COMMUNITY HEALTH CENTER, INC.

"WHERE HEALTH CARE IS A RIGHT, NOT A PRIVILEGE, SINCE 1972"

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CHRONIC CARE MANAGEMENT: EXTENDING OUR CARE AND IMPACT

CHCI Locations

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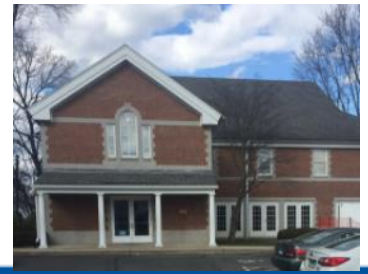


The newly-elected officers of the Board of Directors of Community Action for Greater Middletown gathered this week at CAGM's East Main Street offices. They are (left to right) executive secretary Edith Barnes, president Mark Masselli, vice president Michael Young, and treasurer Eugenie Shaw.

"…Masselli stressed the importance of community engagement. We want a consumer majority board…we are creating advocates to make sure questions are answered, accompany the patient to the hospital if need be."

The Middletown Press, May, 1972

A Long History Of Helping Connecticut's Underserved

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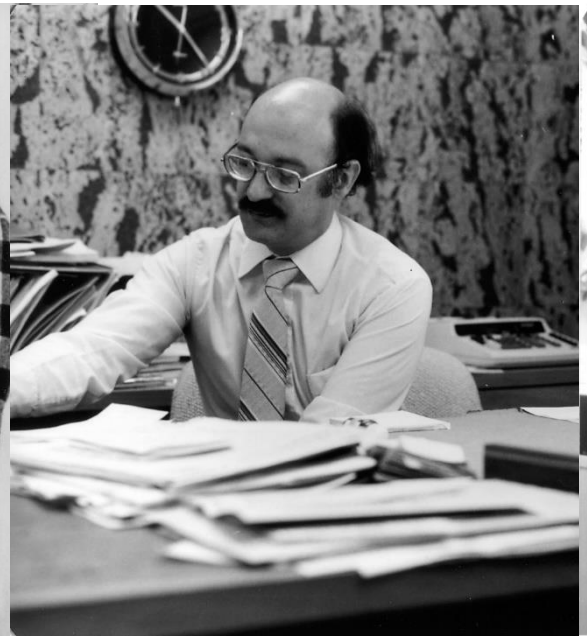
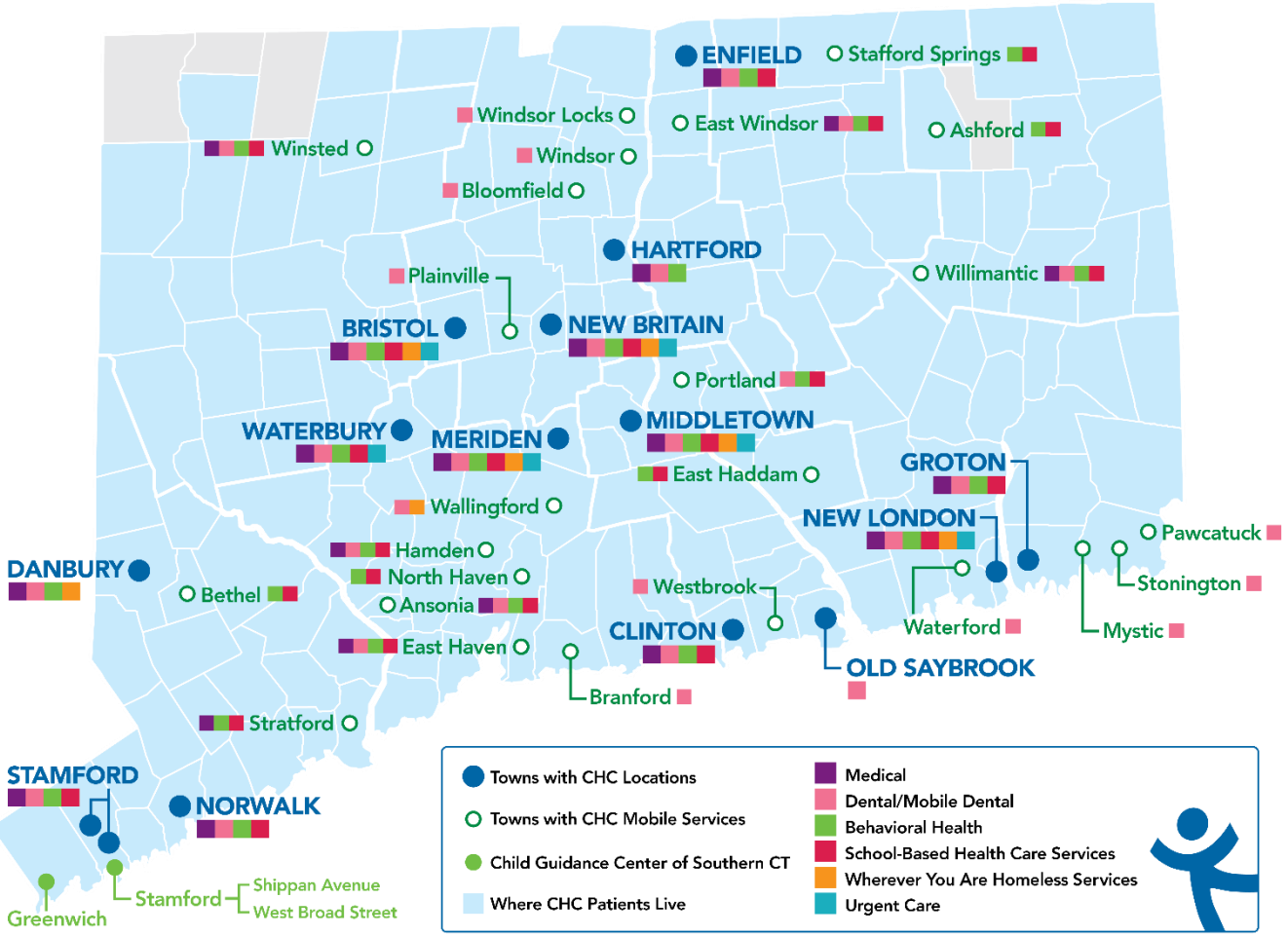



