Chronic Care Management in ACOs

Health Endeavors

Who is Health Endeavors?

- Health Endeavors is a technology development company based in Scottsdale, Arizona since 2008. Our web-based Patient Health Integrated Tools and Healthcare Admin Tools software solutions are used on a daily basis by over 1.5 million users, providing care to over 10 million patients.
- Who are our clients?
  - 40+ MSSP ACOs
    - Early leader of ACO education in partnership with Medicare (2012)
  - Self-Insured Employers
  - Commercial Payor Programs
    - Aetna, BCBS, United, Humana, Cigna, Anthem and Coventry
  - State Medicaid Programs
  - 500+ Hospitals
  - Thousands of physician practices
  - MSOs (Managed Service Organizations
  - Nursing Homes, ASCs, Physician Clinic Systems, Home Health, Hospice

In the Final Rule, CMS has adopted CPT 99490 for Medicare CCM services, which is defined in the CPT Professional Codebook as follows:

- 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.

Core Requirements

- 1. Secure the eligible beneficiary's written consent.
- 2. Have 5 specified capabilities needed to perform CCM
  - Use a certified EHR for specified purposes
  - Maintain an electronic care plan
  - Ensure beneficiary access to care
  - Facilitate transitions of care
  - Coordinate care
- 3. Provide 20+ minutes of non-face-to-face care management services per calendar month.

What is the reimbursement for CCM?

- The national average reimbursement is $41per beneficiary per calendar month.

- This amount is subject to change thereafter based on Congressional action on the Sustainable Growth Rate (SGR) formula.

Which practitioners are eligible to bill Medicare for CCM?

- Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM.

- Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, social workers) are not eligible.

Can more than one provider bill for CCM for the same beneficiary?

- No.
- CMS will pay only one claim for CCM per beneficiary per calendar month.

Who is an eligible beneficiary?

- A beneficiary is eligible to receive CCM if he or she has been diagnosed with 2 or more chronic conditions expected to persist at least 12 months (or until death) that place the individual at significant risk of death, acute exacerbation/ decompensation, or functional decline.

- CMS has not provided a definition or definitive list of “chronic conditions” for purposes of CCM. Nor has the agency offered guidance on how to determine or document the specified acuity level.

Is there a list of chronic conditions on which a provider can rely?

- CMS maintains a Chronic Condition Warehouse (CCW) to provide researchers with beneficiary, claims, and assessment data linked by beneficiary across the continuum of care.

- The CCW includes information on 22 specified chronic conditions. However, the CCW list is not an exclusive list of chronic conditions; CMS may recognize other conditions for purposes of providing CCM.

- **https://www.ccwdata.org/web/guest/condition-categories**

For what purposes must a provider use a certified EHR in furnishing CCM (1st capability)?

A provider is not required to be a meaningful user of a certified EHR technology, **but is required to use "CCM certified technology"** (i.e., for 2015, an EHR that satisfies either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs) to meet the following core technology capabilities:

- ❑ Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a)(3)-(7)

- ❑ Creation of summary care record consistent with 45 CFR 170.314(e)(2) The provider must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission, but does state that facsimile transmission is not acceptable.

- ❑ Additionally, a provider must use CCM certified technology to fulfill any CCM requirement that references a health or medical record. **Specifically, the following must be documented in the beneficiary's record using CCM certified technology:**

- ❖ Beneficiary consent
- ❖ Provision of care plan to beneficiary
- ❖ Communication to and from home and community-based providers regarding beneficiary's psychosocial needs and functional deficits (care coordination)

What is the requirement for an electronic care plan (2nd capability)?

What items are typically included in a care plan?

The provider must develop and regularly update (at least annually) an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the beneficiary's needs.

The plan should **include a list of current practitioners and suppliers** that are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the beneficiary's preventive healthcare needs.

The plan should address all health issues (not just chronic conditions) and be congruent with the beneficiary's choices and values.

While required to bill for CCM, the preparation and updating of the care plan is not part of the reimbursable service. **Instead, these activities may be billed separately as an evaluation and management service (e.g., an annual wellness visit, the initial preventive physical examination, or regular office visit), provided the applicable requirements are satisfied**

Does the care plan have to be created, maintained, and updated using a certified EHR?

CMS requires a provider to "use some form of electronic technology tool or services in fulfilling the care plan element," but acknowledges that "**certified EHR technology is limited in its ability to support electronic care planning at this time**."

