Thank you for joining

Lilypad Webinar #3
Practice Management Best Practices

Monday December 16, 2019 3:00 EST

We will record this 30-minute webinar and send out a link to the recording as well as the slides after the webinar

All participants will be muted

What We'll Cover Today

Practice Management Best Practices
RHC Fun Facts
POND® Program for your clinic
2020 SHIP Grant Opportunity

RHC Practice Management Strategies

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December 16, 2019

UNIVERSITY OF SOUTHERN MAINE
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Maine
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The Challenges of Primary Care

- Primary care's role has declined over the past 40 years:
  - Primary care physicians have lower incomes and higher practice overhead than most specialists
  - Much of their work involves preventive care and simple diagnoses that can be handled safely by PAs, NPS, and APNs
  - They are expected to take on care coordination & population health without adequate reimbursement or IT support
  - Projections (National Center for Workforce Analysis, 11/16):
    - Supply of PCPs will grow more slowly than demand
    - Supply of NPs and PAs will outpace demand
    - Distribution is still a problem in rural areas

Building Blocks of High Performing Primary Care

- Leadership - practice-wide vision, goals, and objectives
- Data driven improvement using HIT to track operational, clinical, and patient experience metrics
- Empanelment–patients linked to PCP & care team
- Team-based care – clinical and non-clinical staff
  - Physicians, PAs/NPs/APNs, pharmacists, behavioral health clinicians, nutritionists, nurses, care mgrs, medical assistants
  - Building teams for preventive services, chronic care, acute care
- Template of the Future
  - Reduced reliance on 15 minute in-person visits, use of e-visits, group appointments, telephone encounters

(Bodenheimer, Ghorob, Willard-Grace, Grumbach, *The 10 Building Blocks of Primary Care.* Annals of Family Medicine, 12(2), March/April 2014, pp: 166-171.)

Opportunities to address unmet needs:

Improve participation in public reporting systems

Chronic care management

Team-based care

Mental health/substance use

Telehealth

Improve RHC Participation in Public Reporting

- Quality reporting
  - RHCs are exempt from participation in MIPS
  - A core element of practice transformation, pay-for-performance, state Medicaid programs, and commercial payers
  - Allows RHCs to concretely demonstrate quality
  - Key – select a set of quality measures and promote wide-spread use by RHCs for public reporting and performance improvement
- Financial and operational reporting
  - MGMA and other data sets are not focused on rural primary care practices

Chronic Care Management

- Care management services in RHCs include:
  - Transitional care management (TCM)
  - Chronic care management (CCM)
  - General behavioral health integration (BHI)
  - Psychiatric Collaborative Care Model (CoCM)
- Care management is considered an RHC service
- Coinsurance/deductibles apply to care mgt services
- Except for TCM, if care mgt services are billed on the same claim as an RHC visit, both are paid
- Care mgt services are reported with revenue code 052x.
- The service period for care management services is a calendar month

Payment for CCM Services

- CCM services are non-face-to-face care management and coordination services for Medicare beneficiaries with two or more chronic conditions
- CCM services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national PFS payment rate for CPT codes 99490, 99487, 99491, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of $67.03 for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

Payment for TCM Services

- TCM services support patient's transition from inpatient, SNF, inpatient rehab, outpatient observation or partial hospitalization settings to home or community settings
- TCM services can be billed by adding CPT code 99495 or 99496 to an RHC claim
- If it is the only medical service provided on that day with an RHC practitioner, it is paid as a stand-alone visit
- If it is furnished on the same day as another visit, only one visit is paid
- For 2019, TCM (CPT code 99495 or 99496) is paid the same as an RHC Visit

Payment for General BHI Services

- General BHI is a defined model of care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions
- General BHI services can be billed by adding the general care management G code, G0511, to an RHC claim, either alone or with other payable services
- Payment is the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, and 99484
- CCM or General BHI (HCPCS code G0511) services are paid at the rate of $67.03 for 2019
- A minimum of 20 minutes of CCM or general BHI services must be furnished within the calendar month

Psychiatric CoCM Services

- CoCM is a specific model in which services are provided by a primary care team of a PCP and a BH care manager working in collaboration with a psychiatric consultant
  - Care is directed by the team with structured care mgt, regular assessments of clinical status, and modification of treatment
  - The psychiatric consultant reviews the clinical status and care of patients and make recommendations the team
  - Services billed by adding psychiatric CoCM G code, G0512, to an RHC claim, either alone or with other payable services
  - Payment is the average of the national PFS payment rate for CPT codes 99492 and 99493
  - For psychiatric CoCM services, the 2019 rate is $145.96
  - A minimum of 60 minutes of psychiatric CoCM services are required to be furnished within the calendar month