Locations and Service Sites in CT



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THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

CHCI Profile:

- Founded: **May 1, 1972**
- Annual budget: **$180m**
- Staff: **1,400**
- Active Patients: **150,000**
- SBHCs across CT: **187**
- Students/year: **17,000**

Year	2019	2020	2021
Patients (CY)	101,121	99,381	99,598

Team-Based Care
"Every Patient Has a TEAM"

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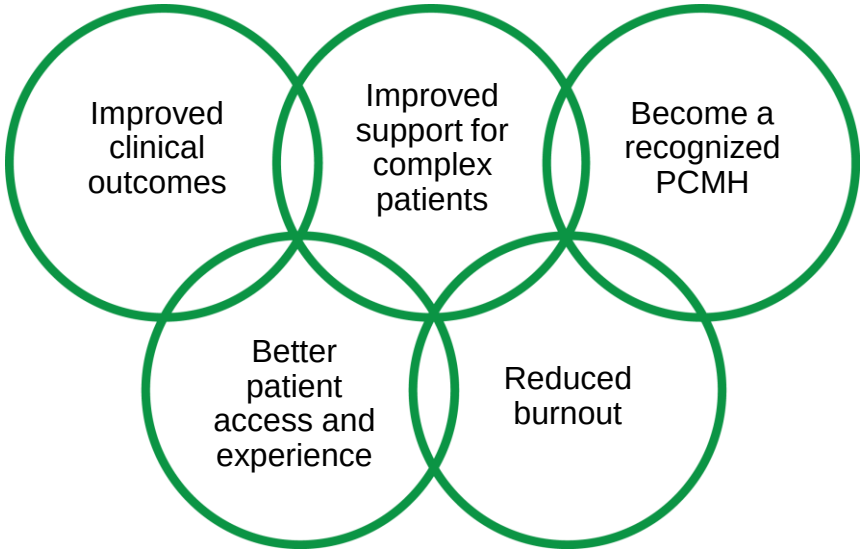

What is Medicare Chronic Care Management (CCM)

Chronic care management (CCM) services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.

