Welcome to TIM Talks

Increased Reimbursement for Care Coordination and the Potential Impact on Community Based Organizations (CBOs)

December 21, 2016

Administration for Community Living

Impact of Expanded Care Management on CBOs

Timothy P. McNeill, RN, MPH
Healthcare Consultant

1. Changes in Care Mgmt Payment
2. Relevance to Health Reform
3. Key Takeaways for CBOs
4. Next Steps

2017 Physician Fee Schedule

- Proposed Ruling
  - Posted November 15, 2016
  - Regulation # CMS-1654F
  - Available: https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf
- Key Change related to CBOs
  - Significant expansion in care management reimbursement
  - Services can be outsourced to a third-party care management company

Proposed Rules Applicable to CBOs

- Chronic Care Management (CCM)
- Complex Chronic Care Management
- Behavioral Health Integration (BHI)

Purpose of additional Care Management resources

- Medicare Access and CHIP Reauthorization Act (MACRA)
  - Physicians and other healthcare providers are mandated to shift towards a value-based payment model
  - Reimbursement will begin to adjust based on outcomes for the population
  - Physicians whose population of Medicare patients have better health outcomes and lower costs will receive higher reimbursement than physicians whose patient populations have worse outcomes and higher costs
  - Physicians have an opportunity to expand care management to achieve improved health outcomes and receive compensation for providing the care management resources

Eligibility for chronic care management services

- Medicare Part B beneficiary
  - Medicare Only
  - Dual Eligible
- Two or more chronic conditions and risk of deterioration in health status if conditions are not managed well
- One of these chronic conditions can be a behavioral health condition
- Examples:
  - Congestive Heart Failure with an comorbidity of depression
  - Diabetes and heart disease

Concerns about access

- MACRA mandates that CMS track access and utilization for chronic care management for high-risk groups including the following:
  - Racial and ethnic minorities
  - Rural Populations

Why would there be a limitations on Physician use?

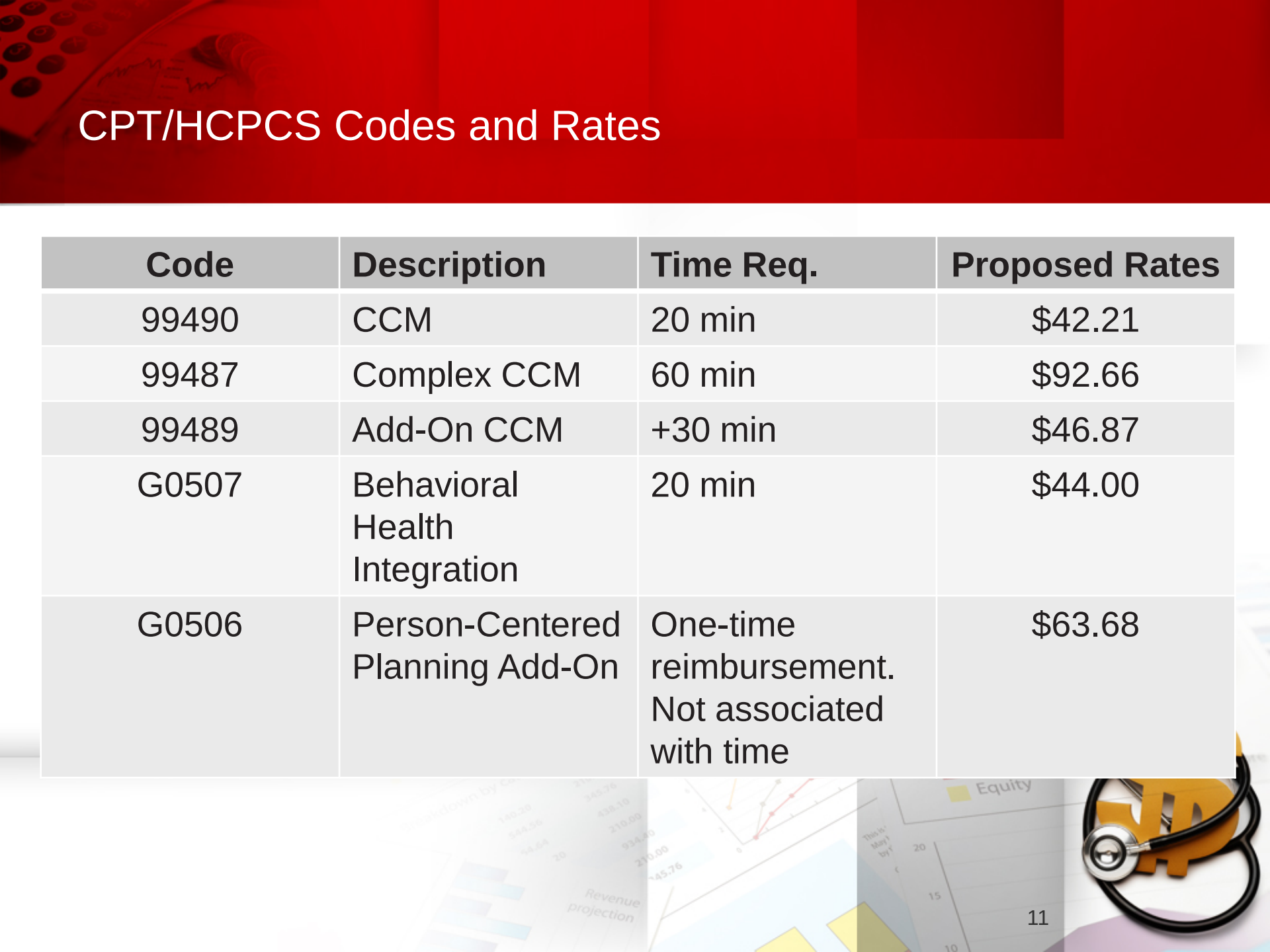
- These new services require the following:
  - Establish a person-centered care plan for care management for each participant
  - Have a clinical staff member that makes contact with each consumer each month and provide care management services according to the person-centered plan.
  - Services must occur for at least 20 min with additional time reimbursable with newly acknowledge codes

