Chronic Care Management

Driving Patient Outcomes for FQHCs Through Scalable Care Capacity

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Introduction

FQHC's are an essential lifeline for nearly 26 million people, allowing patients to receive medical care, vision services, mental health, substance abuse treatment, and oral healthcare within their communities.

U.S. Health Resources & Services Administration's (HSRA) Federally Qualified Health Center (FQHC) program provides tens of millions of Americans in underserved communities with quality, affordable health care in primary care health clinics.

These clinics receive federal funds to operate in specific communities with the goal of providing quality care regardless of a patient's ability to pay. They are an essential lifeline for nearly 26 million people, allowing patients to receive medical care, vision services, mental health, substance abuse treatment, and oral healthcare within their communities.

The FQHC benefit under Medicare became effective October 1, 1991, when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program "lookalikes." They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically-necessary primary health services and qualified preventive health services furnished by a FQHC practitioner.

Chronic Care Management in FQHCs

An estimated 117 million adults have one or more chronic health conditions, and one in four adults have two or more chronic health conditions.

Since January 1, 2016, FQHCs have been able to receive additional payment for the cost of Chronic Care Management (CCM) services with a time requirement of at least 20 minutes when qualified CCM services are furnished to a Medicare patient who has two or more chronic conditions that: Are expected to last at least 12 months or until his or her death; Place him or her at significant risk of death, acute exacerbation/ decompensation, or functional decline. Effective January 1, 2018, FQHCs can also receive payment for CCM when 20 minutes or more of CCM services are furnished and FQHCs bill HCPCS code G0511 either alone or with other payable services, at the monthly national reimbursement rate of $67.03.

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Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $3.3 trillion annual health care costs.

Additionally, many patients who utilize the FQHC are dually eligible Medicare/Medicaid patients. Dual-eligible beneficiaries (Medicare dual eligible or "duals") refers to those qualifying for both Medicare and Medicaid benefits. In 2011 in the United States, approximately 9.2 million people were eligible for "dual" status. Dual-eligible make up 14 percent of Medicaid enrollment, yet they are responsible for approximately 36 percent of Medicaid expenditures. Similarly, duals total 20 percent of Medicare enrollment, and spend 31 percent of Medicare dollars.

Dual-eligible are often in poorer health and require more care compared with other Medicare and Medicaid beneficiaries.

FQHC CCM Combinations

CCM creates a non-face-to-face connection between the patient and a member of the healthcare team...

Patients who seek treatment at FQHCs have often gone months or even years without proper care. Many of them suffer from multiple chronic conditions that have been made worse by a lack of access to quality care. CCM programs that are patient-focused and drive outcomes play an important role in managing FQHC patient populations.

FQHC patient populations suffer from multiple chronic conditions including a high level of social determinants of health.

CCM is a powerful way to engage and assist this population by focusing on the root causes and providing additional access points to care for their patients.

The FQHC medical home team creates the patient-centered care and builds the access points around the patient so that everything they need resides in the health center. FQHCs' goal of assuring access to high-quality, integrated care centers is key to improving health outcomes and reducing wasteful spending.

CCM creates a non-face-to-face connection between the patient and a member of the healthcare team, promoting accountability, regular patient interaction, pro-active healthcare screenings and regularly scheduled visits with the patient's provider in an overall effort to be pro-active instead of reactive. By adding a comprehensive, outcome-driven CCM program, FQHCs can offer patients care in-between the normal provider office visits for such services as fall-risk assessments, immunizations, medication reconciliation, preventative care, appointment scheudling, and many more.

Benefits

Benefits of a CCM program for FQHC providers are profound...

Enterprise Virtual Care brings much-added value to the FQHC healthcare solution by providing clinical support 24/7 for these patients. Together, their focus on preventive care and patient education results in patients that are happy, healthy and spend less time in the hospital. Benefits of a CCM program for FQHC providers are profound: less frustration, the ability to more easily promote wellness and, with more clinicians working with the patients, providers can focus more on acute patients and those in the office for face-to-face visits.

Cost savings from a payer perspective are noted in a recent Mathematica Policy Research report titled "Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report," which analyzed the outcomes of CCM services in primary care from 2015-2016. Among other findings, they discovered that the per beneficiary-per-month (PBPM) cost decreased for CCM beneficiaries after 12 months (most of these savings were realized in in-patient and post-acute care) with the biggest impact coming at month 18, while Medicare payments to physicians increased. Driving care back to the physician office to address the patient care needs at the primary care level helps reduce overall costs and promote better patient outcomes, which are key to a successful program.

Effectively implementing and delivering outcome-driven CCM services can help FQHCs meet quality benchmarks and expand access to care while adding a much-needed revenue stream for the healthcare center.

Conclusion

A proven clinical workflow to integrate within your practice that will focus on the critical goals of your program while staying compliant...

A CCM turnkey solution must offer EMR-connection, be HIPPA-compliant and able to identify patients who meet the requirements for qualification. The solution should include three important parts: effective enrollment that is trackable and compliant; a seamless, monthly CCM program delivery backbone; and rigorous quality and compliance review that includes detailed reporting to show overall enrollment and that care delivery quality and CCM compliance standards are being met.

The monthly care delivery solution must include patient need, track exact time for program delivery activities and a compliant and accurate patient-centered care plan.
Additionally, it must provide an audit of all tasks including both enrollment and care delivery activities, and clear monthly reporting to track outcomes for those patients enrolled in the program. The turnkey solution should include a touch-free coding and billing interface as well so that no additional time is required working from separate systems.

The right turn key vendor will also offer:

- A proven clinical workflow to integrate within your practice that will focus on the critical goals of your program while staying compliant with CMS requirements
- A software platform and turnkey services solution, including experienced outsourced clinical staff, that is driven by provider protocols, identifies barriers to the enrolled patients, and provides appropriate solutions and resources for successful patient outcomes
- A proven track record
- Assistance in meeting your MIPS requirements.

References

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ABOUT ORB HEALTH

Enterprise Virtual Care™ rapidly enables the scalable, highly-effective delivery of chronic care, patient support, and outbound clinical campaigns as a virtual extension of the health system without adding staff, apps, infrastructure, or budget. Patients realize improved access, outcomes, and satisfaction while FQHCs/CHCs, Health Systems, and ACOs increase reimbursements, advance quality measures, and lower the cost curve of healthcare.

For additional information, please contact us at Info@OrbHealth.com