The Centers for Medicare & Medicaid Services (CMS) recognizes that CCM services are critical components of primary care that promote better health and reduce overall health care costs.

Requirements and Components for CCM and Complex CCM

Documentation	CCM services that must be documented in the electronic health record (EHR). Covered services include, but are not limited to: • Management of chronic conditions • Management of referrals to other providers • Management of prescriptions • Ongoing review of patient status
Non-complex CCM (CPT code 99490)	Requirements: • Two or more chronic conditions expected to last at least 12 months (or until the death of the patient) • Patient consent (verbal or signed) • Personalized care plan in a certified EHR and a copy provided to patient • 24/7 patient access to a member of the care team for urgent needs • Enhanced non-face-to-face communication between patient and care team • Management of care transitions • At least 20 minutes of clinical staff time per calendar month spent on non-face-to-face CCM services directed by physician or other qualified health care professional • CCM services provided by a physician or other qualified health care professional are reported using CPT code 99491 and require at least 30 minutes of personal time spent in care management activities
Complex CCM (CPT Code 99487)	Shares common required service elements with CCM, but has different requirements for: • Amount of clinical staff service time provided (at least 60 minutes) • Complexity of medical decision making involved (moderate to high complexity)

CCM Coding

The five CPT codes used to report CCM services are:

1) CPT code 99490 - non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.
2) CPT code 99439 - each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional (billed in conjunction with CPT code99490)
3) CPT code - 99487 complex CCM is a 60-minute timed service provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate- to high-complexity medical decision making.
4) CPT code 99489 is each additional 30 minutes of clinical staff time spent providing complex CCM directed by a physician or other qualified health care professional (report in conjunction with CPT code 99487; cannot be billed with CPT code 99490)
5) CPT code 99491 - CCM services provided personally by a physician or other qualified health care professional for at least 30 minutes.

Care Management Services

What are care management services?

Care management services in RHCs and FQHCs include the following 4 services:

1. Transitional care management(TCM)
2. Chronic care management (CCM)
3. General behavioral health integration(BHI)
4. Psychiatric Collaborative Care Model (CoCM)

Chronic Care Staffing: Our partner for CCM

Chronic Care Staffing, LLC ("CCS") was founded in 2015, the same year Medicare's Chronic Care Management program began.