Accordingly, providers "must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning.

Who must have access to electronic care plan?

1. The care plan must be electronically accessible on a 24/7 basis to all care team members furnishing CCM services billed by the provider.
    - e.g., remote access to EHR, web-based access to care management application, web-based access to an electronic health information exchange (HIE) (facsimile is not sufficient)

2. The provider "must electronically share care plan information as appropriate with other providers" caring for the beneficiary.
    - e.g., secure messaging, participation in HIE (facsimile not sufficient)

3. The provider must make available a paper or electronic copy of the care plan to the beneficiary.
    - Must be documented in CCM certified technology

What is required with respect to beneficiary access to care (3rd capability)?

A provider furnishing CCM must:

1. Provide a means for the beneficiary to access a member of the care team on a 24/7 basis to address acute/urgent needs in a timely manner (determine who constitutes a member of the care team).

2. Ensure the beneficiary is able to get successive routine appointments with a designated practitioner or member of care team.

3. Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (e.g., secure messaging, internet), although the beneficiary is not required to use these methods.

What is required with respect to transitions of care (4th capability)?

A provider must have the capability to do the following:

1. Follow-up with the beneficiary after an **ER visit**.

2. Provide post-discharge transitional care management (TCM) services as necessary (although the provider cannot bill for TCM and CCM during the same month).

3. Coordinate referrals to other clinicians.

4. Share information electronically with other clinicians as appropriate (see prior discussion of summary care record and electronic care plan)

What is required with respect to coordination of care (5th capability)?

- The provider must have the capability to coordinate with home and community based clinical service providers to meet beneficiary's psychosocial needs and functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services).

- The provider's communication with these service providers must be documented in CCM certified technology.

20+ minutes of Non-Face-to-Face Care Management Services

What types of services constitute non-face-to-face care management services?

- These services may be furnished by licensed clinical staff subject to proper supervision.

- Licensed clinical staff, in this context, includes APRNs, PAs, RNs, LSCSWs, LPNs, and what CMS refers to as “medical technical assistants” (CNAs and certified medical assistants).

What level of supervision is required for clinical staff providing non-face-to-face management services?

- Initially, CMS proposed to require direct supervision of clinical staff (i.e., physician or other practitioner present in the same suite of offices and immediately available to provide assistance while non-face-to-face care management services were being provided), with a limited exception for services furnished outside normal business hours.

What level of supervision is required for clinical staff providing non-face-to-face management services?

- **However, the Final Rule requires only general supervision (i.e., physician or other practitioner available by telephone to provide assistance as required). The physician or other practitioner does not have to be the same person under whose name CCM is billed.**

- **Thus, a provider could contract with a third party to provide non-face-to-face care management services (including after-hours availability to address the beneficiary's urgent care needs), provided the third party has electronic access to the beneficiary's care plan. This "subscription service" approach would allow a smaller provider that could not otherwise afford necessary staffing to provide CCM**

Can remote monitoring be included in the 20 minutes?