Team-Based Care

- Team-based care has been linked to improved patient outcomes and may also be a means to improve clinician well-being
- Closely linked with PCMHs, value-base care, and chronic care management
- Requires restructuring of clinical workflows to promote increased sharing of responsibilities across the entire team, which enhances practice efficiency while improving provider, patient, and staff engagement
- A team-based model of care seeks to meet patient needs by engaging them as participants, while encouraging health care professionals to function to the full extent of their education, certification, and experience

Integrated Mental Health Services

- MH services provided by a doctoral-level psychiatrist or a clinical social worker are considered RHCs services and covered under the RHC's Medicare inclusive rate
- Services may also be provided by PCPs, psychiatrists, nurse practitioners, and physician assistants
- Depending on state Medicaid regulations, RHCs may also be reimbursed for other types of masters trained MH professionals - licensed professional clinical counselors
- Integrated MH services fill a vital community need and can reduce the burden on the RHC's primary care staff
- Depending on payer mix and staffing costs – integrated MH services can be self-sustaining

Functional Aspects of Integrated MH Services

- Clinical integration
  - Shared medical records
  - Shared decision making
  - Common treatment plans and models
  - Regular communication
  - Use of critical pathways or practice guidelines
  - Internal referral process
- Structural integration
  - Co-location (e.g. shared space)
  - Staffing - employed or contracted staff
  - Single medical record
  - Shared billing and scheduling systems
  - Shared risk

2019 Telehealth Codes in the Medicare PFS

- Current Medicare telehealth reimbursement policies
  - Services normally conducted in person but furnished via real-time, interactive communication technology
  - Limited to services furnished to beneficiaries treated in certain originating sites located in rural areas
- 2019 changes to the MPS
  - Reflect changes in the management of chronically ill patients
  - Increase access to physicians' services by recognizing a discrete set of services that are defined by and inherently involve the use of communication technology
  - CMS does not consider them to be telehealth services
  - Requires medical necessity and documentation in the record
  - These codes may be used to better serve patients and reduce out of community referrals

Summary of Medicare PFS Changes

Code	Service	Originating Site
G2012	Brief Communication Technology-Based Service (Virtual Check-In)	No
G2010	Remote Evaluation of Pre-Recorded Patient Information	No
99451	Telephone, internet, EHR assessment & management by consultative provider, 5+ minutes	No
99452	ITelephone, internet, EHR assessment & management by treating/requesting provider, 30 min.	No
99446	Interprofessional Internet Consultation by consultative provider, 5-10 minutes	No
99447	Interprofessional Internet Consultation by consultative provider, 11-20 minutes	No
99448	Interprofessional Internet Consultation by consultative provider, 21-30 minutes	No
99449	Interprofessional Internet Consultation by consultative provider, 31 or more minutes	No
G0513	Prolonged Preventive Services (beyond the typical time of the primary procedure), first 30 min.	Yes
G0514	Prolonged Preventive Services each additional 30 minutes	Yes
	End Stage Renal Disease Assessments for purpose of home dialysis ESRD-related assessments	Yes
	Acute Stroke Telehealth Treatment in any hospital, CAH, mobile stroke units, or other sites	Yes
G0396	Alcohol/substance use intervention 15-30mn (Treatment for O/SUDs)	Yes
G0397	Alcohol/substance use intervention – over 30 minutes (Treatment for O/SUDs)	Yes

Brief Communication Technology-Based Service, Virtual Check-In (HCPCS Code G2012)

- Brief non-face-to-face check-in with an established patient via communication technology, to assess if the patient's condition necessitates an office visit
- Provided by physician/other qualified health care providers (QCHPs)
- Does not originate from a related E/M service provided within the previous 7 days nor lead to an E/M service within 24 hours or soonest available appointment
- 5-10 minutes of medical discussion
- Direct interaction between patient and billing provider
- Patient must consent to receiving services

Remote Evaluation of Pre-Recorded Patient Information (HCPCS Code G2010)

- Remote evaluation of recorded video and/or images submitted by an established patient (store & forward)
- Includes interpretation with follow-up with the patient within 24 business hours
- Does not originate from a related E/M service provided within previous 7 days nor lead to an E/M service within next 24 hours or soonest available appointment
- Can take place via phone call, audio/video, secure text messaging, email, or patient portal communication
- Patient must consent to receipt of service

