Unlocking the Potential of Chronic Care Management

How Care Coordination Transforms Patient Care and Clinic Revenue

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Learning Objectives

Understand the "WHY" of Care Coordination

Hear opportunities to improve the Care Coordination model

Gain understanding of the new billing codes for Chronic Care Management

Case Study: Successful Care Management

- Background: 61-year-old F patient, new patient to our office March, PMH: pre-diabetes.
  - Returns for CPE in June: HgA1c of 10.3
- Provider officially diagnosis patient with T2DM and initiates CM
  - CM meets with patient after provider appointment
- Patient comes back to office 2 weeks later for appointment with CM
- Patient and CM keep in touch with monthly and prn phone calls
- Patient comes back in for 3 month recheck in October and A1c has decreased to 5.6

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What is Care Coordination?

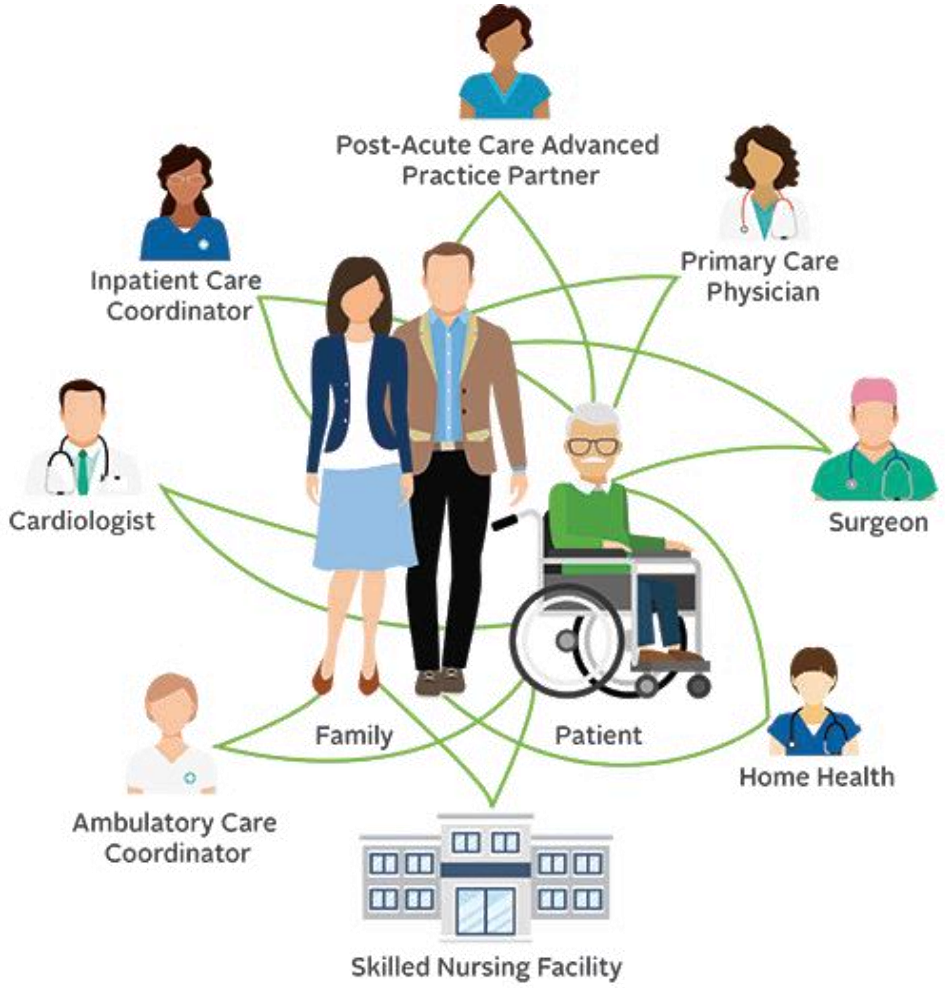
*"…**deliberately** organizing patient care activities and sharing information among all of the participants concerned…"*

Care Coordination | Agency for Healthcare Research and Quality (ahrq.gov)

- Assessing patient needs and providing resources
- Working to identify "what matters most" and developing goals.
- Fostering and encouraging patient engagement.
- Streamlining access to care when and where it is best for the patient.