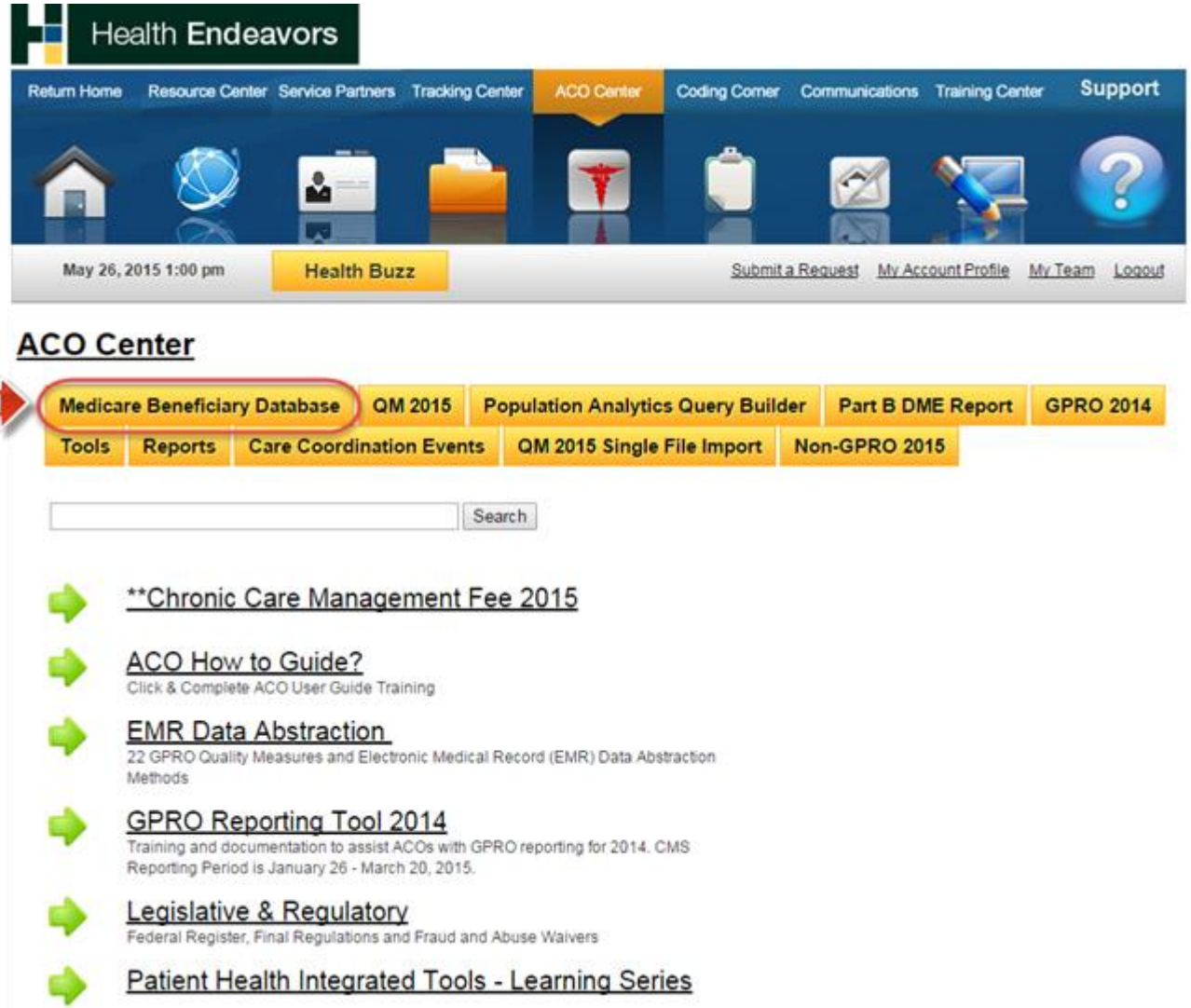
- According to CMS, “practitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries **may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code**, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device.”