Interprofessional Internet Consultation

- Assessment/management services conducted by telephone, internet, or HER record consultations
- Treating provider requests the opinion and/or treatment advice of a consulting specialty provider to assist with the diagnosis/management of the patient's problem
- Face-to-face contact with consultant not required
- Especially useful for managing chronic conditions
- Telephone or internet-based interactions between specialists and treating providers allowed
- Patient consent is required
- Limited to providers eligible to bill for E/M visits

Interprofessional Internet Consultation

- Codes used by consultants
  - CPT Codes 99446, 99447, 99448, and 99449
  - Telephone/internet assessment/management service provided by a consultant to patient's treating/requesting provider
  - 5 - 31 minutes of medical consultative discussion/review
  - Includes a verbal and written report
- Codes used by referring providers
  - 99451 - Telephone, internet, EHR assessment/management service, 5 or more minutes of medical consultative time with consulting provider Includes a written report to the patient's treating/requesting physician or other QHCP
  - 99452 –Similar services as 99451 with 30 minutes of medical consultative time

Opioid and Other Substance Use Disorders

- Treatment of Opioid Use and Other SUDs
- G0396 and G0397-Alcohol/SU intervention, 15-> 30 min
  - Removes originating site geographic limitations and adds the home as permissible originating sites effective 7/1/19
  - No originating site facility fee paid when the originating site is the individual's home
  - Recognition that virtual check-in services “could be used as part of a treatment regimen for O/SUDs, since several components of MAT could be done virtually, or to assess where a patient’s requires an office visit
  - Section 2005 of the SUPPORT Act establishes a new Medicare benefit category for OUD treatment services furnished by OTPs under Medicare Part B, beginning on or after January 1, 2020

Contact Information

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Maine
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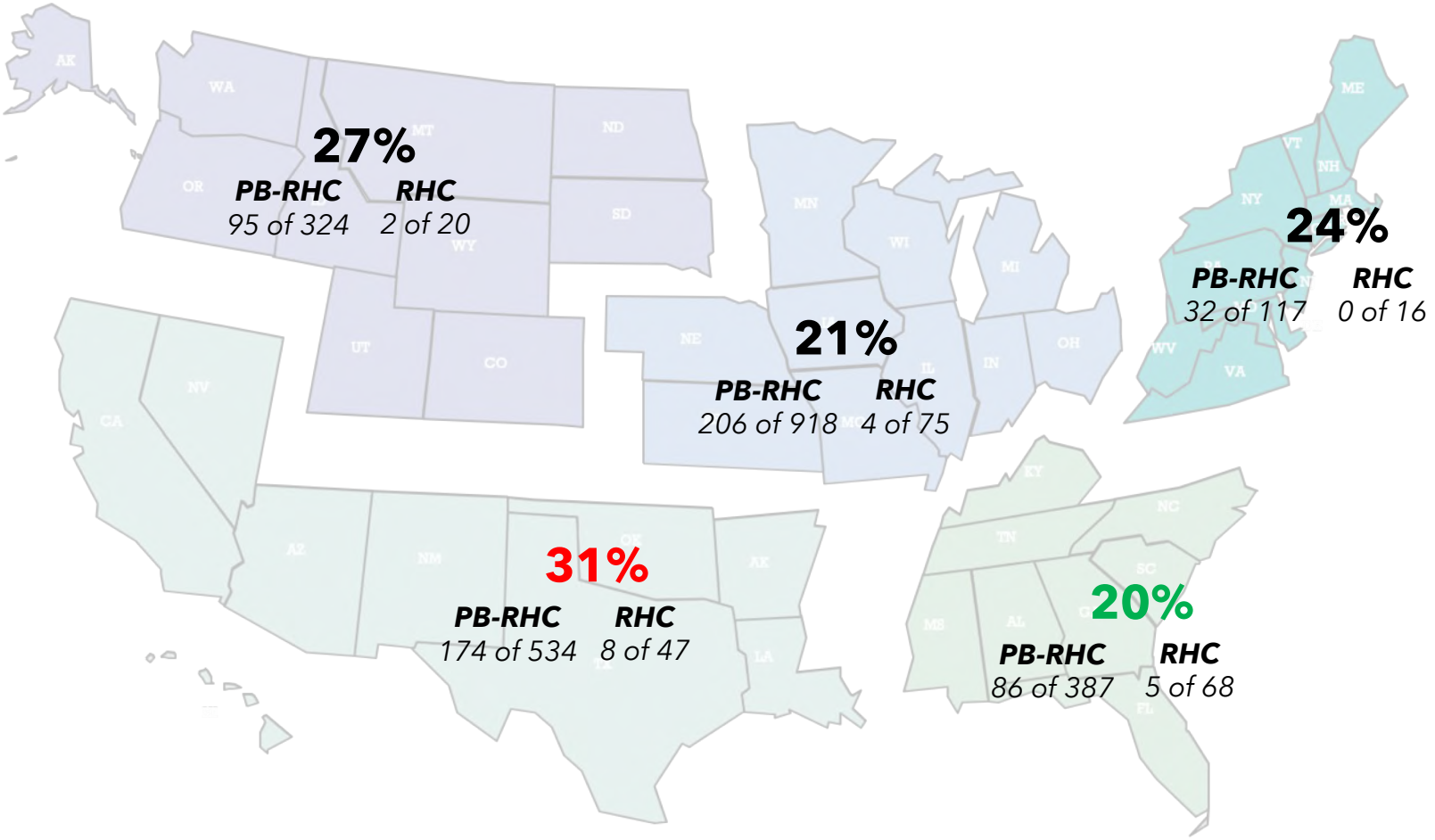
Research Center