When Care Needs to be Coordinated

- Follow up after discharge from the Emergency Department
- Care between PCP and specialists
- Transitions between “home” and facilities (SNF, inpatient hospital stays)
- When social services need to be coordinated
- After labs or diagnostic screenings
- When new or complex medications are prescribed



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Case Study: Successful Care Management

- Patient: 45-year-old new patient to our office with T2DM
- Treatment: Metformin 1,000mg qhs (can not tolerate higher dose) and GLP-1 research injectable medication
  - A1c: 5.7, BMI: 27.83
- 3 months after research study ends and stopping GLP-1
  - A1c: 6.9, BMI: 33.72 – has continued with working on diet and activity
- Prior to research study beginning in July 2023, patient was on 2 oral antidiabetic medications and A1c was 7.9. At this time, patient's insurance denied GLP-1 and no further action was done by patient's previous provider office at that time.
- New request for Mounjaro was submitted 3 months post research study and denied by insurance. CM filed 2 reconsiderations, denied. CM then helped patient file member appeal and finally got approval!

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WHY is This Important?

- Promotes greater efficiency and quality,
- Improves outcomes and patient satisfaction,
- Reduces utilization of $$$ services such as ER visits and hospitalizations.
- Provides the patient with confidence in the “team” and builds relationships.
- Generates Revenue for the practice.
- It’s the right thing to do!

Importance of Primary Care

Primary care is the greatest opportunity to improve health care quality and lower cost.

Every $100 spent on healthcare in the US, approx. $5 is spent on primary care.

Every $1 invested in primary care saves the healthcare system up to $13.

Doubling the nation's current spending on primary care would more than pay for itself in savings.

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The Big Picture

- 90% of the nation's $4.1 trillion in annual healthcare expenditures are for people with chronic and mental health conditions.
- "Nothing kills more Americans than heart disease and stroke. More than 877,500 Americans die of heart disease or stroke every year—that's one-third of all deaths."
- "In 2017, the total estimated cost of diagnosed diabetes was $327 billion in medical costs and lost productivity."

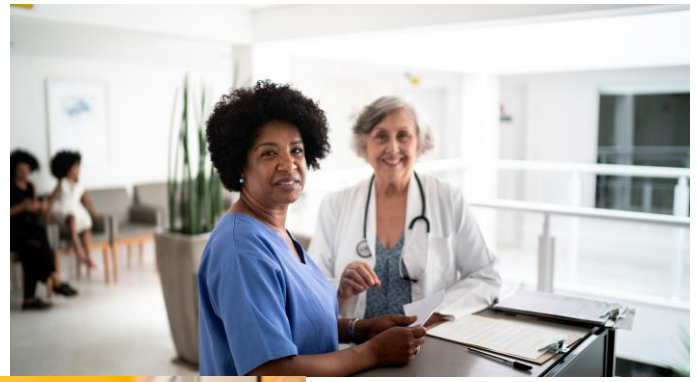
https://www.cdc.gov/chronicdisease/about/costs/index.htm

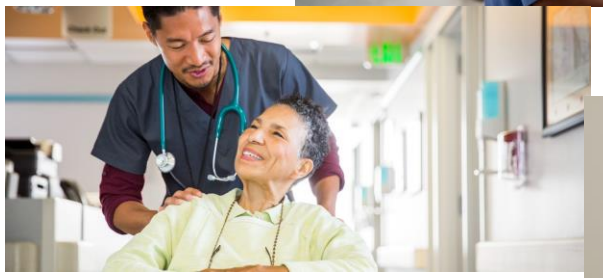
What is Chronic Care Management?

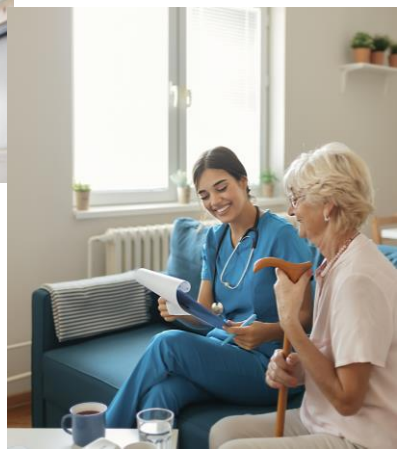
Twenty minutes of services provided to Medicare beneficiaries who have multiple (2 or more) chronic conditions.

Principal Care Management requires only one chronic condition, but 30 minutes of time.

CMS initially patterned this program specifically for PCMHs because they are uniquely prepared to embrace and succeed with the CCM model.







You are doing this work. Get paid for it.

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G0511 Being Replaced by FFS Codes

The purpose of this change is to:

1. Clarify requirements and encourage more RHC's to participate.
2. Recognize the diverse and complex needs of patients in the areas we serve.
3. Accurately compensate providers for the extra services they're providing
4. Promote a more equitable healthcare system.

