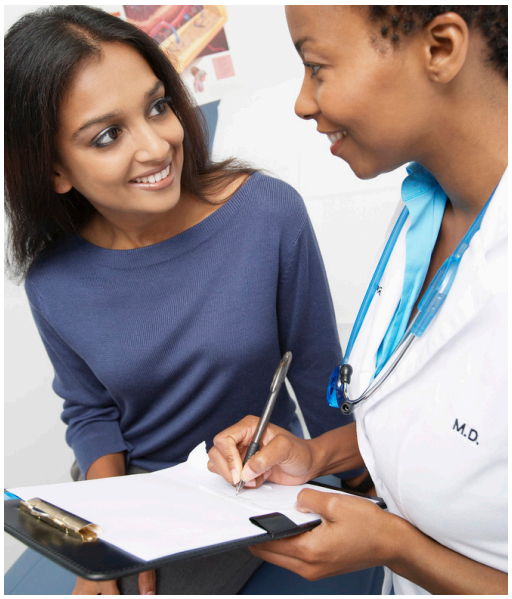
CHRONIC CARE MANAGEMENT BY FEDERALLY QUALIFIED HEALTH CENTERS

PAYMENT FOR NON-FACE-TO-FACE CHRONIC CARE MANAGEMENT SERVICES

Beginning on January 1, 2016, the Centers for Medicare and Medicaid Services will reimburse Federally Qualified Health Centers for non-face-to- face Chronic Care Management ("CCM") services. Significantly, these CCM payments will be in addition to any payments the FQHC receives from face-to-face CCM encounters paid under the FQHC Prospective Payment System ("PPS"). The payment rate will be based on the PPS national average non-facility payment rate, currently around $43.00.



LONG-DUE RECOGNITION OF EXTRA COST

CMS recognizes that the non-face-to-face aspects of chronic care management are not captured in the FQHC PPS payment, particularly for low income populations.

CCM payments are designed to encourage post-discharge services that reduce emergency department visits and hospital or SNF readmissions. This trend started with 2013's Transitional Care Management ("TCM") payments, and continued in 2015 with the inclusion of CCM in the FQHC PPS. Both of these initiatives, however, require a face-to-face encounter by an FQHC practitioner.

This new payment will be for services that are not captured in the PPS rate, and will be paid as part of the FQHC benefit, using the 99490 CPT code to identify that the requirements for payment are met and a separate payment should be made.

ELIGIBILITY, COINSURANCE AND CONSENT

A qualifying patient must have at least two chronic conditions that are expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline. The patient must also receive at least 20 minutes of PPS-qualifying CCM services per calendar month from a FQHC practitioner. TCM services cannot also be billed, and only one practitioner may bill the PPS CCM code per month per patient.

The guidance surrounding these non-face-to-face CCM payments is contained in CMS' 2016 Physician Fee Schedule Final Rule. The Final Rule sets forth multiple notice and consent requirements, including informing the patient: of the availability and nature of services; that the care will be recorded in an electronic health record ("EHR"); that written consent is required as to both the services and the electronic communication of the patient's information with other treating providers; how to give and revoke consent; how the patient's information may be shared; that coinsurance will apply; and that the FQHC cannot provide or bill for CCM services if another agency has provided them during the calendar month.

Also, in responding to comments in the preamble to the Final Rule, CMS clarified that it expects FQHCs to make all notice material available in languages appropriate to the patient population served.

SCOPE OF SERVICES

Along with the requirements related to notice and consent, the Final Rule established numerous requirements as to the scope of eligible non-face-to-face services. The first of these scope-of-service requirements is the initiation of CCM services during a comprehensive Evaluation/Management ("E/M"), Annual Wellness Visit ("AWV") or Initial Preventative Physical Examination ("IPPE") encounter. This initial E/M, AWV or IPPE encounter may not be included in the required 20 minutes of monthly CCM time.

The patient must experience "continuity of care" with a FQHC practitioner with whom the patient is able to receive successive visits. A FQHC practitioner includes a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist or social worker, or, under certain conditions, an RN or LPN furnishing care to a homebound FQHC patient.

Care management for the patient's chronic conditions must incorporate a variety of items, including: systematic assessment of a patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

A patient-centered plan of care document must be created by the FQHC practitioner in consultation with the patient, caregiver and other key practitioners treating the patient to assure that care is provided in a way that is congruent with patient choice and values. The Final Rule sets forth numerous required elements of a care plan, including its link to the patient's EHR.

The electronic care plan must be available 24/7 to all practitioners within the FQHC who are furnishing CCM services and whose time may count toward the required 20 minutes per month.

The FQHC must manage care transitions, including referrals to other clinicians, visits following emergency department encounters, and visits following discharge from a hospital or SNF. Relevant information must be provided to other providers through electronic exchange of a summary care record regarding these transitions.

The FQHC must have adequate personnel to deliver transitional services in a timely manner. The FQHC must also coordinate with home and community-based providers to support the patient's psychosocial needs and functional deficits, and must document the same in the EHR.

The FQHC must have secure messaging, internet, or other asynchronous non-face-to-face consultation methods, in addition to the telephone. Faxing does not qualify. Fortunately, these methods are only required to be "available" - there is no requirement that they be used with every patient.

ELECTRONIC HEALTH RECORD REQUIREMENTS

CMS recognizes that EHR technology will be critical to the access and coordination necessary for effective chronic care management. Accordingly, an FQHC billing for CCM services will need certified health IT for the recording of demographic info; health-related problems; medications and medication allergies; a clinical summary record; and other scope of service requirements that reference an EHR. IT technology must be certified to the edition(s) of certification criteria acceptable for the EHR Incentive Programs as of the previous December 31st. Lastly, applicable HIPAA standards would apply to all electronic sharing of patient information.

TODAY'S PRACTICE MODEL

At first glance, the numerous requirements of the CCM payment program may lead an FQHC to ask whether the additional payment is worth the extra cost.

However, a closer review shows that this "coordinated and documented" approach to chronic care management is simply today's best-practice model. It is a cornerstone of the accountable care structure, and will be a key element of care delivery and cost-containment in the years ahead. Many FQHCs are already embracing this model of coordinated care. Through this new payment mechanism, CMS is merely rewarding those dynamic FQHCs for the extra work and expense they have already chosen to bear, and encouraging others to vigorously follow suit.

Joel K. Goloskie
Senior Counsel

Joel K. Goloskie is Senior Counsel with Pannone Lopes Devereaux & O'Gara LLC and a member of the Health Care, Litigation, and Corporate & Business Teams. His experience ranges from compliance and HIPAA privacy matters to regulatory filings and approvals, contract drafting and management, and mergers and acquisitions. He has assisted health care clients as they dealt with compliance orders and deferred prosecution agreements, and has represented clients in both civil and criminal matters in federal court.

PANNONE LOPES DEVEREAUX & O'GARA LLC
counselors at law

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