CCM Improvement Cohort Session 2

How did everyone do with their homework from last time?

Please share any barriers or challenges you experienced.

Homework Items:

- Review CCM templates and build into EMR
- Enroll 10 new patients
- Identify your EHR champion - someone who can help you learn how to run reports and use your EHR's CCM dashboard (if applicable). Find out what reporting capabilities your EHR has for CCM
- Review the CCM Program Build Checklist

Program Build Checklist

CCM Program Build Checklist

Program Setup

- [ ] Create CCM job description (RN, LPN, MA, or Care Coordinator role)
- [ ] Hire and/or designate staff for CCM
- [ ] Train staff on Medicare CCM requirements (billing, documentation)
- [ ] Establish a supervising provider and oversight process

Policies & Forms

- [ ] Develop a CCM patient consent form (or customize an existing one)
- [ ] Review clinic's patient assistance/financial policy for CCM copays
- [ ] Create policy for enrollment, disenrollment, and patient refusal

EHR & Documentation

- [ ] Ensure a **care plan template** exists in the EHR (customize if needed)
- [ ] Set up a **CCM documentation note**
- [ ] Create workflows for **medication reconciliation** and care gap reviews
- [ ] Build a consistent EMR flag or tag for enrolled CCM patients

Patient Identification & Enrollment

- [ ] Generate an eligible patient list (2+ chronic conditions, ≥12 months expected)
- [ ] Develop a process to review eligibility lists regularly (e.g., at huddles)
- [ ] Train front desk/MA staff to introduce CCM at check-in or AWVs
- [ ] Implement workflow for obtaining and scanning consent into chart
- [ ] Set enrollment targets (e.g., 5–10 new patients per provider per week)

Care Management Workflows

- [ ] Establish a standard workflow for monthly CCM touches (calls, chart review, etc.)
- [ ] Define productivity expectations (e.g., 5 new patients/day for new CCM staff)
- [ ] Incorporate CCM into morning huddles to flag opportunities
- [ ] Develop transition of care (TOC) and hospital follow-up process
- [ ] Standardize frequency of medication reconciliation (e.g., 3x/year for high-risk)

Billing & Finance

- [ ] Confirm billing workflows with revenue cycle staff (CPT 99490, 99439, 99487, 99489)
- [ ] Set up billing compliance checks to ensure CMS requirements are met
- [ ] Track claims paid vs. denied, and monitor revenue by provider/clinic
- [ ] Run a break-even analysis (patients needed to cover staff costs)

Program Monitoring

- [ ] Assign a "data champion" to pull CCM reports from EHR/claims
- [ ] Monitor enrollment vs. eligible population
- [ ] Track touches completed, care gaps closed, and patient outcomes
- [ ] Review financial performance monthly (claims submitted, paid, copays collected)
- [ ] Hold regular team meetings to review progress and barriers

Sustainability & Growth

- [ ] Build a growth plan (enrollment goals, staff expansion, outreach strategy)
- [ ] Tie CCM metrics to clinic quality/value-based programs (ACO, MIPS, pay-for-performance)
- [ ] Gather patient success stories to share with leadership and staff
- [ ] Develop a succession/back-up plan for CCM staff to ensure continuity
- [ ] Update templates, workflows, and policies annually for compliance changes

Patient-Centered Care Plan

A comprehensive approach to healthcare that puts you at the center of your care decisions. This personalized plan ensures your health goals, concerns, and preferences guide every aspect of your treatment journey.

Comprehensive Care Plan

A comprehensive care plan is a patient-centered, electronic document developed, revised, and monitored to guide the management of chronic conditions. It is based on a thorough assessment of the patient's physical, mental, cognitive, psychosocial, functional, and environmental factors, alongside an inventory of available resources and support systems. This plan ensures that patient health goals, concerns, and preferences are central to every aspect of their treatment journey.

Key Components of the Care Plan

A comprehensive care plan focusing on managing chronic conditions typically includes the following elements:

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Ongoing revision and monitoring (per code descriptors)
- Cognitive and functional assessments
- Symptom management strategies
- Planned interventions
- Medical management protocols
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners
- Periodic review schedule

Plan Availability and Distribution

The comprehensive care plan must be made available promptly both within and outside the billing practice. Patients and their caregivers should receive a copy of the care plan when necessary.