G0511 is going away July 1, 2025

Snapshot of Reimbursment

2025 Chronic Care Managment		
Description	**Code**	**Average Reimbursement**
20 Minutes per month	99490	$60.49
20 additional minutes per month (limit 2)	99439	$45.94
60 minutes per month, complex	99487	$131.66
30 additional minutes per month, complex (no limit)	99489	$70.52
30 minutes of provider time	99491	$82.18
30 additional minutes of provider time (no limit)	99437	$57.58
***20 minutes per month (RHC & FQHC)**	**G0511**	**$72.90**

*G0511 no longer available after July 1

Financial Rewards-20 Minutes of CCM (99490)

- 25 patients — $1,512 per month
- 50 patients — $3,024 per month
- 100 patients — $6,049 per month
- 200 Patients — $12,098 per month

Care Management Team at NPHC

- Care Manager
  - BSN
- 2 Care Coordinators
  - MAs

- Previously had a behavioral health technician acting as care coordinator

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Billing at NPHC

BCBS/PH

- PDCM Billing Codes
  - G9001, G9002 – In office
  - 98966-98968 – Telephone
  - 99487, 99489 – Care Coordination (w/o pt.)
  - G9007 – Care Conference
  - 98961, 98962 – Group ed.
  - G9008 – Care Oversight
  - S0257 – Advance Directive Counseling
- BCBS – check if CM coverage in Availity
- PH – Covers all CM

Michigan Center for Clinical Systems Improvement (n.d.)

Medicaid

- Incentive Programs
- Example:
  - McLaren Health Plan
  - $2PMPM if measure met

Medicare/Medicare Advantage

- Used most at NPHC
  - CCM – 99490, 99439
  - Complex CCM – 99487, 99489
  - Behavioral Health Integration – 99484
  - Community Health Integration – G0019, G0022
  - Principal CM – 99426, 99427

(National Association of Rural Health Clinics, 2024)

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Advanced Primary Care Management Services

APCM services combine elements of several existing care management and communication technology-based services you may have already been billing for your patients. This payment bundle reflects the essential elements of advanced primary care, including:

- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Principal Care Management (PCM)

APCM services allow you to:

- Provide patients with a wide range of services to meet their individual needs based on complexity
- Bill for these services using a monthly bundle (instead of billing for each individual service or recording minute by minute)

https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services

Comparing APCM to CCM….

- CCM (99490) pays more than the first 2 levels of APCM.
- APCM Level 3 pays more ($110) than CCM but the patient must be a QMB*.
- APCM has no time requirements.

HCPCS	RVU	Average Rage	Covers
G0556	0.25	$15	Monthly fee for Level 1 patients with one or no chronic conditions with specific bundled serviced requirements
G0557	0.77	$50	Monthly fee for Level 2 patients with 2 or more chronic conditions with specific service requirements
G0558	1.67	$110	Monthly fee for Level 3 QMB beneficiaries with 2 or more chronic conditions with special service requirements

*Qualified Medicare Beneficiary. Approximately 85% of dual eligible patients are QMB's.
The patient will have a QMB card.

Requirements for CCM

- Verbal or written consent
- Care plan updated at least annually
- 24/7 access to care
- Appropriate documentation

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Patient Consent

- Written or verbal consent is required before billing for CCM services. This helps the patient to understand the additional benefits they are receiving, ensure they are engaged and make them aware of their cost sharing responsibilities. Informed consent is only required once unless they switch to a different CCM practitioner.
- It is important to inform the patient that only 1 practitioner can furnish and bill CCM services during the calendar month.
- The patient has the right to refuse CCM services at any time.

Benefits to the patient

Copy of Care Plan

Opt-out

Co-pay

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication,
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:
    - Referrals to other health care providers,
    - Follow-up after I visit an emergency department,
    - Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
- Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that _____ is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient Name (please print): _____
Patient Date of Birth: _____

Patient or Guardian Signature: _____
Date: _____

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Co-Pay (Biggest Barrier)

- CMS is restricted and can't waive the co-insurance.
- Cost isn't a small thing. Address it with the patient and be transparent.
- Demonstrate for them what it might save them over time.
  - Hospitalization co-pay can be around $1600 and that would pay for 5 years of CCM services.
  - Are we being positive when we speak to the patient about the service?
  - "Fast Pass"- a benefit is being able to have access to their clinical team when THEY need it.

Consent

- Consent for CM in New Patient Paperwork

- Verbal Consent
  - “Care management is a billable service we offer, and you may be responsible for any member cost share or if it goes towards your deductible. You can always choose not to participate with care management”
  - Like to remind patients we are reaching out with care management when we contact them.

