NATIONAL ASSOCIATION OF Community Health Centers®

CHRONIC CARE MANAGEMENT

This information is current as of 12/21/2023

NACHC's STRATEGIC PILLARS

1

Equity and Social Justice

Center everything we do in a renewed commitment to equity and social justice

2

Strengthen and reinforce the infrastructure for leading and coordinating the Community Health Center Movement, notably consumer boards and NACHC itself

3

Develop a highly skilled, adaptive, and mission-driven workforce reflecting the communities served

4

Reliable and Sustainable Funding

Secure reliable and sustainable funding to meet increasing demands for Community Health Center services

5

Improved Care Models

Update and improve care models to meet the evolving needs of the communities served

6

Supportive Partnerships

Cultivate new and strengthen existing mutually beneficial partnerships to advance the shared mission of improving community health

To learn more about NACHC's Strategic Pillars visit https://www.nachc.org/about/about-nachc/

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

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AGENDA

1. Intro to Chronic Care Management (CCM)
2. Key Components of CCM
3. Regulatory Landscape, and Incentives
4. Quality Improvement, and Patient Engagement
5. Business Case and NACHC Resources
6. Billing for non-FQHC services (M/C part B)

Chronic Care Management

Refers to a comprehensive and coordinated approach to healthcare aimed at improving the overall health outcomes and quality of life for patients with chronic conditions.

CCM involves intentional ongoing management and support provided to individuals dealing with conditions such as diabetes, hypertension, heart disease, and others that require long-term care. By embracing Chronic Care Management, FQHCs enhance their role as community healthcare leaders, positively impacting the health outcomes of vulnerable populations and improving the overall well-being of the communities they serve.

Which providers are qualified to bill for CCM

- Physicians- (MD), (DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse Midwife (CNM)
- **Marriage and Family Therapist (MFT)
- **Mental Health Counselor (MHC)
- * Support staff provide services under the general supervision of the Qualified Health Provider (QHP)

Patient Enrollment Requirements

- **Eligibility-** The patient's provider determines if the patient meets the criteria for PCM, CCM or CCCM

- **Patient consent** is required and can be obtained at the time of service and can be written or verbal, further it must be documented the provider disclosed cost-sharing requirements (via Part B deductible and coinsurance)

- An **Initiating Visit** is required for new patients or patients that have not been seen within the past year

Key Components of Chronic Care Management

- Care Plan Development
- Remote Patient Monitoring
- Medication Management
- Coordination of Care Team

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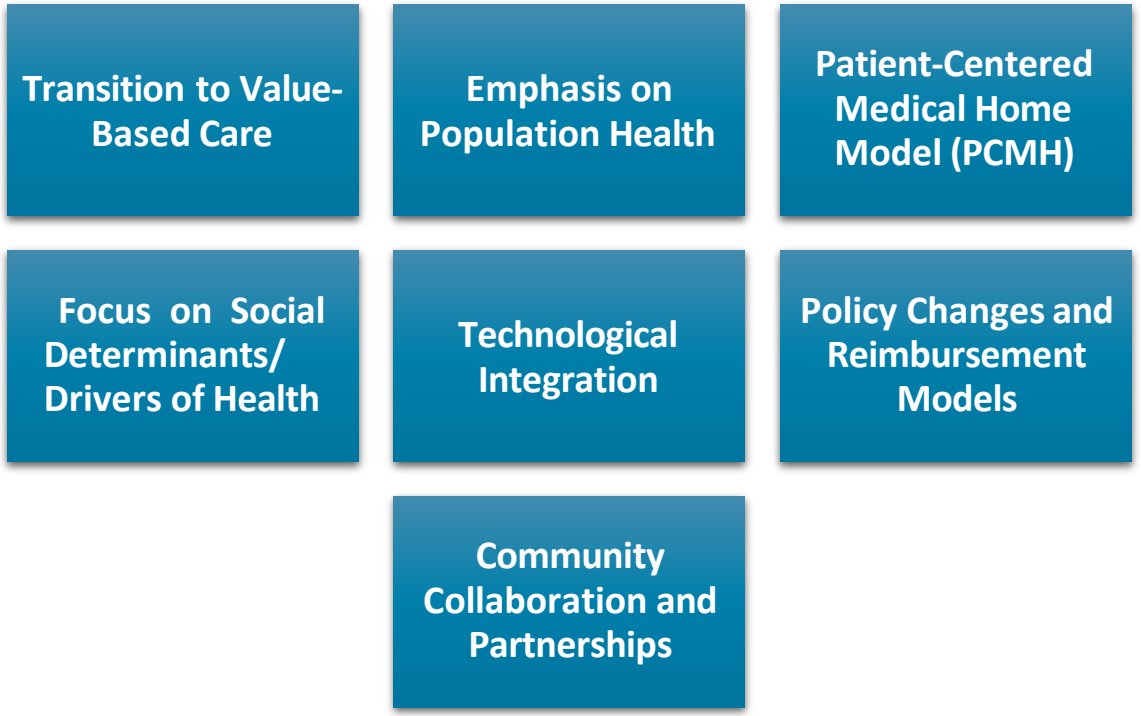
The Evolving Landscape of HealthCare Services within the FQHC