Patient Centered Care Plan

Patient name: DOB

Last Medicare Wellness Exam

Patient Pharmacy:

Current Chronic Conditions:

Current diagnosis list pulls in here

Patient Goal: (PCMH requirement)

Patient Concerns/ Barriers to Care:

Plan to Achieve Care Plan Goals:

Provider Guide Goals:

Lab/ Clinic Appointments Due

Resources and Support: (Besides your health care team who would you turn to for health-related problems (family, friends, spiritual support, neighbor.)

Other providers involved in Care/ Specialists/ Counselors/ DME suppliers:

Preventive Screenings/ Immunizations

Immunizations Due now:

Flu

Zoster

Pneumovax 23

Treatment Goals/Targets

These are mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example, LDL cholesterol <100, BP<150/90, weight of 150 pounds, 7 hours of uninterrupted sleep, average pain level of 5, ability to walk to my mailbox daily):

Diet:

Exercise:

Safety

Smoking

Future appointments planned:

Current Medication List:

Med list should pull in from EMR here

Please review your medication list and report any changes.

Your Chronic Care manager is:

Your Health Foundation

Patient Information

Name, date of birth, and last Medicare Wellness Exam date establish your healthcare baseline and eligibility for preventive services.

Current Chronic Conditions

Your diagnosis list provides a complete picture of chronic conditions requiring ongoing management and monitoring.

Pharmacy Partnership

Your designated pharmacy ensures medication coordination and accessibility for optimal treatment outcomes.

Setting Your Health Goals

Patient Goals (PCMH Requirement)

Your personal health objectives drive our care approach. These goals reflect what matters most to you - whether it's managing pain, improving mobility, or maintaining independence.

Concerns & Barriers

We identify obstacles that might prevent you from achieving optimal health, including transportation, financial constraints, or family responsibilities.

Provider Guided Goals

Clinical outcomes established by the provider based on medical necessity, evidence-based guidelines. These goals guide the care team in monitoring chronic conditions ensuring interventions align with the provider's plan of care.

Your Care Team Strategy

01

Plan Development

Create actionable steps to achieve your care plan goals through evidence-based interventions.

02

Provider Coordination

Establish clear provider guide goals that align with your personal objectives and clinical needs.

03

Appointment Scheduling

Coordinate necessary lab work and clinic appointments to monitor progress and adjust treatment.

Your Support Network

Personal Support

Family, friends, and neighbors who provide emotional support and practical assistance with health-related challenges.

Healthcare Specialists

Other providers, specialists, counselors, and DME suppliers involved in your comprehensive care coordination.

Community Resources

Spiritual support, community organizations, and local resources that contribute to your overall wellbeing.

Preventive Care Schedule

Immunizations Due Now

- Flu vaccine - Annual protection
- Zoster (Shingles) - Age-appropriate prevention
- Pneumovax 23 - Pneumonia prevention

Preventive Screenings

Regular screenings based on age, risk factors, and clinical guidelines to detect health issues early.

Measurable Treatment Targets

Mutually agreed upon, specific goals to improve or control your medical conditions and manage symptoms effectively.

<100

LDL Cholesterol

Target level for cardiovascular health

<140/90

Blood Pressure

Optimal range for heart health

7

Sleep Hours

Uninterrupted rest for recovery

5

Pain Level

Average manageable pain score

Lifestyle Management Plan

Diet

Nutritional guidelines tailored to your conditions, preferences, and cultural needs for optimal health outcomes.

Exercise

Physical activity recommendations appropriate for your fitness level and health conditions, from walking to structured programs.

Safety

Home safety assessments, fall prevention strategies, and medication safety protocols to prevent accidents.

Smoking Cessation

Support resources and strategies for tobacco cessation if applicable to your health goals.

Medication Management

Current Medication List

Your complete medication list pulls directly from your electronic medical record, ensuring accuracy and preventing dangerous interactions.

Regular Review Process

Please review your medication list regularly and report any changes, including over-the-counter medications, supplements, or discontinued prescriptions.

Future Appointments

Scheduled follow-up appointments ensure continuous monitoring and medication adjustments as needed.