- CHC selected them as our vendor after determining that we were more likely to be successful with a vendor fully incentivized to accomplish the CCM visits
- Vetted their performance with other FQHCs. Determined that they have a robust Quality Assurance program – strict CMS compliance is a priority—and leadership is quite responsive to any identified issues.
- CCS specializes in delivering Chronic Care Management (CCM), Health Risk Assessments (HRA) for Annual Wellness Visits (AWV), and other virtual care services tailored to meet their clients' needs.
- CCS manages the process from securing patient consent, enrolling and developing care plan, making the 20 minute calls per month, and ensuring patients get key messages from CHC
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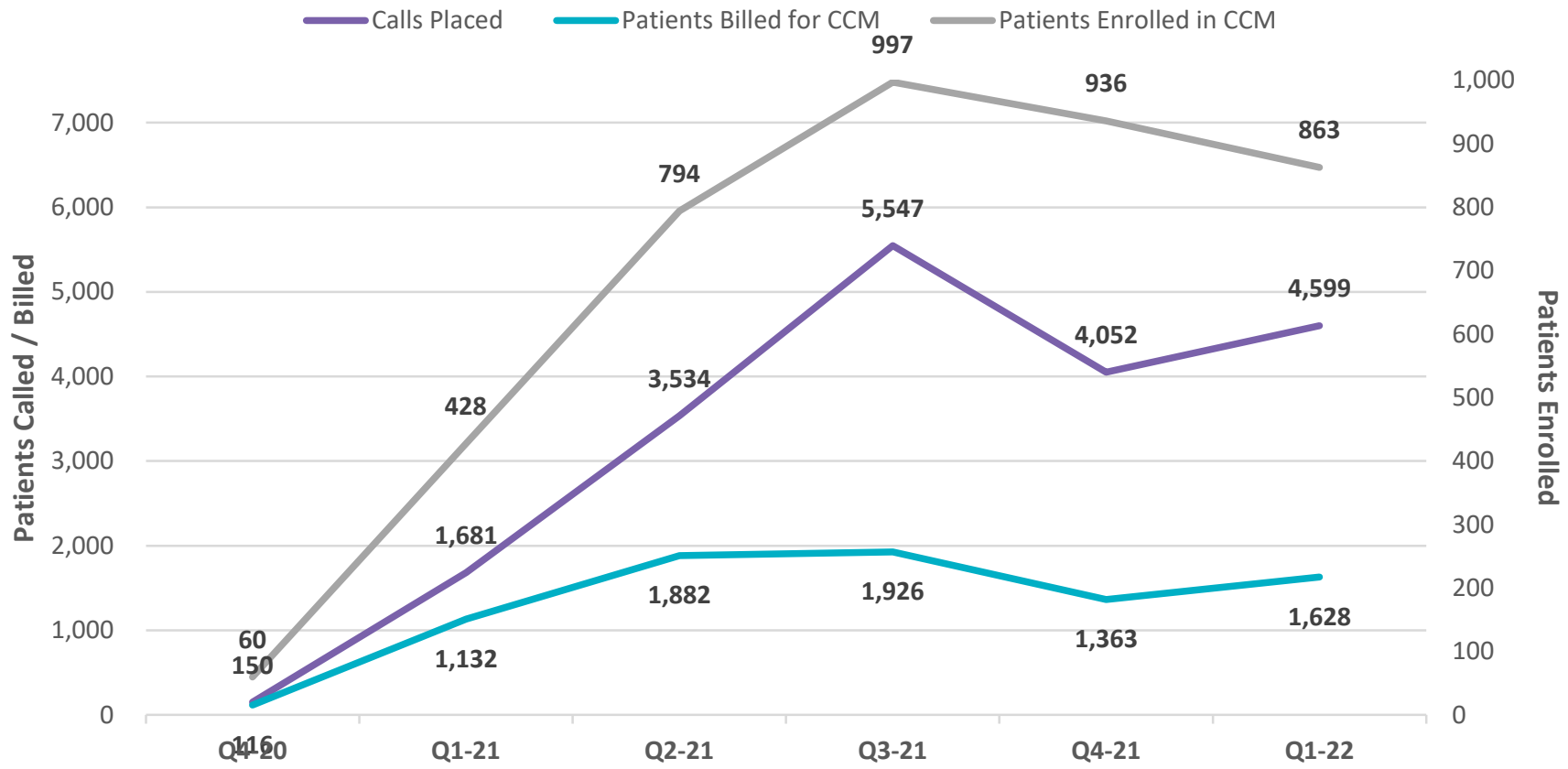
Community Health Center, Inc. CCM Metrics



CCM Monthly Concentrations

Month	CCM Concentration	Month	CCM Concentration
January	Remind and schedule patients for AWV appointments (as needed)	July	Hydration, skin cancer / sun exposure education Severe weather preparedness
February	Fall risk screening and prevention, Medication Adherence	August	Tobacco screening
March	Comprehensive Diabetic Screen (A1C-6-9- every 6 months, A1C >9- 1-3 months).	September	Colonoscopies 50-75 years old every 10 years
April	Web enable virtual visits in EMR	October	Vaccinations (flu, pneumonia, shingles vaccines)
May	Social determinants of health review (financial, transportation, support system, nutrition)	November	Mammograms until age 74 at least every 2 years
June	Pain and functional status screening	December	Depression screen