Characterized by the following shifts:



REIMBURSEMENT for CARE MANAGEMENT SERVICES

Effective January 1, 2024, care management services furnished in FQHCs include transitional care management (TCM), chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), and general behavioral health integration (BHI) services. **CCM services are paid at the average of the national non-facility PFS payment rates, either alone or with other payable services, using general care management HCPCS code G0511 expanded**. At least 20 minutes of qualifying CCM services must be furnished in a calendar month to bill for this service.

Chronic Care Management (CCM) incentivizes CHC's in several ways

- Increased Reimbursement Opportunities
- Value-Based Care Alignment
- Preventative Care focus
- Enhanced Patient Outcomes
- Care Coordination Efficiencies
- Patient Engagement and Loyalty
- Reduced Health Disparities
- Improved Population Health

Care Management Aligned with QAPI and Patient Engagement

- Outcome Measuring and Monitoring
- Continuous Quality Assessment
- Data Driven Decision Making
- Care Coordination Enhancement
- Patient Centered Care Models
- Personalized Care Plans
- Health Literacy Education
- Share Decision Making
- Regular Communication
- Remote Patient Monitoring

BUSINESS CASE FOR CHRONIC CARE MANAGEMENT

BUSINESS CASE FOR CHRONIC CARE MANAGEMENT

Chronic Care Management Benefits

- Care Coordination
- Quality of Life
- Access to Care
- Patient Satisfaction
- Healthcare Savings
- Achieving Healthcare Goals

ATTRIBUTION

What - Attribution, or 'assignment,' is the process that payors use to assign patients to a provider for the purpose of tracking accountability for quality, patient experience, and total cost of care

Why - Attribution is foundational to value-based payment arrangements, and therefore, critical for health centers to understand and manage

How –

- DEVELOP AN ACCURATE UP-TO-DATE LIST OF PROVIDERS ELIGIBLE FOR ATTRIBUTION
- UNDERSTAND THE ATTRIBUTION METHODOLOGY OF PAYORS
- DEVELOP PROCESSES FOR THE INTAKE OF ATTRIBUTION LISTS
- LEVERAGE ATTRIBUTION LISTS TO INFORM EMPANELMENT
- IDENTIFY A PROCESS FOR PATIENTS WHO ARE NOT ATTRIBUTED BUT RECEIVE CARE FROM YOUR HEALTH CENTER
- USE ATTRIBUTION INFORMATION TO DRIVE PATIENT ENGAGEMENT AND CARE NEEDS

