2019 Medicare Updates for FQHCs: 
CCM, BHI, CoCM, RPM and VCS

Chronic Disease Burden in the United States

Chronic Care Overview

- Half of all adult Americans have a chronic condition – 117 million people
- One in four Americans have 2+ chronic conditions
- 7 of the top 10 causes of death in 2015 were from chronic diseases
- People with chronic conditions account for 86% of national healthcare spending
- Racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care

CMS and Chronic Care

- Medicare benefit payments totaled $702 billion in 2017
- Two-thirds of Medicare beneficiaries have 2+ chronic conditions
- 99% of Medicare spending is on patients with chronic conditions
- Annual per capita Medicare spending increases with beneficiaries’ number of chronic conditions

Sources: CMS, CDC, Kaiser Family Foundation, AHRQ
What is CCM?

- A Medicare reimbursement program for managing care for beneficiaries with multiple chronic conditions.

Medicare Fee For Service beneficiaries with **2+ chronic conditions** expected to last at least 12 months are eligible.

G0511 – a monthly reimbursement for 20 minutes of clinical staff time spent on non-face-to-face care coordination per patient.

The non face-to-face time can be provided by **clinical staff** members, including **external care managers**.

Chronic Care Management (CCM)

Monthly payment to:

- FQHCs
- CCM G–Codes
  - 20 minutes/month
  - $67 (national)

“incident to” the services of the supervising (billing) practitioner – general supervision.
CCM for FQHC’s

CCM
- **G0511** (January 2018)-CCM services can be billed by adding the general care management G code to a claim, either alone or with other payable services

CCM Requirements

<table>
<thead>
<tr>
<th>Patient</th>
<th>Provider</th>
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<tbody>
<tr>
<td>2 or more chronic conditions</td>
<td>Must use a certified EHR &amp; 24/7 Access to Care Management Services</td>
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<tr>
<td>Serious Health Risk or risk of death</td>
<td>20 min/patient/month &amp; Comprehensive Patient-Centered Care Plan</td>
</tr>
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<td>Must consent to CCM service</td>
<td>Documented time spent with patient &amp; Care Plan available 24/7 to entire staff</td>
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<tr>
<td>May have Co-pay</td>
<td>Monthly Reports and Summary of CCM &amp; Care Plan shared with EMR and other providers</td>
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Non Face 2 Face Activities

- Monthly Clinical Chart Review
- Audio/Video Visit with patient, caregiver or family
- Physician Review of labs/test
- Physician review of care plan
- Discussion with other providers
- Scheduling Appointment/Services
- Referrals
- Rx Refills
- Portal Messaging
- ePrescribe
- Home Health/Hospice
- Care Plan Reconciliation
- Medico-Legal Coordination

- Audio/Video Visit with Provider
- Audio call with Facility
- Updating Patient Health Record
- Lab/Radiology Orders
- Patient/Facility Forms
- Physician Review of Consult Notes
- Physical review of hospital/facility records
- Initial Patient-Centered Care plan
- Letter to patient
- Letter to provider
- Preauthorization

Assessing the Opportunity/Cost

- General CCM Financial Projections- 2019 G0511 Rate $67.03

<table>
<thead>
<tr>
<th>Estimated Number of Medicare Patients</th>
<th>Assume 75% with 2+ Chronic Conditions</th>
<th>Assume 50% Adoption Rate</th>
<th>Assume 90% of patients meet monthly service requirements</th>
<th>Potential Monthly Revenue @ $67.03 (Gross)</th>
<th>Potential Annual Revenue (Gross)</th>
<th>Assumed Annual Cost of providing CCM @ $40 per billable patient (Net)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200</td>
<td>900</td>
<td>450</td>
<td>405</td>
<td>$27,135</td>
<td>$325,620</td>
<td>$131,220</td>
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POLL QUESTION

What best describes your experience with CCM

1. Have not considered billing for CCM
2. Early stages – looking into CCM
3. Plans set to implement CCM in 2019
4. Currently billing for CCM

Obstacles to implementing CCM

FQHCs are already providing CCM services, but they still need technology and staff to implement, scale, and monitor the program.

- How do you identify eligible patients and track enrollment requirements?
- How do you compliantly and efficiently document & track time for 100s of patients?
- How do you know who is close to 20 mins so that you can complete the service?
- How do you efficiently tabulate who is billable at the end of each month?