Patient Satisfaction Survey

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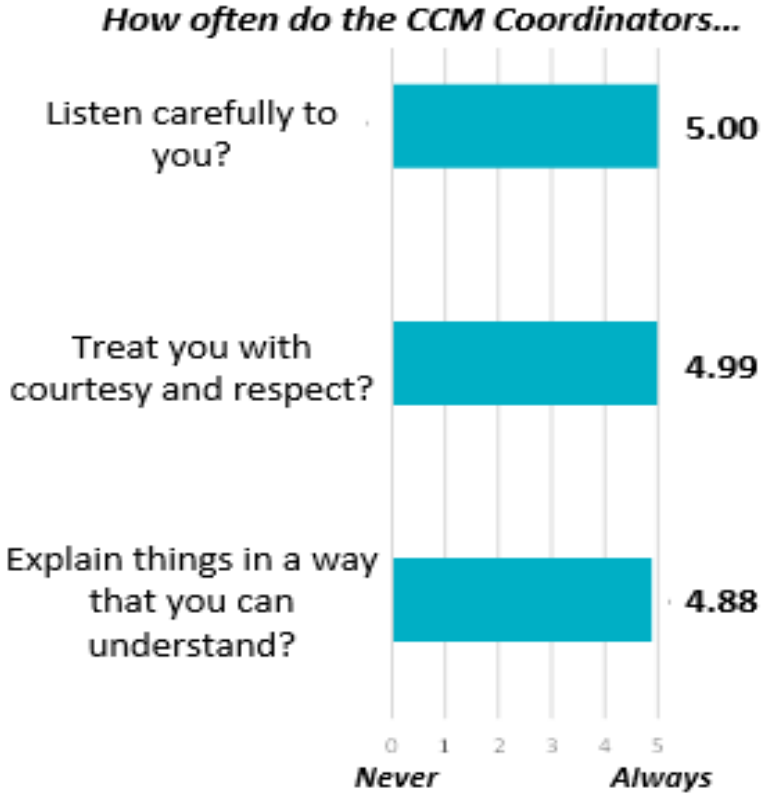
Survey Data



Survey Quotes

- "My nurse that calls is very special, she always explains things to me so I can understand it and I look forward to the calls each month."
- "She always listens carefully to me and if she doesn't have the answer she will find out for me."
- "It makes me feel safe and comfortable to have someone call and check on me."
- "I appreciate the calls because I like that I can call back to ask my coordinator a question."
- "I like that she gives me time at the end of each call to ask her questions."

CCM Keys to Success

1. Focus on CMS compliance and clinical quality.
2. Detailed launch plan with buy in from key stakeholders.
3. High quality Care Coordinators with CCM specific training program.
4. Communication and collaboration between PCPs, practice managers, and CCM team.
5. Access to automated reports and data and the ability to run ad hoc CCM reports.
6. Customized monthly concentration schedule designed to improve quality measures.
7. Optimal workflows within the EMR to capture data that can help improve quality measures.

Why doesn't everyone enroll in Medicare CCM?

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Multiple factors contribute to less than total population of elders being enrolled:

- Medicare Advantage Plans May Not Cover CCM; may provide it themselves
- Healthier, younger CCM eligible patients may not perceive need and decline enrollment
- Patient may be getting an in-home service—not eligible for CCM if they are. This includes PT, Skilled, Nursing etc.
- Patient who has Medicare only—no secondary insurance—may not be willing to pay the co-pay nor apply for sliding scale discount or nominal rate
- Patients may die, relocate, enter SNF, or simply stop participating

CHCI Experience

- We sent 14,483 presumed eligible patients to them. (enrolled in Medicare for at least one year, and patient has at least (2) chronic conditions)
- CCS determined right off the top that 2500 were not eligible, mostly due to Med. Adv. plan.
- Of the remainder: 107 have simply declined—weighted towards the “newly old.
- 100 are deceased
- 300 were getting some kind of in-home service that disqualified them for payment
- 2500 are under age 65, dually eligible for Medicaid and Medicare due to disability
- Several thousand have been contacted but not enrolled-—will be focused on this group next.

CHC Experience with Contracted Vendor

- Regular, on-going communication is critical with an assigned key representative of the vendor (weekly initially, may be less after that
- Vendor's staff nurses are credentialed by CHC as OLCPs (Other licensed and certified personnel), work within our EMR, and go through HR orientation and training appropriate to the role.
- Learning curve on both sides is steep: development of care plan that is acceptable to both, communication with providers, clarifying pathway for escalating any concerns
- Bilingual staffing by vendor is a huge plus for patients—but may be used by patients (who can call CCS directly) for help beyond anticipated scope of service (e.g. "I went to the specialist and they gave me these instructions but I don't understand them")

Pros and Cons of Contracted vs. Internal

- Focus: This is what they do. Each 20 minute billable call may take many call attempts to reach. Each enrollment may take a full hour.
- Con: Vendor may experience the same challenges in recruiting and turnover that we all do, and this can impact service.
- In addition to the nurse delivered services, there is extensive behind the scenes work on the part of the vendor to ensure eligibility, engage and gain consent, develop care plan, monitor calls for quality assurance, and train their staff
- As much as they aim for being “as if” CHC nurses, there are clearly gaps in style and “ways of doing things” that we are always addressing—all calls are recorded for review.