STAFFING CARE TEAMS

BUSINESS CASE ASSUMPTIONS

MEDICARE PAYOR MIX FOR CHCS

PERCENTAGE OF MEDICARE PATIENTS ELIGIBLE FOR CCM

ESTIMATE ON NUMBER OF MONTHS BILLED

BUSINESS CASE SPREADSHEET

1	Chronic Care Management									
2	Description									
3	Annual Unique Patients	6,000								
4	Percentage Of Patients covered by Medicare *	15%								
5	Annual Unique Medicare Patients	877.2								
6	Percentage Of Patients that Qualifies for CCM**	63.40%								
7	Number of Potential CCM Patients	556								
8		40%								
9		222								
10	Average Months Billed Per Patient***	9	40,042.4	Minutes	667	Hours	83	Days	0.32	FTEs
11	CCM Monthly Payment	$ 72.98								
12	Potential Revenue Generated	$ 146,114.81								
13	20% Patient Responsibility	$ 29,222.96								
14	Reimbursement from Medicare	$ 116,891.85								
15										
16	*Percentage of Patients Covered by Medicare from 2022 UDS report Medicare									
17	**Percentage of Patients that Qualifies for CCM from County Table Multiple Chronic Care Prevalence by Age 2019 Survey									
18	*** Estimate on Number of Months of Service									
19										
20										
21	SALARY ASSUMPTIONS (include benefits costs)									
22		Avg hourly rate w/ FB	Rate per minute							
23	Admin staff	$ 26.81	$0.45							
24	MA/ clinical support staff	$ 26.81	$0.45							
25	Pharmacy staff	$ 26.81	$0.45							
26	Nursing	$ 56.88	$0.95							
27	Total Rate by Minute		$2.29							
28										
29	Total Cost Max		$ 91,637.09							

Non-FQHC Services

Billable to Medicare Part B

What Care Management Services are Billable under Medicare **GO511**

Principal Care Management

…for patients with **one complex chronic condition** expected to last at least 3 months with significant risk if unmanaged

.

Chronic Care Management

…for patients with **two or more non-complex chronic conditions**

Complex Chronic Care Management

…for patients requiring **moderate to high medical decision-making and more time to provide CCM services**

Transitional Care Management

…for the patient's **transitioning to a community setting after discharge from an acute care setting**.

(*Reimbursement Tips: Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services: • Chronic Care Management (CCM) • Complex Chronic Care Management (CCCM) • Principal Care Management (PCM)*, n.d.)

Documentation Requirements

Patient Consent

Face –to-Face Time

Progress Notes and Documentation

Comprehensive Care Plan

Medication Management

Care Team Communication

Health Assessment and Monitoring

Patient Education and Self-Management

Billing and Coding Documentation

Audit & Compliance

Billing Medicare for CCM

General Care Management GO511

- Principle Care Management (PCM)
- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)

Chronic Pain Management

Behavioral Health Integration

Medical Telehealth Services

Virtual Communications

"virtual check–ins"

Psychiatric Collaborative Care Model GO512

(Reimbursement Tips: Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services: • Chronic Care Management (CCM) • Complex Chronic Care Management (CCCM) • Principal Care Management (PCM), n.d.)

Training

Staff Training

Educational Programs

Ongoing Professional Development

Compliance Requirements

Compliance Program

Documentation Standards

Billing Integrity

Audit and Monitoring

External Audits

Informed Consent

Patient Engagement

Interdisciplinary Team Collaboration

Electronic Health Record (EHR)

Telehealth and Remote Monitoring

Audit & Compliance

Other Non-FQHC Services Billable under Medicare Part B

1

- Labs
- Refraction (eye exam)
- Chiropractic
- Podiatry

2

- Diabetic Self Management Training (DSMT)
- Medical Nutritional Therapy (MNT)

3

- Services split by Professional (PC)
- &
- Technical Component (TC)**

Value Transformation Framework

Leading the Transition to Value-Based Care

Value Transformation Framework

- ✓ Supports systems change
- ✓ Organizes and distills evidence-based interventions
- ✓ Incorporates evidence, knowledge, tools and resources
- ✓ Links health center performance to the Quintuple Aim