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Comprehensive Care Plan

- Patient-centered
- Electronic or physical copy must be provided to the patient
- Share with other providers and individuals involved in care

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Patient Name: _____ Date: _____

Patient-Centered Health Improvement Plan

Care Plan developed in collaboration with patient by: _____

Patient Name: _____ Date: _____

Patient-Centered Health Improvement Plan

Problem:

_____

Barriers:

_____

_____

Plan to overcome barriers:

_____

_____

Goals:

_____

_____

Plan:

How: _____

Where: _____

When: _____

Frequency: _____

Confidence rating_____ (0-10)

Support System: Who can help?

_____

_____

Follow up:

_____

Care Plan developed in collaboration with patient by: _____

Care Plans

- Templates that are specific for each code
- Physical copy specific for patient

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Advanced Access

Providing the **right care…** at the **right time…** at the **right place**!

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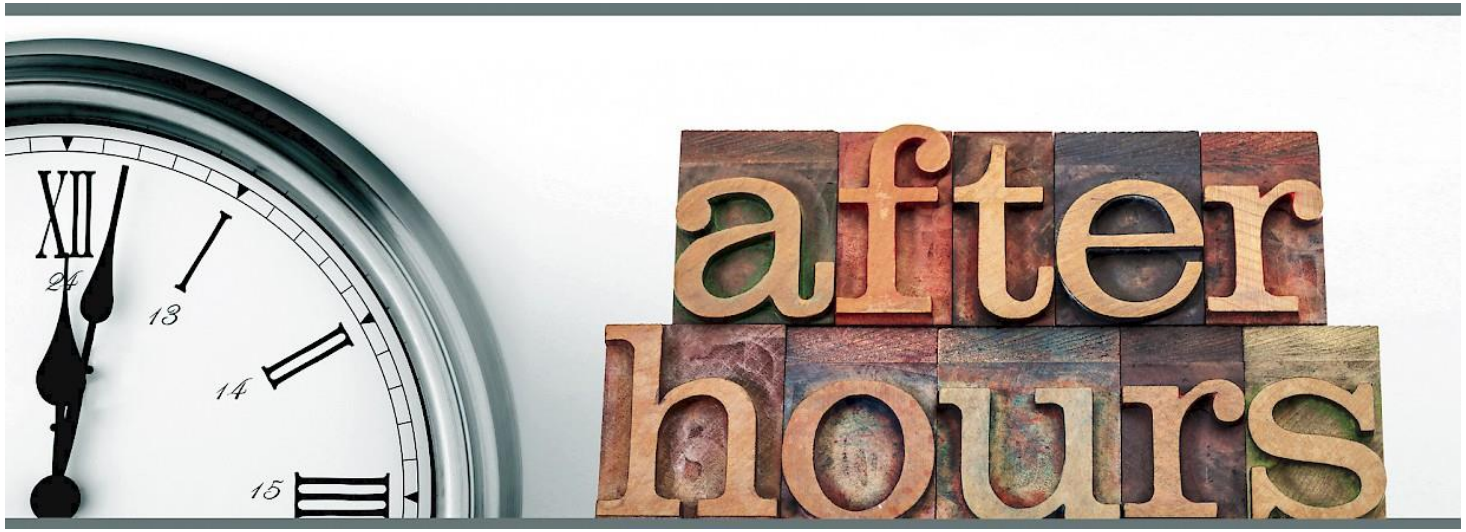
Meeting the Needs

- Same day appointments for urgent illness;
- Evidence of expanded weekday, evening, and/or weekend appointment offerings; and
- Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.



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24/7 Access at NPHC

- Open M-F 7am-5pm
- Offer walk-in clinic hours daily
- Provider always on call

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CCM Documentation for Billing

- Eligible CCM billing code.
- Qualifying diagnosis codes.
- Minutes spent on CCM activities.
- Description of CCM activities.
- Identification of staff performing CCM activities.

Where Do We Start??