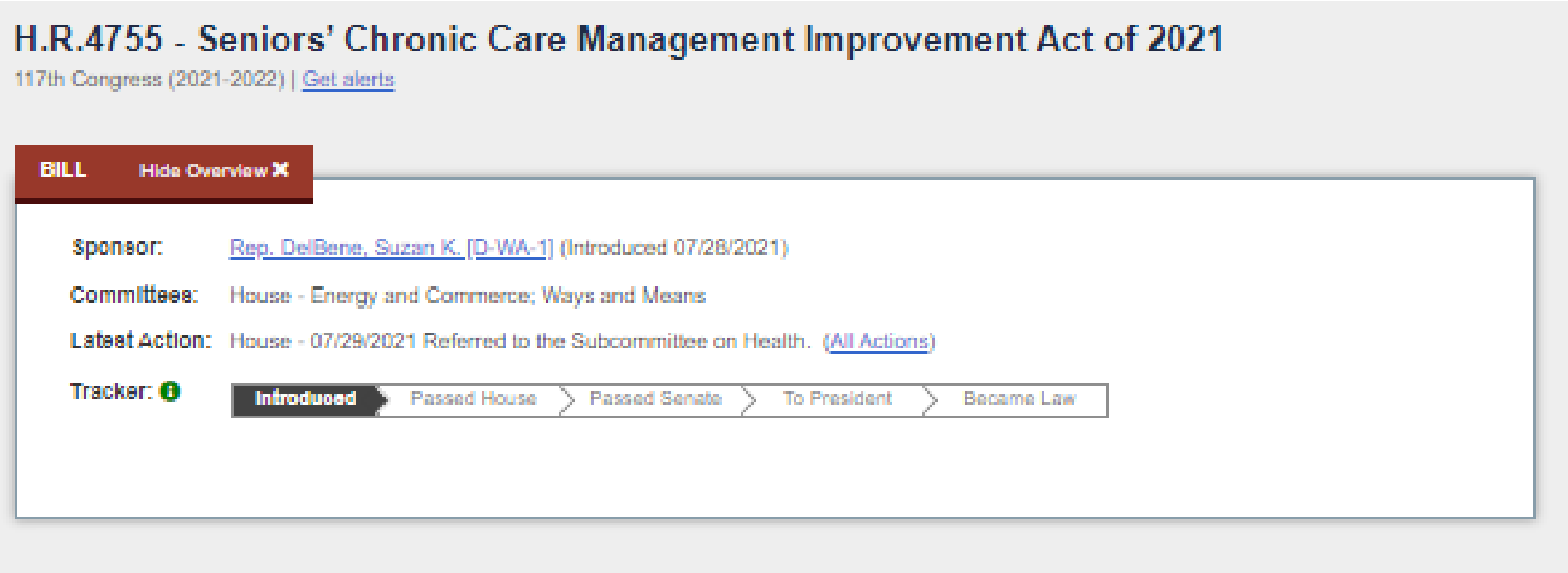
Health Care Professionals Who May Furnish and Bill CCM Services

Only one physician or other qualified health care professional who assumes the care management role for a beneficiary can bill for providing CCM services to that patient in a given calendar month.

While services may be provided by a clinical staff person, the service must be billed under one of the following:

- Physician
- Clinical nurse specialist (CNS)
- Nurse practitioner (NP)
- Physician assistant (PA)
- Certified nurse midwife
- Non-physicians must legally be authorized and qualified to provide CCM in the state in which the services are furnished.

