year 2011 Edition EHR is acceptable, but it will change in the future
- It is not clear how CMS will adjudicate claims if the patient gives consent to multiple providers
- The CCM payment amount is subject to SGR cuts, if they occur on April 1st 2015
- TCM codes pay significantly more than CCM – may be best to hold off CCM claims on TCM months
Things to Watch Out For

• Lots of entities out there are seeking to provide you services for billing CCM

• Variety of models:
  – Assign everything including billing (another provider)
  – Outsource services & you bill per vendor reports/data
  – Only electronic tools for you to use
  – Consulting only (maybe some paper artifacts)

• If you are fairly organized (Level 3 PCMH):
  – Your cost = 25% to 30% of revenue (including billing)
  – Decide what the hassle factor is worth to you
  – Fair value (you do billing) ~50% of revenue = $20 PPPM
Resources

- Sign up for our pilot [http://www.bizmedtoolbox.com](http://www.bizmedtoolbox.com) (link to signup form will be on Home page – active practices only, please)


- AAFP Resources (paid members only) [http://www.aafp.org/practice-management/payment/coding/ccm.html](http://www.aafp.org/practice-management/payment/coding/ccm.html)
Contact info: Margalit Gur-Arie
mgurarie@bizmedsolutions.com
Mobile: 314.651.9137

To sign up for the CCM Collaborative:
www.bizmedtoolbox.com
(link to signup form will be on Home page – active practices only)

For more information and assistance:
On the web: www.bizmedsolutions.com
Email: support@bizmedsolutions.com
Phone: 1-866-861-0160