RHC Fun Facts

Medicare Cost Report Errors

Medicare Cost Report Errors

Percentage of Organizations with Material Cost Report Errors

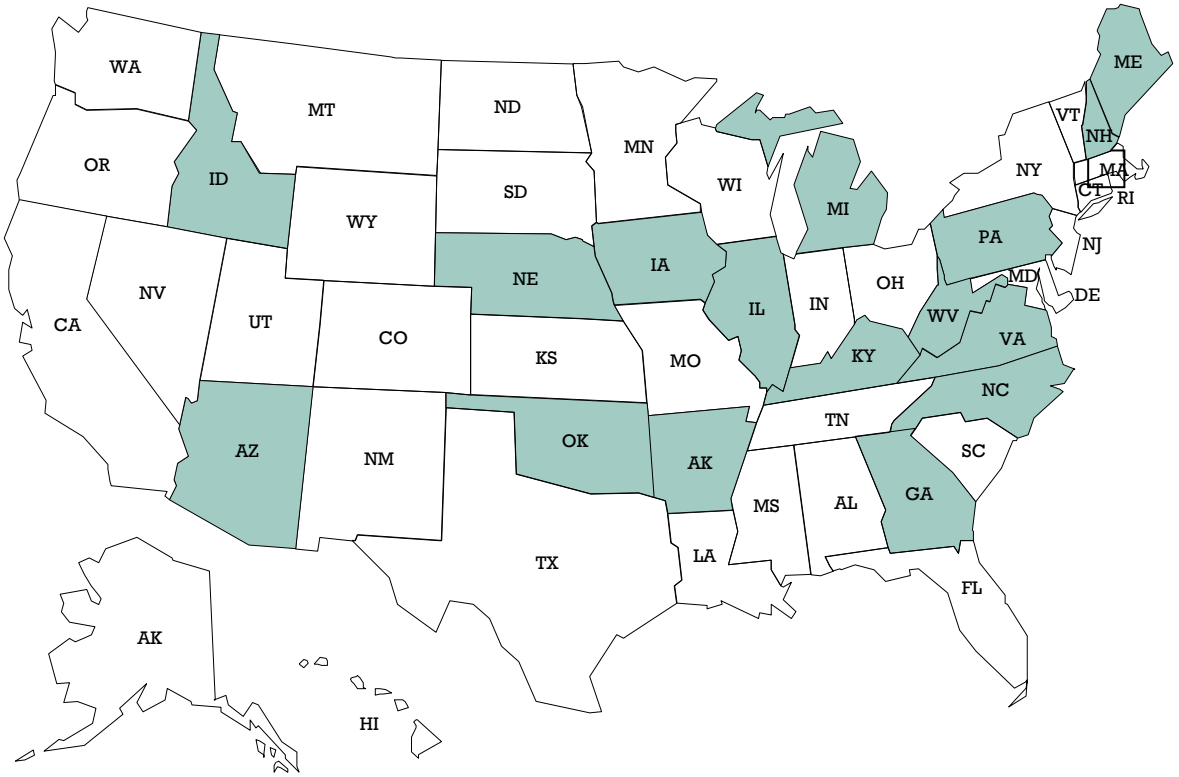


About POND®

About POND®

Developed by Lilypad, POND® is the only analytics and benchmarking system dedicated specifically to rural primary care practices