2022 Bill to remove cost-sharing component did not make it into law



H.R.4755 - Seniors' Chronic Care Management Improvement Act of 2021

117th Congress (2021-2022) | Get alerts

BILL Hide Overview

Sponsor: Rep. DelBene, Suzan K. [D-WA-1] (Introduced 07/26/2021)

Committees: House - Energy and Commerce; Ways and Means

Latest Action: House - 07/29/2021 Referred to the Subcommittee on Health. (All Actions)

Tracker: Introduced > Passed House > Passed Senate > To President > Became Law

https://www.cms.gov/sites/default/files/2022-04/MLN909188_ChronicCareManagement_MAR2022.pdf

117th CONGRESS
1st Session

H. R. 4755

To amend title XVIII of the Social Security Act to remove cost-sharing responsibilities for chronic care management services under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES
July 28, 2021

Ms. DelBene (for herself, Mr. Welch, and Mr. Duncan) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to remove cost-sharing responsibilities for chronic care management services under the Medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Seniors' Chronic Care Management Improvement Act of 2021".

SEC. 2. REMOVING COST-SHARING RESPONSIBILITIES FOR CHRONIC CARE MANAGEMENT SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(1) in subsection (a)(1)—

(A)in subparagraph (CC), by striking "and" at the end; and

(B) in subparagraph (DD), by inserting before the semicolon at the end the following: "and (EE) with respect to chronic care management services (as described in section 1848(b)(8)) furnished on or after January 1, 2022, the amount paid shall be an amount equal to 100 percent of the lesser of the actual charge for such services or the amount determined under such section;"; and

(2) in subsection (b), in the first sentence—

(A) in paragraph (11), by striking "and" at the end; and

(B) in paragraph (12), by inserting before the period at the end the following: ", and (13) such deductible shall not apply with respect to chronic care management services (as described in section 1848(b)(8)) furnished on or after January 1, 2022".

CCM Services Additional Info

CCM services are extensive, including:

- Structured recording of patient health information
- Keeping comprehensive electronic care plans
- Managing care transitions and other care management services
- Coordinating and sharing patient health information promptly within and outside the practice CCM service elements apply to complex and non-complex CCM, unless otherwise specified.

You'll typically furnish CCM services outside face-to-face patient visits and focus on advanced primary care characteristics like:

- Continuous patient relationship with chosen care team member
- Supporting patients with chronic diseases in achieving health goals
- 24/7 patient access to care and health information
- Patient receiving preventive care
- Patient and caregiver engagement
- Prompt sharing and using patient health information

Patient Eligibility

- Eligible CCM patients will have multiple (2 or more) chronic conditions expected to last at least 12 months or until the patient's death and or that place them at significant risk of death, acute exacerbation and or decompensation, or functional decline
- These services aren't typically **face-to-face** and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month
- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (like number of illnesses, number of medications, repeat admissions, or emergency department visits) or the typical patient profile in the CPT prefatory language
- CCM services can also help reduce geographic and racial or ethnic health care disparities

Patient Consent

Get the patient's written or verbal consent for CCM services before you bill for them. This helps ensure patients are engaged and aware of their cost sharing responsibilities. This also helps prevent duplicate practitioner billing. You must also inform the patient of these items and document it in their medical record:

- Availability of CCM services
- Possible cost sharing responsibilities
- Only 1 practitioner can furnish and bill CCM services during a calendar month
- Patient's right to stop CCM services at any time (effective the end of calendar month)
- Patients need to provide informed consent only once unless they switch to a different CCM practitioner

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

Comprehensive Care Management

- Assess the patient's medical, functional, and psychosocial needs
- Make sure the patient receives timely recommended preventive services
- Review medications and any potential interactions
- Oversee the patient's medication self-management
- Coordinate care with home- and community-based clinical service providers

Transition Care Management

- Manage care transitions between and among health care providers and settings, including referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Create and exchange or share continuity of care document(s) promptly with other practitioners

Chronic Care Management Service Summary

Initiating Visit

- ❑ Face-to-face E/M visit, AWV, or IPPE for new patients or patients who the billing practitioner hasn't seen within 1 year before CCM services start.

Structured Recording of Patient Health Information Using Certified EHR Technology

- ❑ Record the patient's demographics, problems, medications, and medication allergies using certified EHR technology. A full EHR list of problems, medications, and medication allergies must inform the care plan, care coordination, and ongoing clinical care.

24/7 Access & Continuity of Care

- ❑ Provide 24/7 access to physicians or other qualified practitioners or clinical staff, including providing patients or caregivers with a way to contact health care practitioners in the practice to discuss urgent needs no matter the time of day or day of week.
- ❑ Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments.

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