New Medicare Reimbursement Opportunities for Rural Health Clinics

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Presented by:
Martie Ross
Principal | PYA, P.C.

Martie Ross

(800) 270-9629
mross@pyapc.com

PYA, P.C.
9900 West 109th Street #130
Overland Park, Kansas 66210

Following a successful two-decade career as a healthcare transactional and regulatory attorney, Martie now serves as a trusted advisor to providers navigating the ever-expanding maze of healthcare regulations. Her deep and wide understanding of new payment and delivery systems and public payer initiatives is an invaluable resource for providers seeking to strategically position their organizations for the future..

Martie synthesizes complex regulatory schemes and explains in straightforward and practical terms their impact on providers. She has made hundreds of presentations to professional and community organizations on a broad range of industry topics..

Martie received a Bachelor of Arts and a Juris Doctor from the University of Kansas. She is an active member of the American Health Lawyers Association, the Kansas Association of Hospital Attorneys, and the Greater Kansas City Society of Healthcare Attorneys.

Medicare Part B Reimbursement for Care Management Services

- Transitional Care Management (2013)
- Chronic Care Management (2015)
- Care Plan Development (2017)
- Complex Chronic Care Management (2017)
- Behavioral Health Integration (2018)
- Psychiatric Collaborative Care Model (2018)
- Interprofessional Internet Consultations (2019)
- Virtual Check-Ins (2019)
- Remote Patient Monitoring (2019)

Medicare RHC Reimbursement for Care Management Services

I. Transitional Care Management – TCM
II. Chronic Care Management - CCM
III. Behavioral Health Integration - BHI
IV. Psychiatric Collaborative Care Model - CoCM

True or False?

An RHC may bill Medicare for remote patient monitoring services.

I. Transitional Care Management

- Scope of service
  - Communicate with patient within 3 business days of discharge from inpatient or SNF
  - Perform face-to-face visit within 7 or14 days
  - Provide non-face-to-face care management services for 30 days post-discharge (no specific time requirement)
- Reimbursement
  - Add CPT 99495 (7 days) or 99496 (14 days + high complexity) to RHC claim; DOS = date of face-to-face visit
  - Paid at RHC encounter rate; not separately reimbursable if another service furnished on same day

II. Chronic Care Management

- Use general care management G code, G0511
- Payment set annually at average of Part B national rate for CPT 99490, 99487, 99491, and 99484
- 2019 rate = $67.03
  - Compare with Part B Montana rate for 99490 = $43.08
- May be billed alone or on claim for RHC billable visit (both will be paid)
- Only one unit per month, regardless of total time
- Report with revenue code 052x

Key Considerations

1. Eligible beneficiaries
2. Consent to receive CCM
3. Five specified capabilities
4. Care management services

1. Eligible Beneficiaries

- 2+ chronic conditions
  - No definitive list
  - CMS Chronic Condition Warehouse
- Expected to last at least 12 months, or until the death of the patient; place patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Not presently receiving home health care or hospice supervision or certain ESRD services from any provider

Initiating Visit

- If patient has not been seen in the practice in the last 12 months, must discuss CCM as part of a face-to-face visit
  - Not a component of CCM; may be billed separately
- No initiating visit required if patient seen in last 12 months (consent still required)

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2. Consent

- Provider cannot bill for CCM unless and until secures beneficiary’s consent
  - Documented verbal consent
- If beneficiary revokes consent, cannot bill for CCM after then-current calendar month

Elements of Consent

- Beneficiary must acknowledge provider has explained:
  1. Nature of CCM services and how they are accessed
  2. Only one provider at a time can furnish CCM
     - NOTE: RHC will not be paid for CCM if another provider with more recent consent also bills for CCM for the same month
  3. Beneficiary may stop CCM services at any time by revoking consent, effective at end of then-current calendar month
  4. Beneficiary responsible for copayment/deductible

Who Gets Paid?

- RHC #1 secures Jane's consent for CCM on January 2
- RHC #2 secures Jane's consent for CCM on January 17
- Both RHCs provide Jane with 20 minutes of care management services in January *and* February.
- Which RHC will be reimbursed for CCM services furnished to Jane in January?
- Which RHC will be reimbursed for CCM services furnished to Jane in February?

3. Five Specified Capabilities

- Provider must demonstrate following capabilities:
  - A. Use of certified EHR for specified purposes
  - B. Electronic care plan
  - C. Beneficiary access to care
  - D. Transitions of care
  - E. Coordination of care
- Submission of claim = attestation of capabilities

A. Use of Certified EHR

- Structured recording of the following consistent with 45 CFR 170.314(a)(3) –(7)
  - Patient demographic information
  - Problem list
  - Medications and medication allergies
- Creation of structured summary care record consistent with 45 CFR 170.314(e)(2)
  - Not required to use specific tool or service to transmit summary care record for care coordination purposes

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B. Electronic Care Plan

- Maintain regularly updated electronic care plan for beneficiary
  - Based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of beneficiary’s needs
  - Inventory of resources and supports
  - Addresses all health issues (not just chronic conditions)
  - Congruent with beneficiary’s choices and values
- Preparation and updating of care plan is not a component of CCM
  - One-time billing for care plan development