Our Current States

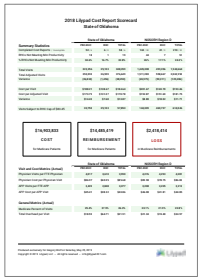


If you are located in one of these states you have access to the POND program right now

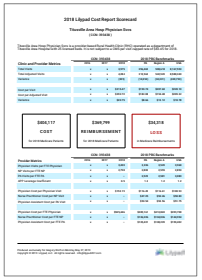
How Does It Work?

Cost Report Scorecards

State Scorecards

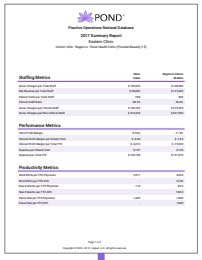


Clinic Scorecards



POND Analytics

Clinic Scorecard



Interactive Tools

To gain access to these reports and tools the required data must be entered into the POND web application

2020 SHIP Grant

SHIP Grant

SHIP allowable investments include activities to assist small rural hospitals with their quality improvement efforts and with their adaptation to changing payment systems through investments in hardware, software and related trainings. This includes aiding with value and quality improvement.

Value-Based Purchasing (VBP) Investment Activity

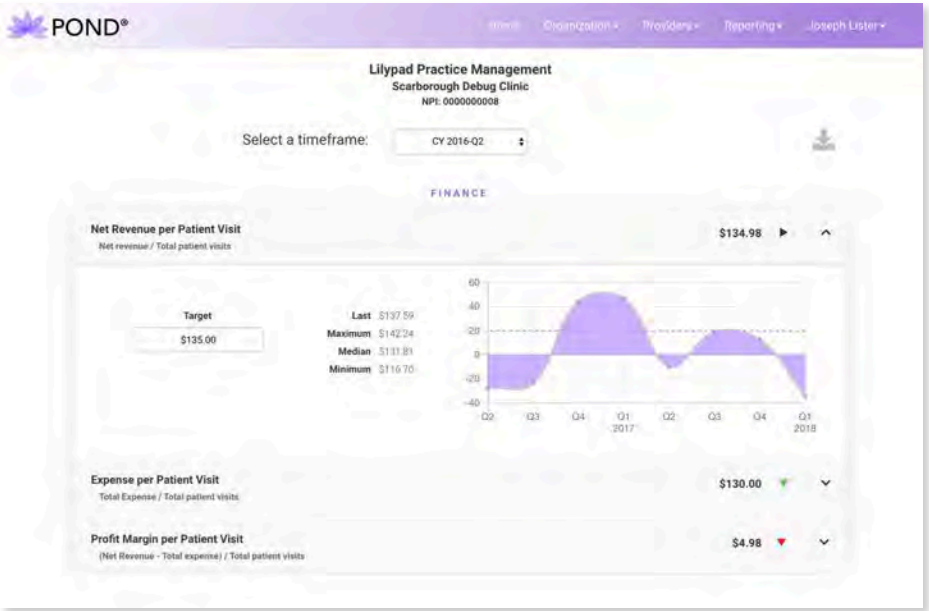
D. Provider-Based Clinic Quality Measures Education

Any activity that supports educational training for provider-based clinic quality improvement reporting and scores

$12,000

Annual per Hospital funding

Lilypad's SHIP Grant Offering



POND® Practice Management
+
Rural Health Clinic Educational Resources

Lilypad's SHIP Grant Offering

Lilypad's new Practice Management web application enables RHCs to collect, report and benchmark rural relevant financial, operational and quality metrics every quarter. The tool helps clinical teams set targets, build dashboards and share information among all of your clinic staff and providers. The new Practice Management web application integrates diagnostic and educational resources to ensure your clinic optimizes :

1. PB-RHC Consolidation
2. Productivity Standards
3. Optimal Hospital Linkage
4. 340B Optimization
5. Specialty Care Integration
6. Patient Panel Development
7. HCC Education and Monitoring
8. CCM, TCM and BHI Implementation
9. Fair Market Valuation Basis
10. Quality Measurement/Benchmarks

Join Us Next Month

Practice Alignment: Integrating Specialty Care
Monday, January 20th at 3:00 EST

Thanks for Joining

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