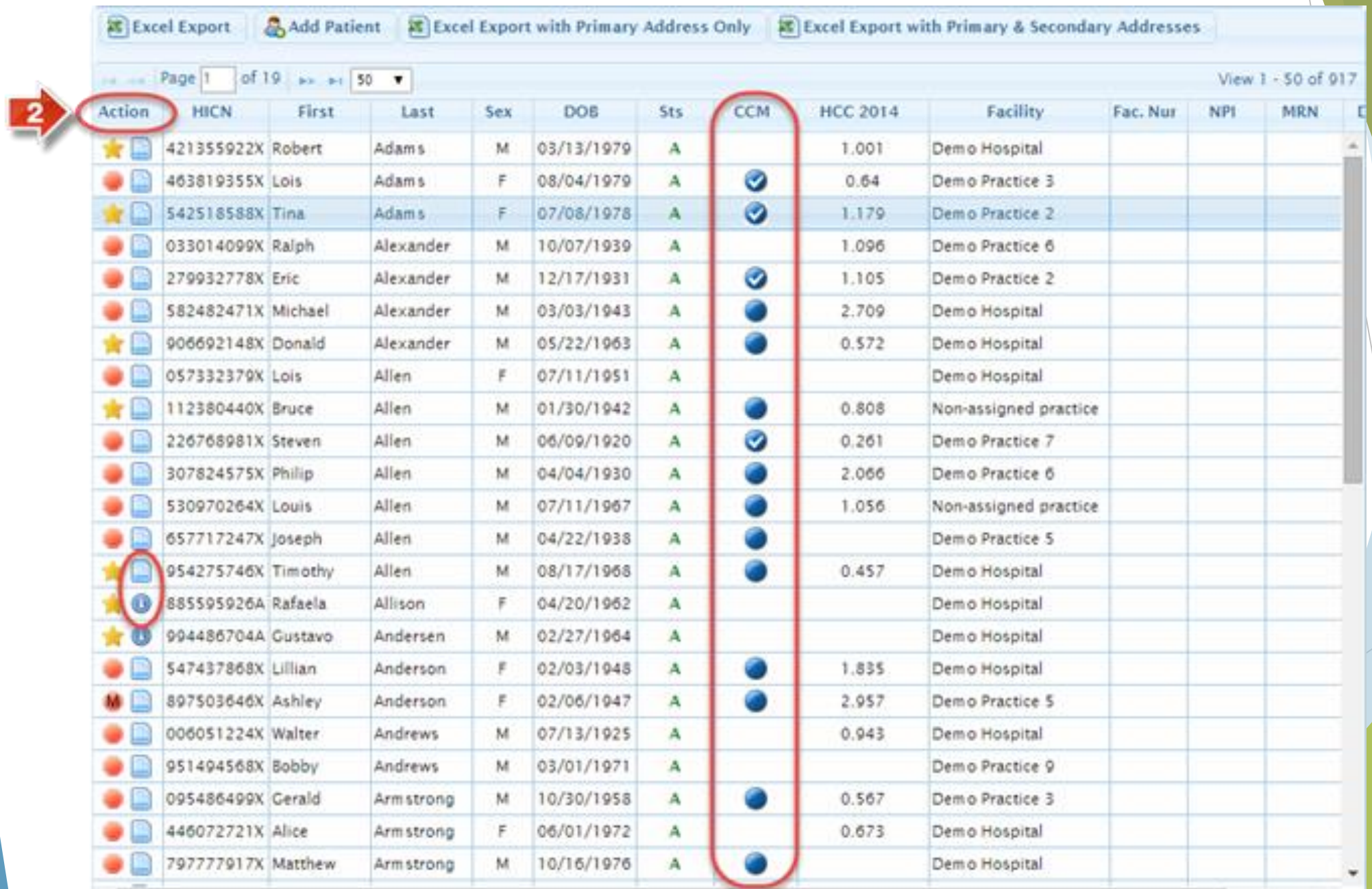
What time counts toward the 20 minute minimum requirement?

- Time spent providing services on different days or by different clinical staff members in the same month may be aggregated to total 20 minutes.
- However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted.
- Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.

The Health Endeavors CCM Tool

Health Endeavors


Health Endeavors
Return Home
Resource Center
Service Partners
Tracking Center
ACO Center
Coding Corner
Communications
Training Center
Support
May 26, 2015 1:00 pm
Health Buzz
Submit a Request
My Account Profile
My Team
Logout
ACO Center
1
Medicare Beneficiary Database
QM 2015
Population Analytics Query Builder
Part B DME Report
GPRO 2014
Tools
Reports
Care Coordination Events
QM 2015 Single File Import
Non-GPRO 2015
Search
**Chronic Care Management Fee 2015
ACO How to Guide?
Click & Complete ACO User Guide Training
EMR Data Abstraction
22 GPRO Quality Measures and Electronic Medical Record (EMR) Data Abstraction Methods
GPRO Reporting Tool 2014
Training and documentation to assist ACOs with GPRO reporting for 2014. CMS Reporting Period is January 26 - March 20, 2015.
Legislative & Regulatory
Federal Register, Final Regulations and Fraud and Abuse Waivers
Patient Health Integrated Tools - Learning Series