New Chronic Care Management Certification

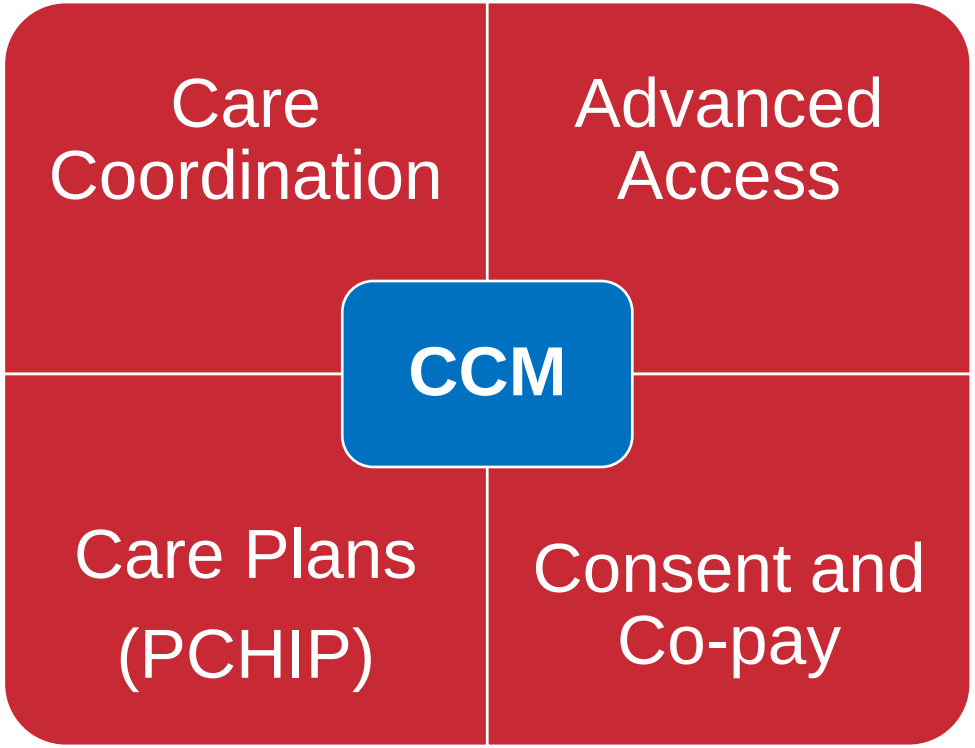
-Improved Patient Outcomes

-Foundation for a successful CCM program

-Access to tools, templates and support

-Additional revenue for the clinic

-Stepping stone to Patient-Centered Medical Home accreditation by meeting 50% of the standards



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The Art of the Huddle

Team Huddle Checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.

Team Huddle

- Stand up
- Meet before the daily schedule starts
- Be consistent-have a plan
- Check-in and announcements
- Use visuals- score cards, dashboards, bulletins
- Preview patients coming in
- Identify potential challenges/concerns
- Keep meeting short- no more than 10 minutes
- Be courteous and respectful
- Positive feedback and praise

Go Team!

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Care Conferences

- Weekly scheduled time with each provider
- Mark MAs schedule in the mornings
- Briefly touch base on a patient before/after CM sees them
- Provider/MA will come grab one of us if they identify a patient that would benefit from CCM

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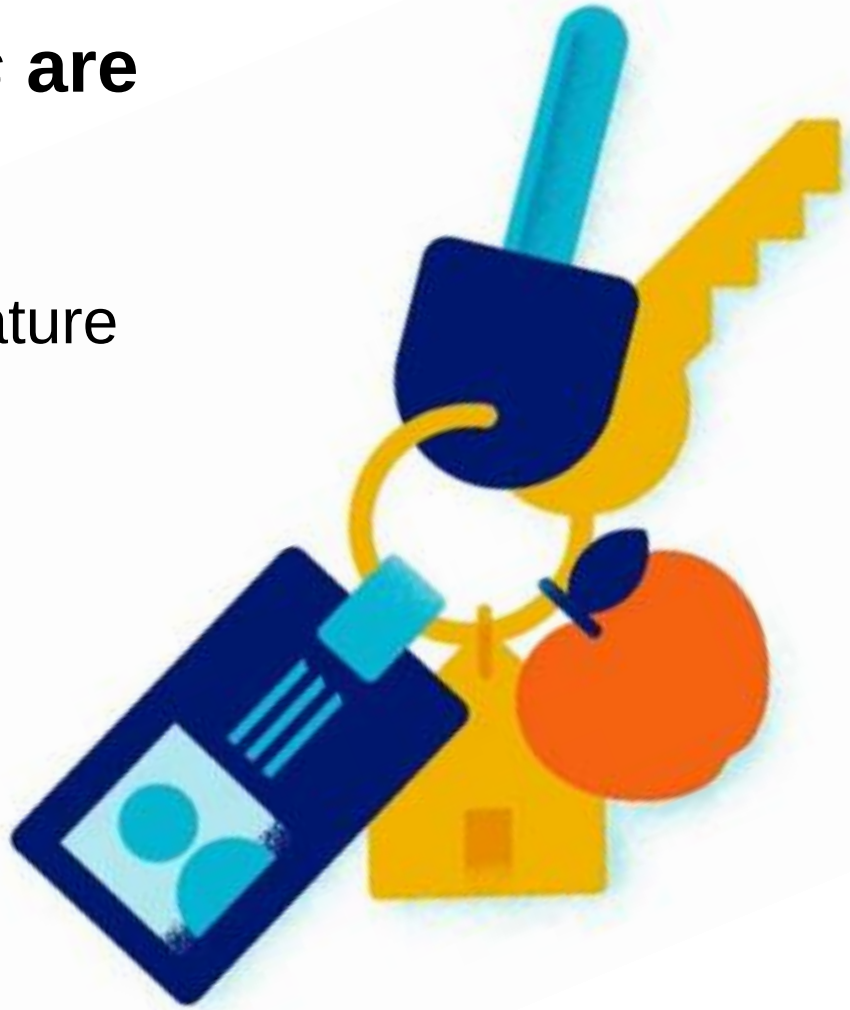
Social Drivers of Health