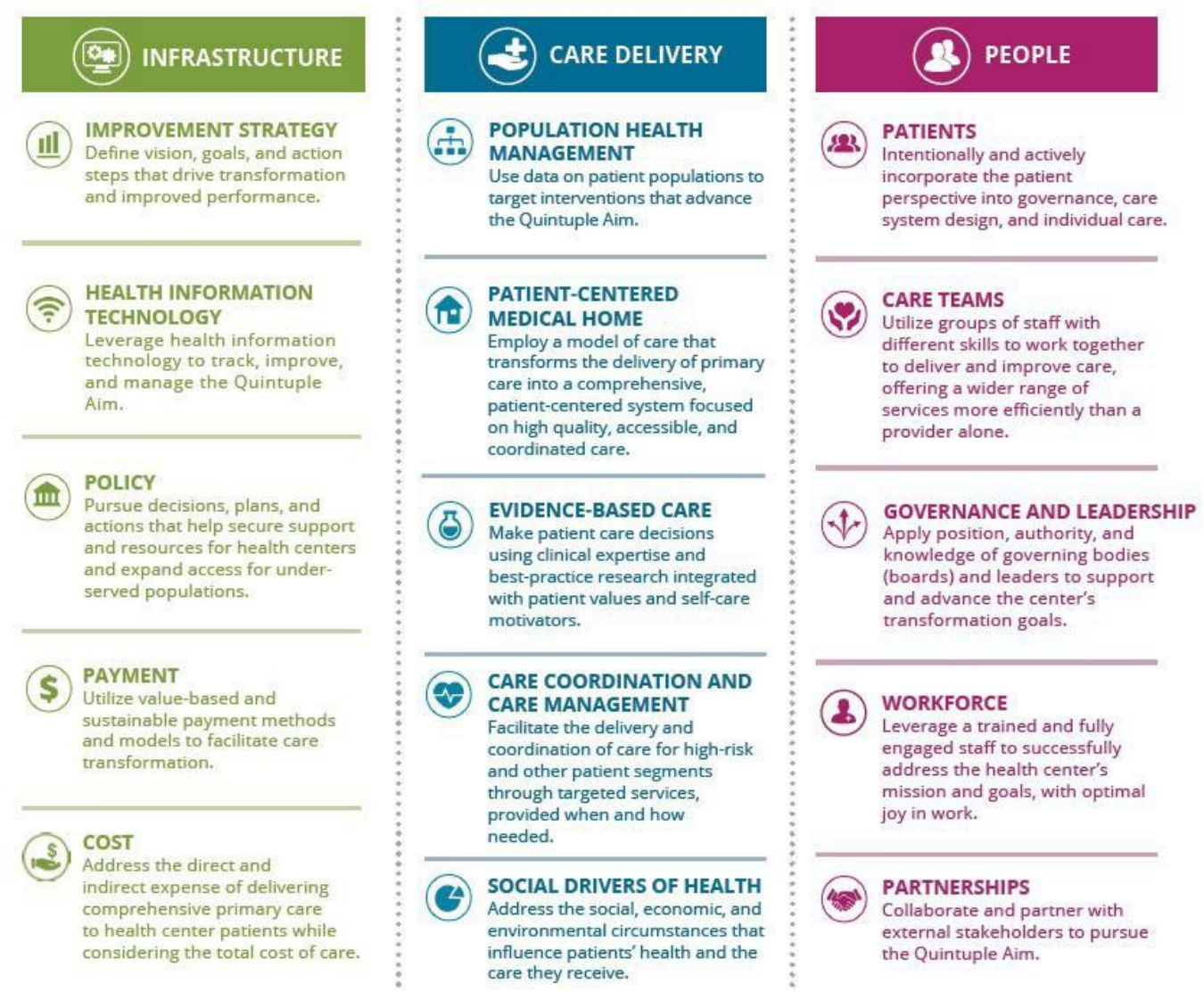
elevate

National Learning Forum

700+ CHCs | 75+ PCAs/HCCNs | >15 Million Patients

- ✓ Monthly Webinars
- ✓ Supplemental Sessions
- ✓ Evidence-Based Action Guides
- ✓ Action Briefs
- ✓ eLearning Modules
- ✓ Tools & Resources
- ✓ Professional Development Courses
- ✓ Online Learning Platform