Excel Export
Add Patient
Excel Export with Primary Address Only
Excel Export with Primary & Secondary Addresses
Page 1 of 19
50
View 1 - 50 of 917
2
Action
HICN
First
Last
Sex
DOB
Sts
CCM
HCC 2014
Facility
Fac. Nur
NPI
MRN
421355922X Robert Adams M 03/13/1979 A 1.001 Demo Hospital
463819355X Lois Adams F 08/04/1979 A 0.64 Demo Practice 3
542518588X Tina Adams F 07/08/1978 A 1.179 Demo Practice 2
033014099X Ralph Alexander M 10/07/1939 A 1.096 Demo Practice 6
279932778X Eric Alexander M 12/17/1931 A 1.105 Demo Practice 2
582482471X Michael Alexander M 03/03/1943 A 2.709 Demo Hospital
906692148X Donald Alexander M 05/22/1963 A 0.572 Demo Hospital
057332379X Lois Allen F 07/11/1951 A Demo Hospital
112380440X Bruce Allen M 01/30/1942 A 0.808 Non-assigned practice
226768981X Steven Allen M 06/09/1920 A 0.261 Demo Practice 7
307824575X Philip Allen M 04/04/1930 A 2.066 Demo Practice 6
530970264X Louis Allen M 07/11/1967 A 1.056 Non-assigned practice
657717247X Joseph Allen M 04/22/1938 A Demo Practice 5
954275746X Timothy Allen M 08/17/1968 A 0.457 Demo Hospital
885595926A Rafaela Allison F 04/20/1962 A Demo Hospital
994486704A Gustavo Andersen M 02/27/1964 A Demo Hospital
547437868X Lillian Anderson F 02/03/1948 A 1.835 Demo Hospital
897503646X Ashley Anderson F 02/06/1947 A 2.957 Demo Practice 5
006051224X Walter Andrews M 07/13/1925 A 0.943 Demo Hospital
951494568X Bobby Andrews M 03/01/1971 A Demo Practice 9
095486499X Gerald Armstrong M 10/30/1958 A 0.567 Demo Practice 3
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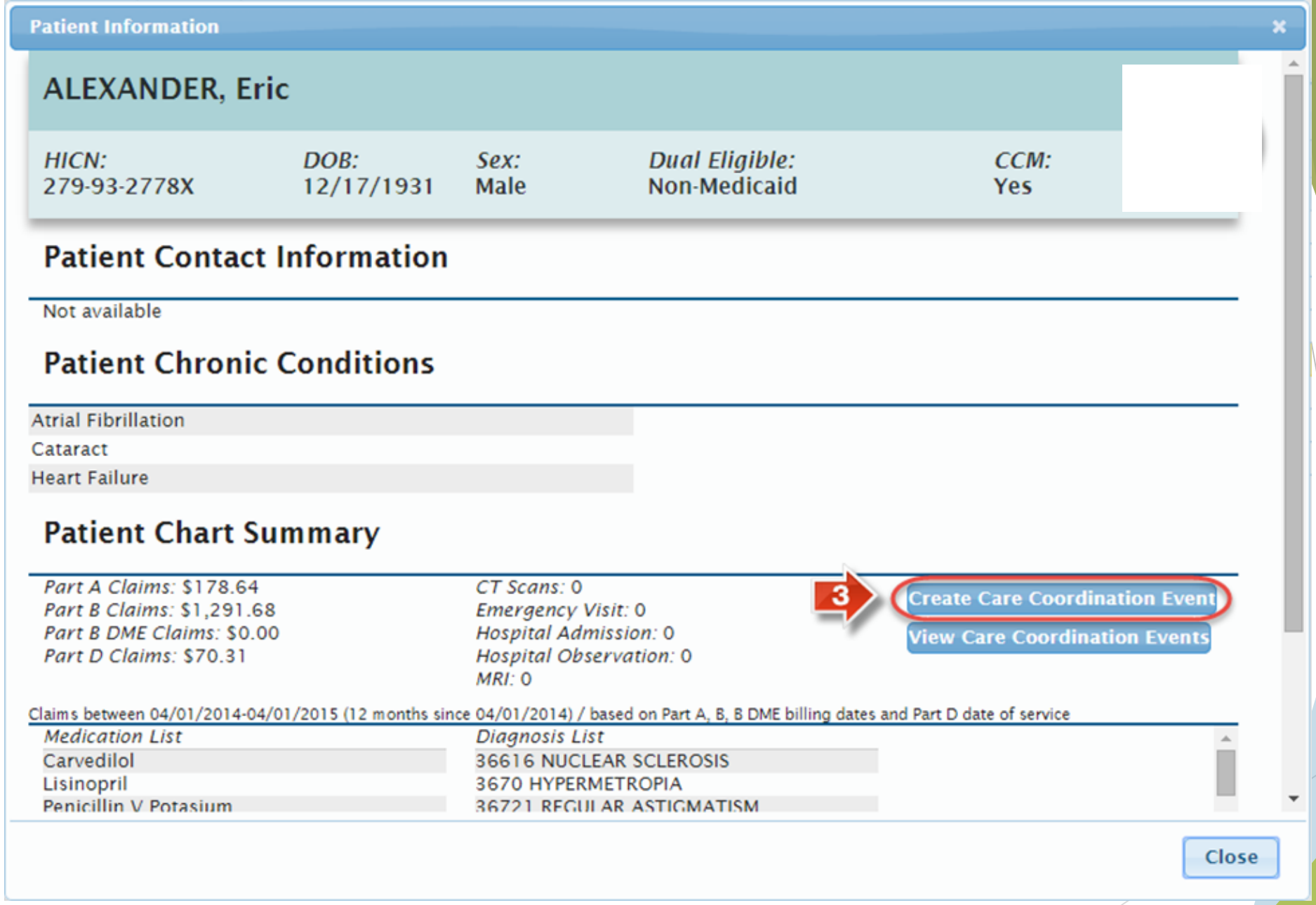
797777917X Matthew Armstrong M 10/16/1976 A Demo Hospital