Technology Tool

- “must electronically capture care plan information”
- “use some form of electronic technology tool or services in fulfilling the care plan element”
  - “certified EHR technology is limited in its ability to support electronic care planning at this time”
  - “practitioners 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”

Access To Electronic Care Plan

- "must electronically share care plan information as appropriate with other providers" caring for patient
  - E.g., secure messaging, participation in HIE - not facsimile
- Provide paper or electronic copy to beneficiary
  - Must be documented in certified EHR

C. Beneficiary Access To Care

1. Means for beneficiary to access provider in the practice* on 24/7 basis to address acute/urgent needs in timely manner
2. Beneficiary's ability to get successive routine appointments with designated practitioner or member of care team
3. Enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone + asynchronous consultation methods (*e.g.*, secure messaging, internet)

**person whose time is counted in 20 minutes of non-face-to-face care management services per month*

D. Transitions of Care

- Capability and capacity to do the following:
  - Follow-up after ER visit
  - Provide transitional care management
  - Coordinate referrals to other clinicians
  - Share information electronically with other clinicians as appropriate
    - Summary care record and electronic care plan
    - No specific manner of transmission required

E. Coordination of Care

- Coordinate with home and community-based clinical service providers to meet beneficiary's psychosocial needs and functional deficits
  - Home health and hospice
  - Outpatient therapies
  - DME suppliers
  - Transportation services
  - Nutrition services
- Communications with these providers must be documented in medical record

4. Care Management Services

- Performed by clinical staff under ***general*** supervision
  - No physical presence, no review of individual services
- Types of services (non-exclusive)
  - Performing medication reconciliation, oversight of beneficiary self-management of medications
  - Ensuring receipt of all recommended preventive services
  - Monitoring beneficiary's condition (physical, mental, social)
- Documentation
  - Date and time (start/stop?)
  - Person furnishing services (with credentials)
  - Brief description of services

20+ Minutes

- 20+ minutes non-face-to-face care management services per calendar month
  - Cannot carry over time from month-to-month
  - Cannot count time while beneficiary hospital/SNF inpatient
- Furnished by clinical staff under physician/mid-level general supervision
  - No physical presence requirement
  - Not required to sign notes
- 20 minutes can be aggregated but not rounded up
- May be provided by different individuals, but cannot count double for two staff members providing services at the same time

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Shared Staffing

- CMS acknowledges providers may not have internal capacity to provide CCM
- Arrangements with 3rd parties permitted
  - Sufficient integration (e.g., use of EHR)
  - Responsibility for key components allocated between parties; billing provider ultimately responsible

CCM Impact on Total Cost of Care

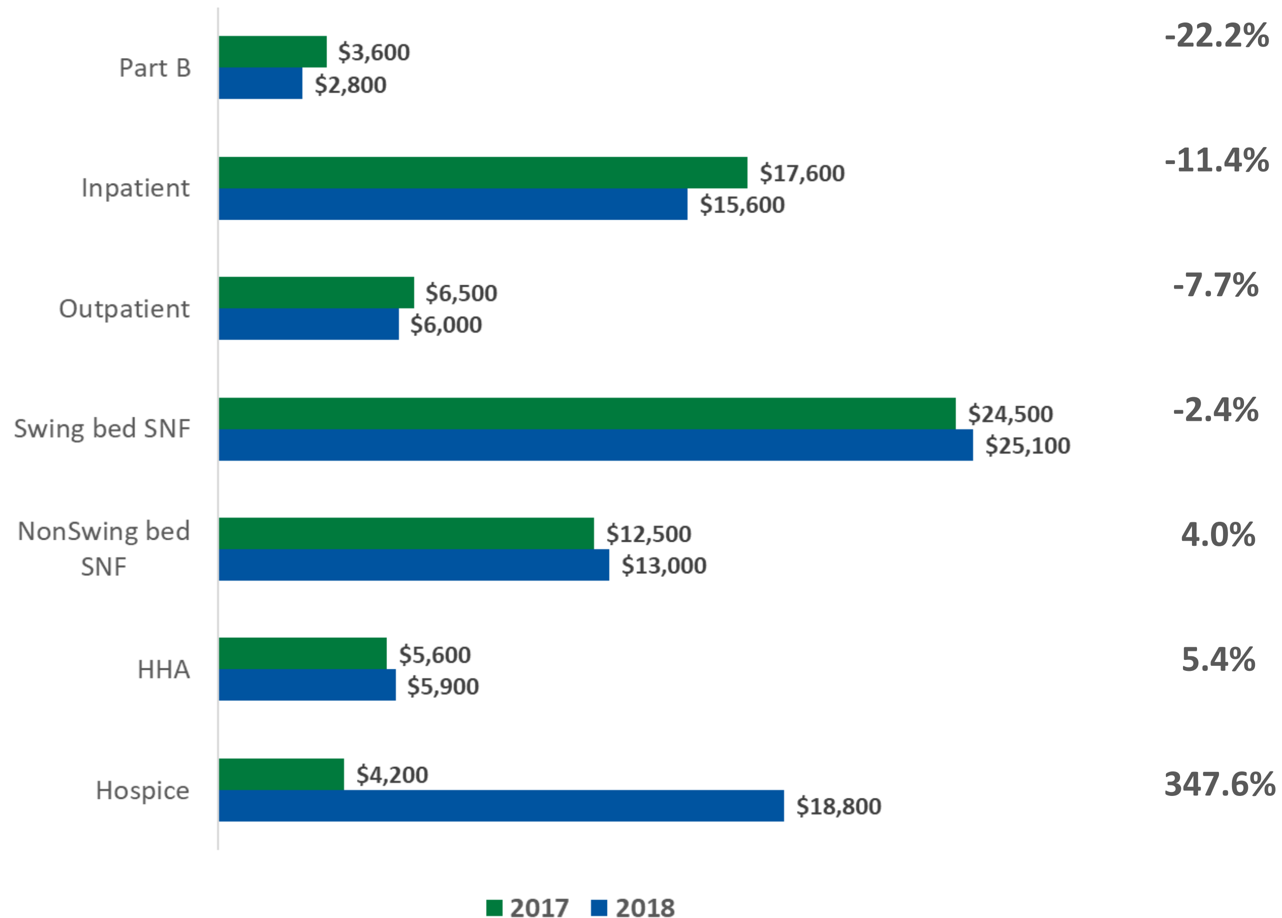
- Kansas Clinical Improvement Collaborative
  - Providers in 36 rural communities participating in Medicare Shared Savings Program
  - Centralized care management team
  - Bill services under G0511
  - Revenue more than sufficient to fund delivery of services