Social determinants and _social drivers_ are often used interchangeably.

- *Social determinants* of health, by the very nature of the word, are predetermined or fixed.

- *Social drivers* of health are similar. They affect health outcomes, but it's important that these influences aren't treated as finite.



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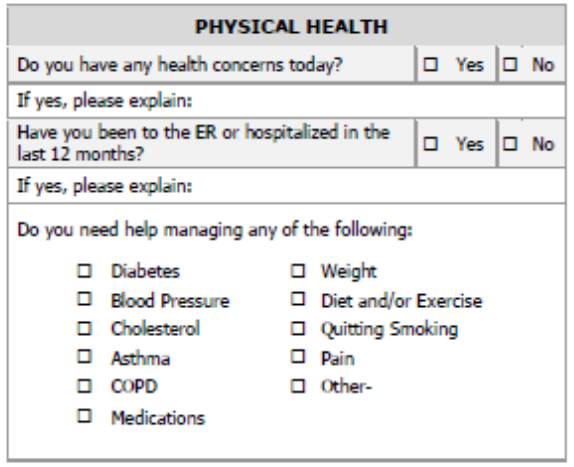
Needs Assessment

- Who gets one?
- How often?
- Is staff trained to assess and address?
- What is your follow-up?

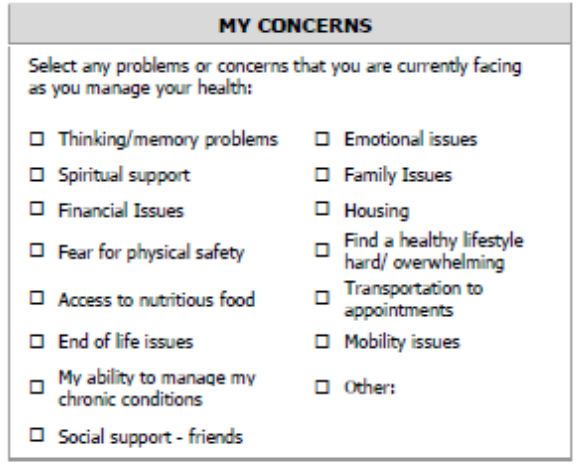


PHYSICAL HEALTH

Do you have any health concerns today?	☐ Yes	☐ No
If yes, please explain:		
Have you been to the ER or hospitalized in the last 12 months?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

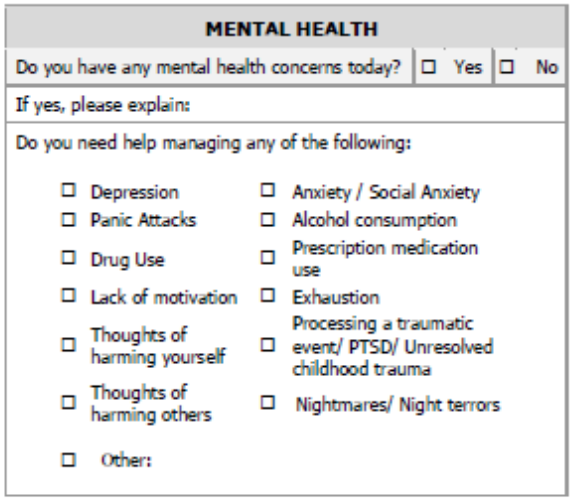
- ☐ Diabetes
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Asthma
- ☐ COPD
- ☐ Medications
- ☐ Weight
- ☐ Diet and/or Exercise
- ☐ Quitting Smoking
- ☐ Pain
- ☐ Other-



MY CONCERNS

Select any problems or concerns that you are currently facing as you manage your health:

- ☐ Thinking/memory problems
- ☐ Spiritual support
- ☐ Financial Issues
- ☐ Fear for physical safety
- ☐ Access to nutritious food
- ☐ End of life issues
- ☐ My ability to manage my chronic conditions
- ☐ Social support - friends
- ☐ Emotional issues
- ☐ Family Issues
- ☐ Housing
- ☐ Find a healthy lifestyle hard/ overwhelming
- ☐ Transportation to appointments
- ☐ Mobility issues
- ☐ Other:

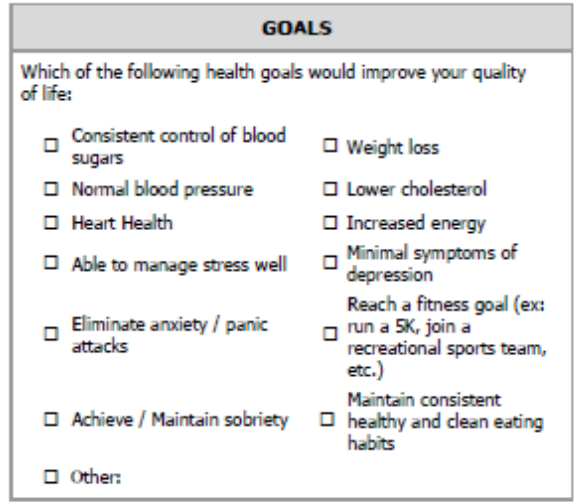


MENTAL HEALTH

Do you have any mental health concerns today?	☐ Yes	☐ No
If yes, please explain:		

Do you need help managing any of the following:

- ☐ Depression
- ☐ Panic Attacks
- ☐ Drug Use
- ☐ Lack of motivation
- ☐ Thoughts of harming yourself
- ☐ Thoughts of harming others
- ☐ Other:
- ☐ Anxiety / Social Anxiety
- ☐ Alcohol consumption
- ☐ Prescription medication use
- ☐ Exhaustion
- ☐ Processing a traumatic event/ PTSD/ Unresolved childhood trauma
- ☐ Nightmares/ Night terrors



GOALS

Which of the following health goals would improve your quality of life:

- ☐ Consistent control of blood sugars
- ☐ Normal blood pressure
- ☐ Heart Health
- ☐ Able to manage stress well
- ☐ Eliminate anxiety / panic attacks
- ☐ Achieve / Maintain sobriety
- ☐ Other:
- ☐ Weight loss
- ☐ Lower cholesterol
- ☐ Increased energy
- ☐ Minimal symptoms of depression
- ☐ Reach a fitness goal (ex: run a 5K, join a recreational sports team, etc.)
- ☐ Maintain consistent healthy and clean eating habits

Identify a life goal or reason that motivates you to work towards better health.

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SDOH

- Community Connections
- Every patient once a year
- Care coordinator triages
  - Manage in-house
  - Send to CHW

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COMMUNITY connections

Welcome to Community Connections. We can work together to help you and your family stay healthy!

Name _____ _____

Name of Health Care Provider_____

Question	Yes	No
In the past month, did poor physical health keep you from doing your usual activities, like work, school or a hobby?	☐	☐
In the past month did poor mental health keep you from doing your usual activities, like work, school, or a hobby?	☐	☐
In the past 3 months, was there a time when you needed to see a doctor but could not because it cost too much?	☐	☐
In the past 3 months, have you had to eat less than you feel you should because there is not food?	☐	☐
Is it hard to find work or another source of income to meet your basic needs?	☐	☐
Are you worried that in the next few months, you may not have housing?	☐	☐
Has it been difficult to go to work or school because you couldn't find care for a child or older adult?	☐	☐
Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be something you would like to work on in the next 6 months?	☐	☐
Do you have trouble getting to school, work or the store because you don't have a way to get there?	☐	☐
In the past 3 months, have you had a hard time paying your utilities?	☐	☐
Have you been a patient in the Emergency Room 2 or more times in the past 6 months?	☐	☐

You identified some needs today that may make being healthy very difficult. Would you like someone from our team to assist you in person, via phone or text to work on the needs that you identified today? ☐ Yes ☐ No If yes, please fill out your contact information below. Thank you.