Your Chronic Care Manager

This comprehensive care plan ensures coordinated, patient-centered healthcare that addresses your unique needs, goals, and preferences. Regular updates and reviews keep your plan current and effective.

Dedicated Support

Your assigned Chronic Care Manager coordinates all aspects of your care plan and serves as your primary healthcare advocate.

Hospital Discharge Care Plan

This comprehensive discharge care plan outlines essential information and instructions for your continued recovery and health management following hospitalization.

Admission Diagnosis

Clearly states the primary reason for your hospitalization and any relevant secondary diagnoses that require ongoing management.

- *Primary Diagnosis: Acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD)*
- *Secondary Conditions: Hypertension, Type 2 Diabetes*

Hospitalization Details

Key information regarding your recent hospital stay.

- *Hospital Name: General Community Hospital*
- *Hospital Address: 123 Main Street, Anytown, USA*
- *Date of Admission: October 18, 2024*
- *Date of Discharge: October 23, 2024*

Discharge Medications

A complete list of all medications to be taken after discharge, including new prescriptions, dosage adjustments, and instructions for use. It's crucial to review this list carefully with your healthcare provider.

- *New Prescription: Prednisone 20mg, take 1 tablet daily for 5 days.*
- *Adjusted: Metformin 500mg, continue 2 tablets twice daily.*
- *Discontinued: Ibuprofen (as directed by physician).*

Provider Recommendations

Important instructions and recommendations from your healthcare providers for follow-up care, symptom management, activity restrictions, and any necessary lifestyle modifications.

Specialist Appointments

Details for any scheduled follow-up appointments with specialists, including date, time, and location.

- *Dr. Smith, Pulmonology: Scheduled October 25, 2024, at 2:30 PM.*
- *Dr. Lee, Endocrinology: Scheduled November 1, 2024, at 10:00 AM.*

Next Clinic Appointment

Information regarding your next scheduled appointment with your primary care provider.

APCM Codes for 2025

	Code Requirements
G0556	• Clinical staff provide the APCM services • A physician or other qualified health care professional who's responsible for all primary care directs the clinical staff and serves as the continuing focal point for all needed health care services • The services include all of the elements, as appropriate, listed below under "What Are the APCM Billing Requirements?"

G0557	• The patient has 2 or more chronic conditions. These conditions must:
	  ◦ Be expected to last at least 12 months or until the death of the patient
	  ◦ Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
	• The services include all of the requirements for code G0556

G0558	• The patient is a Qualified Medicare Beneficiary with 2 or more chronic conditions. These conditions must:
	  ◦ Be expected to last at least 12 months or until the death of the patient
	  ◦ Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
	• The services include all of the requirements for code G0556

Federal law prohibits Medicare providers and suppliers, including pharmacies, from billing individuals in the QMB group for Medicare cost sharing. Medicare beneficiaries enrolled in the QMB group have no legal obligation to pay Part A or Part B deductibles, coinsurance, or copayments for any Medicare-covered items and services.

What are the APCM billing requirements?

Get patient consent.

Provide 24/7 access and continuity of care,

Provide comprehensive care management

Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan.

Coordinate care transitions

Provide enhanced communication opportunities.

Conduct patient population-level management.

You must:

- Analyze patient population data to identify gaps in care
- Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients

Measure and report performance. including assessment of primary care quality, total cost of care, and meaningful use of Certified EHR Technology (CEHRT). You can either:

- Report the Value in Primary Care MIPS Value Pathway (MVP). You'll report performance starting in 2026 for CY 2025.
- Participate in a Medicare Shared Savings Program Accountable Care Organization (ACO), Realizing Equity, Access, and Community Health (REACH) ACO, Making Care Primary model, or Primary Care First model.

Action Items

1. Submit one completed care plan for review, ensuring no Protected Health Information (PHI) is included.
2. Develop or refine a front desk workflow process for capturing Chronic Care Management (CCM) consents.
3. Determine your total Medicare/MAP patient population. Analyze your clinic census to identify how many of these patients visit your clinic monthly.
4. Prepare questions for the upcoming open office hour.

Upcoming Dates:

- **Next Open Office Hour:** September 26, 2025, 12:00 PM - 1:00 PM
- **Next Cohort Session 3:** October 3, 2025, 12:00 PM - 1:00 PM