Data Set

1. Identify Care Collaborative ACO beneficiaries who received CCM services (CPT Code 99490) in 2016 or 2017 using the Medicare Claims and Claim Line Feed (“CCLF”) data. Exclude any beneficiary who died in 2018 (the “CCM Beneficiaries”).
   - Total = ~ 1,500 beneficiaries
2. Identify all Part A and B claims for each CCM Beneficiary between 01/01/2017 and 12/31/2018.
3. Determine the care setting for each claim by using the CLM_TYPE_CD.
4. Calculate the actual amount paid by CMS on each claim by adjusting the payment based on the CLM_ADJSMT_TYPE_CD (Original – Cancellation + Adjustment).

Average Payments

2017-2018 % Reduction



-22.2%

-11.4%

-7.7%

-2.4%

4.0%

5.4%

347.6%

II. Behavioral Health Integration

- Provision of care management services for individuals with any behavioral health or psychiatric condition (including substance abuse)
- Same rules as CCM with regard to initiating visit, consent, and 20+ minutes care management services; different rules on capabilities (next slide)
- Same billing rules as CCM

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BHI Capabilities

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales
- Behavioral healthcare planning relating to behavioral/psychiatric health problems
  - Including revisions for those not progressing or whose status changes
- Facilitating and coordinating treatment
- Continuity of care with designated care team member

Does It Make Sense?

- Furnish CCM/BHI to 100 beneficiaries per month ($67.03 x 100) = $6,703 x 12 months = $80,436
    - Assume 10% billing cost (less $8,042.60)
    - Assume 15% collection rate (less $12,065)
    - Net revenue = $60,329

III. Psychiatric Collaborative Care Model

- Use psychiatric CoCM G code, G0512
- Payment set annually at average of of Part B national rate for CPT 99492 and 99493
- 2019 rate = $145.96
- May be billed alone or on claim for RHC billable visit (both will be paid)
- Only one unit per month, regardless of total time
- Report with revenue code 052x

CoCM Team

- RHC Primary Care Practitioner
  - Oversees beneficiary's ongoing care and supervises behavioral healthcare manager and clinical staff
- Behavioral Health Care Manager
  - At least bachelor's degree in behavioral health field or clinicial with behavioral health training
  - Same as BHI + provide brief psychosocial interventions; maintenance of registry; working with psychiatric consultant
- Psychiatric Consultant
  - Medical professional trained in psychiatry qualified to prescribe full range of medications
  - Participate in regular reviews of clinical status of beneficiaries receiving CoCM services; consults with primary care practitioner; facilitates referrals for direct provision of psychiatric care when clinically indicated

CoCM

- Same rules as CCM for initiating visit, consent
- At least 70 minutes in first month; 60 minutes in subsequent months
  - Aggregate time for all team members
  - No separate billing for same time

Co-Payment Quandry

Is an RHC required to charge the beneficiary the 20% co-payment for care management services?

A. No, they are considered preventive services for which Medicare provides 100% coverage.
B. No, if such copayment waiver is consistent with the RHC's financial assistance policy.
C. Yes, no matter what.

Final Note - Cost Reporting

- Costs of providing RHC care management services (CCM, BHI, CoCM) are reportable costs that must be included on RHC cost report
- Reported in “Other than RHC Services” section
- Not used in determining RHC AIR rate

Thank You!

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