Leading the Transition to Value-Based Care



The Value Transformation Framework

15 Change Areas organized by 3 Domains:

Infrastructure: the components, including health information systems, policies, and payment structures, that build the foundation for reliable, high-quality health care

Care Delivery: the processes and proven approaches used to provide care and services to individuals and target populations, such as evidence-based care and social drivers of health

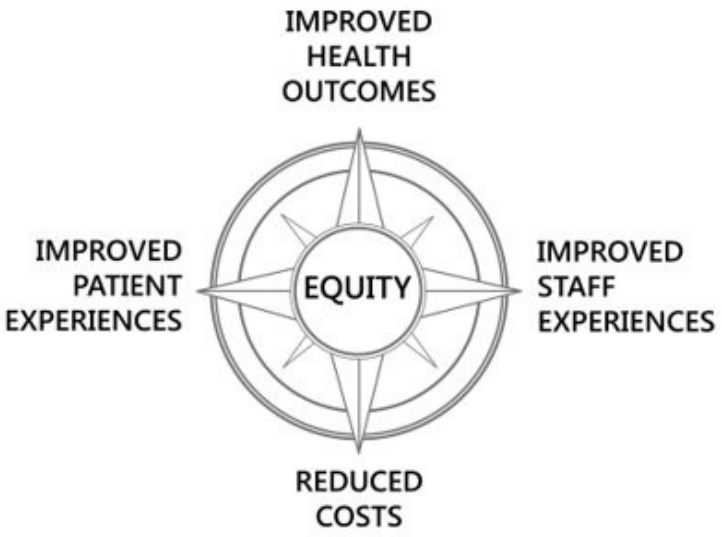
People: the stakeholders who receive, provide, and lead care at the health center, as well as partners that support the goals of high-value care

Leading the Transition to Value-Based Care

Our Goal

Improved Health Center Performance through Systems Transformation

Quintuple Aim Goals



Scan the code to access FREE resources and register for Elevate!

Contact QualityCenter@nachc.org with any questions.

QUESTIONS?

THANK YOU!

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Community Health Centers®

PLEASE VISIT US ONLINE nachc.org

Resources

The Importance of Chronic Care Management

For Federally Qualified Health Centers

- Patient Outcomes
- Cost Efficiency
- Preventative Care
- Patient Engagement
- Alignment with FQHC Mission
- Value –Based Care

The Scope of Chronic Care Management

FQHCs play a crucial role in serving medically underserved populations, and many of these individuals often have complex healthcare needs: The **scope of CCM** in CHCs typically includes:

1. **Holistic Patient Care**
2. **Preventative Services**
3. **Patient Engagement**
4. **Care Coordination**
5. **Technology Integration**
6. **Culturally Competent Care**
7. **Reimbursement and Financial Sustainability**

Program Requirements to bill for Care Management

CMS will reimburse health centers for the following Care Management Services:

- **Principal Care Management-** for patients with **one complex chronic** condition expected to last at least 3 months with significant risk if unmanaged
- **Chronic Care Management**-personalized and supportive services for patients with **two or more non-complex chronic conditions** to coordinate care and achieve positive health outcomes.
- **Complex Chronic Care Management** requiring moderate to high medical decision-making and more time to provide CCM services
- **Documentation Requirements-** *All services must be documented and must meet monthly time requirements*

Advanced Care Management Tools and Resources

- Health Coaching
- Health Education
- Nurse visits
- Motivational Interviewing
- Medication Management
- Remote Patient Monitoring
- Home Care Management
- Transition of Care Management
- Enabling …Supportive Services
- Medical Transportation
- Utility assistance

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