Patient Information
ALEXANDER, Eric
HICN:
279-93-2778X
DOB:
12/17/1931
Sex:
Male
Dual Eligible:
Non-Medicaid
CCM:
Yes
Patient Contact Information
Not available
Patient Chronic Conditions
Atrial Fibrillation
Cataract
Heart Failure
Patient Chart Summary
Part A Claims: $178.64
Part B Claims: $1,291.68
Part B DME Claims: $0.00
Part D Claims: $70.31
CT Scans: 0
Emergency Visit: 0
Hospital Admission: 0
Hospital Observation: 0
MRI: 0
3
Create Care Coordination Event
View Care Coordination Events
Claims between 04/01/2014-04/01/2015 (12 months since 04/01/2014) / based on Part A, B, B DME billing dates and Part D date of service
Medication List
Carvedilol
Lisinopril
Penicillin V Potasium
Diagnosis List
36616 NUCLEAR SCLEROSIS
3670 HYPERMETROPIA
36721 REGULAR ASTIGMATISM
Close

Create Event for

Patient Chart / View Patient's Events / Manage Templates / Manage Care Coordination Partners

- General Links
- Tools
- Event Links

Patient Chart Summary

10

Template Hypertension

Current Date

05/21/2015

Followup Date

05/21/2015

Don't see your Event type below? Create One!
Type Of Care Coordination Event

Choose One

Don't see your Service Partner below? Create One!
Care Coordination Event Partner

care coordination event partner[]

Description

description

Add follow up notes

Hypertension

A custom description for this template

Control Blood Pressure

Control Blood Pressure Measurable Goal

Blooc

Blood pressure will be maintained as per MD recommendation Date

05/22/2015

Other Date

mm/dd/yyyy

Control Blood Pressure Interventions

- [x] Medication as ordered by MD
- [x] Monitor blood pressure as ordered by MD
- [x] Provide education about signs and symptoms of hyper/hypotension
- [ ] Other

Medication as ordered by MD Date

05/22/2015

Monitor blood pressure as ordered by MD Date

05/22/2015

Provide education about signs and symptoms of hyper/hypotension Date

05/22/2015

Other Date

mm/dd/yyyy

Control Blood Pressure OutCome Status

- (•) Ongoing/Revised
- ( ) Resolved

Control Blood Pressure Comments/Notes

Control Bloo

11 **Create Form**

Dietary Planning

Dietary Planning Measurable Goal

Redu

Reduce salt intake Date

05/22/2015

Reduce fat intake Date

05/22/2015

Other Date

mm/dd/yyyy

Dietary Planning Interventions

- [x] Provide education on Heart Healthy Diet
- [x] Educate about label reading technique
- [x] Avoid prepared foods
- [x] Avoid high salt and high fats
- [ ] Other

Provide education on Heart Healthy Diet Date

05/22/2015

Educate about label reading technique Date

05/22/2015

Avoid prepared foods Date

05/22/2015

Avoid high salt and high fats Date

05/22/2015

Dietary Planning OutCome Status

- (•) Ongoing/Revised
- ( ) Resolved

Dietary Planning Comments/Notes

Dietary Plan

Hypertension

A custom description for this template

Control Blood Pressure

Control Blood Pressure Measurable Goal

Blooc

Blood pressure will be maintained as per MD recommendation Date

05/22/2015

Other Date

mm/dd/yyyy

Control Blood Pressure Interventions

- [x] Medication as ordered by MD
- [x] Monitor blood pressure as ordered by MD
- [ ] ~~Provide education about signs and symptoms of hyper/hypotension~~
- [ ] Other