Print Name: _____ **DOB:** ___/___ / ___ **Gender:** _____

Parent/Guardian Name (If a minor): _____ **County:** _____

Address:_____ **City:**_____ **Primary phone:** _____

Preferred method of client contact: ☐ Phone ☐ Text

Signature_____ **Date:**_____ **Alt.phone:**_____

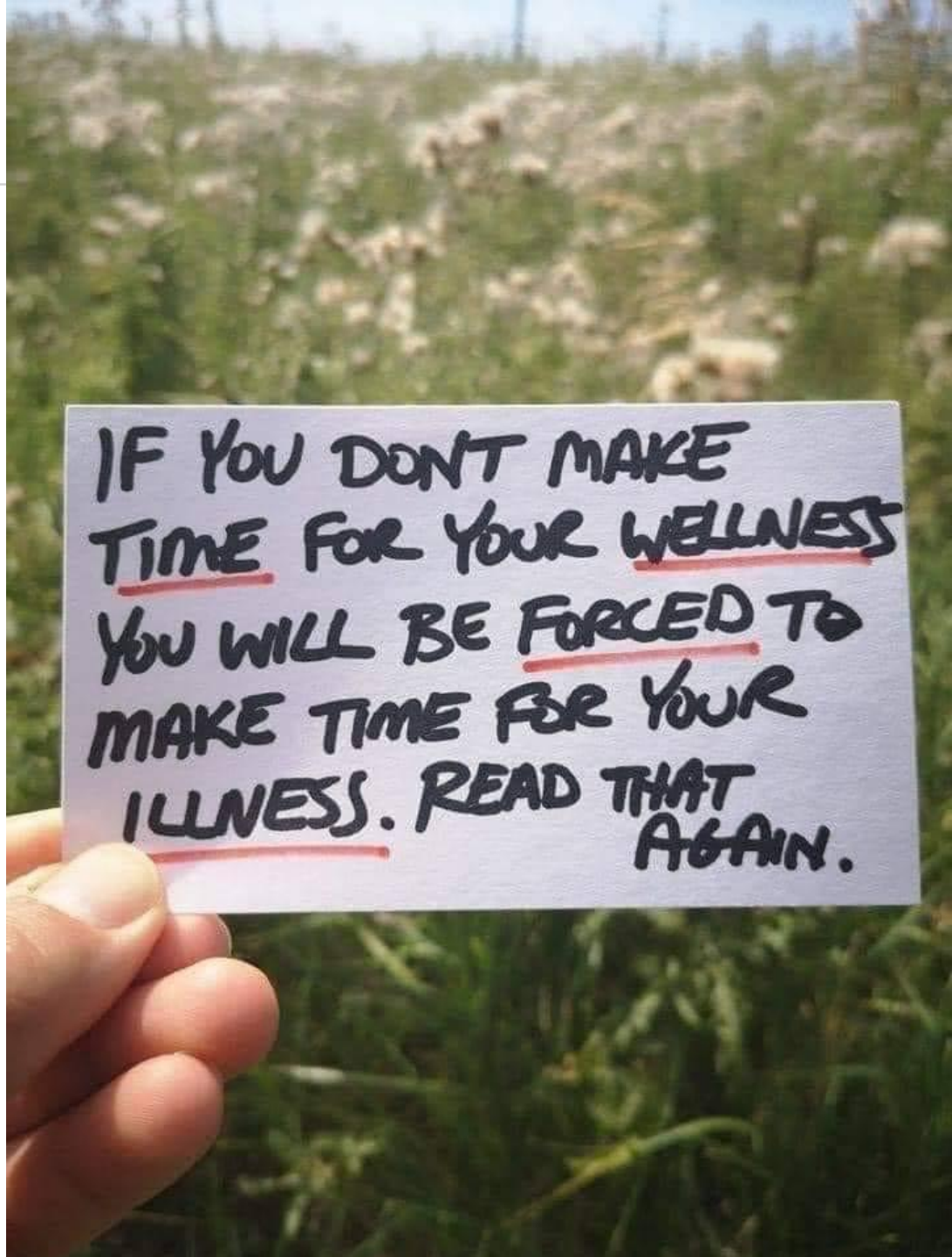
Responsible Representative Name (Optional): _____ **Phone:** _____

(We will not share any information with the Responsible Representative unless you have signed permission to do so.)

Wellness Visits

Why should you do them?

- Wellness visits are an efficient way to capture preventive screenings and close care gaps.
- Not all the work has to be done by the provider.



AWVs at NPHC

- Done by care coordinator

- Identify patients that would benefit from CCM

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Future Directions in 2025

Behavioral Health

Preventative Care and Education

Group Visits

Policy Changes

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Benefits of CCM (recap)

- Better quality care
- Improved outcomes
- Lower healthcare costs
- Engaged patients
- Net new revenue
- Happier providers and staff

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Let’s Do This!

- CCM Certification Program with TCT
- Identify your population
- Select 5-10 patients to start
- Follow the claims
- Adjust staffing
- **Enroll! Enroll! Enroll!**

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Strategies for Success

- Integrated Care Teams
  - Providers, MA's, MOA's, Practice manager/assistant
- Community partnerships
- Technology
- Continuing Education
- Monthly Health Topics
- Pilot Programs
- Cold Calls

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Questions

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