- Who is going to be the CCM Champion who implements and manages the program?
- Who is going to enroll patients and create their care plans?
- Who is going to monitor patients close to 20 mins and make calls to ensure that enrolled patients receive the full scope of services?
Options for Starting CCM

**Internal CCM Program**
- Good option if you have sufficient clinical staff and management resources
- Easier to integrate some activities within EMR
- Need to have a system to track time and activities
- Patients may appreciate interacting with local staff

**External CCM Program**
- No need to hire and train additional staff
- Less internal effort and faster time to launch
- Service partner is 100% focused on results
- No need to create protocols, scripts & templates
- Less time required to manage staff
- Program continuity likely to be better
- Likely to have a greater number of sustained patients
- No up front Investment: Cost is performance based

Succeeding at CCM

**Implementation Specialists**
- Staff education & training
- Enrollment & other
- Documentation & time tracking
- Ongoing performance analysis & training

**Purpose-built CCM Platform**
- Care planning
- EBM protocols for chronic diseases
- Performance & audit reporting

**Dedicated Care Managers**
- Patient enrollment & care planning
- Care coordination & management
- Scale CCM services
- Help identifying & closing gaps in care
POLL QUESTION

In-house or Outsourced Chronic Care Management?

1. Using in-house staff for the patient engagement
2. Outsourcing the patient engagement
3. Combination of in house and outsourcing
4. Not applicable

CCM Frequently Asked Questions

- What activities count towards the 20 minute requirement?
  - Video chat, phone calls, emails, and messaging with the patient and their caregiver and family members
  - Lab, report, and image review and processing
  - Care plan creation, revision, and review
  - Chart documentation
  - Medication reconciliation, overseeing patient self-management of medication
  - Medication refills
  - Referring to and consulting with other providers and time spent closing the referral loop
  - Communicating with home and community based providers
  - Remote monitoring of physiological data
  - Post-discharge follow-up
CMS statement

We believe that the use of digital technologies that provide either one-way or two-way data between MIPS eligible clinicians and patients is valuable, including for the purposes of promoting patient self-management, enabling remote monitoring, and detecting early indicators of treatment failure.

Behavioral Health Integration & Psychiatric Collaborative Care Model

- Behavioral Health Integration (BHI)
- Psychiatric (CoCM)
Behavioral Health Integration

- General BHI (HCPCS code G0511) – The 2019 rate is $67
  - 20 minutes or more of general behavioral health integration services
- Psychiatric CoCM (HCPCS code G0512) - The 2019 rate is $146
  - 60 minutes or more of subsequent psychiatric CoCM services
Care Management Services – Billing, Claims Processing, and Payment Q & A

- Are care management services required to be billed on a claim with an FQHC visit?
  - No. Care management services can be billed either alone or on a claim with an FQHC billable visit.

- Will care management services be paid in addition to an FQHC visit?
  - Yes. If care management services are billed on the same claim as an FQHC visit, both will be paid.

- If an FQHC submits a claim for a billable visit and a care management service, would these be added together to determine the payment?
  - No. The FQHC would be paid 80% of the lesser of its charges or the fully adjusted PPS rate for the billable visit, plus 80% of the charges for care management.

- What revenue code should be used for care management services?
  - Care management services should be reported with revenue code 052x.
CMS & TELEHEALTH

CY 2019 Changes Include:

• Brief Communication Technology-based Service, e.g. Virtual Check-in Includes check-in services used to evaluate whether or not an office visit or other service is necessary (FQHCs may bill G0071). $13.69

• Remote Evaluation of Pre-Recorded Patient Information – Created a specific new code to describe remote professional evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology (FQHCs may bill G0071). $13.69

• Additionally, new codes for remote patient monitoring

Virtual Communication Services

Things to Keep in Mind:

• The new code to bill for VCS (live video or store and-forward) is G0071.
• There must be at least 5 minutes of communication.
• The patient must have been seen by the FQHC in the past year.
• The service is provided by an FQHC practitioner.
• FQHCs will NOT receive their PPS rates.
• Coinsurance would apply to FQHC claims.
• Face-to-face requirement is waived.
• These are not to be considered substitutions for an in-person visit.
• No frequency limitation is implemented at this time.
• January 1, 2019.
What Are the New RPM Codes?

- CPT code 99453: “Remote monitoring of physiologic parameter(s) (e.g. weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.” The Medicare payment for these services is $21.
What Are the New RPM Codes?

- CPT code 99457: “Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.” The Medicare payment for these services is $54.

What Are the New RPM Codes?

- CPT code 99454: “Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.” The Medicare payment for these services is $69.
What Are the New RPM Codes?

- **CMS** is in the process of writing a technical correction
- Changing *direct supervision* to *general supervision*
- Similar business model to CCM. Organization can contract with outside vendor to deliver RPM services.

https://www.cchpca.org/contact/ask-question

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