Medication as ordered by MD Date

05/22/2015

Monitor blood pressure as ordered by MD Date

05/22/2015

Provide education about signs and symptoms of hyper/hypotension Date

05/22/2015

Other Date

mm/dd/yyyy

Control Blood Pressure OutCome Status

- (•) Ongoing/Revised
- ( ) Resolved

Control Blood Pressure Comments/Notes

Control Bloo

12 **Edit Form**

Dietary Planning

Dietary Planning Measurable Goal

Redu

Reduce salt intake Date

05/22/2015

Reduce fat intake Date

05/22/2015

Other Date

mm/dd/yyyy

Dietary Planning Interventions

- [ ] ~~Provide education on Heart Healthy Diet~~
- [ ] ~~Educate about label reading technique~~
- [x] Avoid prepared foods
- [x] Avoid high salt and high fats
- [ ] Other

Provide education on Heart Healthy Diet Date

05/22/2015

Educate about label reading technique Date

05/22/2015

Avoid prepared foods Date

05/22/2015

Avoid high salt and high fats Date

05/22/2015

Dietary Planning OutCome Status

- (•) Ongoing/Revised
- ( ) Resolved

Dietary Planning Comments/Notes

Dietary Plan

Email alerts

Health Endeavors

Template None selected

Current Date

04/17/2015

Followup Date

04/30/2015

Don't see your Event type below? Create One!

1 **Type Of Care Coordination Event**

Home Health

Don't see your Service Partner below? Create One!

2 **Care Coordination Event Partner**

× Home Health XYZ - Kris Yates × Home Health ABC - Bob Jones

Description

description

Add follow up notes

add follow up notes

3 Send Email Alert

× Home Health XYZ - Kris Yates × Home Health ABC - Bob Jones

On the Horizon

For the CCM tool- Hip and Knee Bundle

Health Endeavors

How it works:

- Under this proposed model, the hospital in which the hip or knee replacement takes place would be accountable for the costs and quality of care from the time of the surgery through 90 days after—what's called an "episode" of care.
- Depending on the hospital's quality and cost performance during the episode, the hospital would either earn a financial reward or be required to repay Medicare for a portion of the costs. This payment would give hospitals an incentive to work with physicians, home health agencies, and nursing facilities to make sure beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications. Hospitals would have additional tools – such as spending and utilization data and sharing of best practices - to improve the effectiveness of care coordination.
- By "bundling" these payments, hospitals and physicians have an incentive to work together to deliver more effective and efficient care.
- This model would be in 75 geographic areas throughout the country and most hospitals in those regions would be required participate.

Summary of major provisions

- Episodes would begin with admission to an acute care hospital for an LEJR procedure (Hip or knee replacement) that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the IPPS and would end 90 days after the date of discharge from the acute care hospital.
- The episode would include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.
  - MS-DRG 469 (Major joint replacement or reattachment of lower extremity with Major Complications or Comorbidities (MCC)) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without MCC).

Episode of Care includes:

- Physicians' services.
- Show citation box
- Inpatient hospital services (including readmissions)
- Inpatient psychiatric facility (IPF) services.
- LTCH services.
- IRF services.
- SNF services.
- HHA services.
- Hospital outpatient services.
- Independent outpatient therapy services.
- Clinical laboratory services.
- Durable medical equipment (DME).
- Part B drugs.
  - excluded from CCJR drugs that are paid outside of the MS-DRG, specifically hemophilia clotting factors
- Hospice.

Quality Measure and Reporting Requirements

- Quality Measures:
  - Complication measure
    - Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551).
  - Readmission measure
    - Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550).
  - Patient experience survey measure
    - HCAHPS survey (NQF #0166).
- CMS intends to publicly report this information on the Hospital Compare Web site

The Health Endeavors Approach

- Combine Population analytics data and the CCM tool to satisfy the quality outcomes and cost efficiencies required by CMS
- Templates for TKR and THR within the HE tool to satisfy the Quality Measures component
- Survey Capabilities to satisfy the HCAHPS survey (NQF #0166).

Why use the Health Endeavors CCM tool?

- Key benefits:
  - One single location where all Care coordinators can provide care management to identified members for 20+ minutes a month
  - Templates are modifiable to your practice/hospital workflow and demands
  - Monitor beneficiary's condition and update chronic care management activities as needed within one central location
  - Perform ongoing medication adherence and reconciliation
  - Ensure beneficiaries schedule preventative services
  - Streamline patient care needs in a secure format
  - Disease management reporting to reflect gaps in care