Support for Physicians to Expand Utilization of CCM

- Option to outsource services to a third party care management company with expertise in working with target populations
- Patient contact and care management is expected to be non-face-to-face
- Add-on code for reviewing the person-centered plan
- Services can be provided by “Clinical Staff” as compared to administrative staff
  - Clinical staff can be leased employees, contractors, or employees of a third party care management company

CPT/HCPCS Codes and Rates

Code	Description	Time Req.	Proposed Rates
99490	CCM	20 min	$42.21
99487	Complex CCM	60 min	$92.66
99489	Add-On CCM	+30 min	$46.87
G0507	Behavioral Health Integration	20 min	$44.00
G0506	Person-Centered Planning Add-On	One-time reimbursement. Not associated with time	$63.68



Description of the population receiving CCM today

- 513,000 Unique Medicare beneficiaries received the service
- Frequency = 4 times per person
- Participants tend to have a higher disease burden and suffer from social determinants of health
- Recipients are more likely to be dual-eligible
- Physicians report clinical staff spending 45 – 60 min per month per beneficiary on CCM

Hospital Interview - December 2016

- I conducted an Interview with a hospital with higher than average readmission rates and a higher volume of Medicaid Dual-Eligible beneficiary population
- TCM/CCM Solution: Outsourced care management to a for-profit third party care management company
- Findings: Third party company makes a person-centered plan and makes suggestions about community resources to obtain necessary services – “They often give patients the number to the Office of Aging to get help”
  - Outcomes: Services not available (waiting lists)
  - System difficult to navigate

Behavioral Health Integration (BHI)

- Care Coordination for persons with a behavioral health diagnosis
- This service can be provided by a third party care management company
- Services can be reimbursed for the same beneficiary receiving CCM – during the same month
- BHI services
  - Outreach and engagement
  - Initial assessment/person-centered planning
  - Development of patient registries
  - Patient activation and health system navigation

Economics of Expanded Care Management

- Anywhere USA AAA
  - 50 year experience providing care management services for older adults and persons with disabilities in our local market
  - Medicaid Waiver provider with 60% of the waiver participants being dual-eligible beneficiaries
  - Total Waiver population = 1,500 participants (900 Duals)
  - Complex CCM for the 50% of the Duals in Waiver
  - $450 X $92.66 = $41,697 per month
    - Annual revenue = $500,364

Key Takeaways

- Primary population receiving CCM today includes dual-eligible beneficiaries (total population = 513,000)
- MedPac data reports approximately 10 million dual-eligible beneficiaries nationwide
- MACRA baseline performance established CY2017
- Physicians can outsource CCM to a third-party care management company
- Third party must provide services using U.S. based clinical staff (cannot outsource to foreign call center)

Key Takeaways Cont.

- Current participants are more likely to suffer from social determinants of health
- Health outcomes for dual-eligible populations are negatively impacted by social determinants
- Poor Health Outcomes = MACRA reduction in physician reimbursement (baseline established 2017)

The Potential Role of the CBO

- Operate as a third-party Care Coordination / Care Management provider
  - Transitional Care Management (TCM)
  - CCM / Complex Care Management
  - Behavioral Health Integration (BHI)
- CBOs can become a direct supplier of services or support the provider to deliver these services
  - Clinical integration between community-based organizations and providers impacted by Alternative Payment Models and MACRA
  - Additional reimbursement pass through to CBO partner

Steps to Contracting for Care Management

- Market Analysis
- GAP Analysis
- Target physician groups serving the population that matches my strength and history
- Develop a business model that is cost-neutral to the provider
- Test the process for data capture and results starting with shared beneficiaries
- Transition model to reimbursement for care management

Prepare for Potential Push-back

- Your Organization has no experience providing care management services
  - We are the leading waiver case management provider in the region serving primarily duals and Medicaid and the only OAA service provider
- We cannot outsource the service unless your staff become our employees
  - Regulations specifically allow physicians to outsource the service to a third party and have no employer relationship with the staff performing the work
  - Services can be provided under General supervision

Prepare for Potential Push-back (cont.)

- You don't have evidence-based programs for this population
  - PEARLS, Stanford, Fall Prevention, etc.
- Only licensed staff can perform care management service
  - Requirements include clinical staff using CPT definition (AMA specifically supporting Health Coaches for this purpose)
- ACA will be repealed and replaced
  - MACRA is a separate bipartisan bill
- HIPAA prevents us from sharing any information with you to provide care management services
  - Requirements specifically outline that HIPAA requirements DO NOT prevent a physician from sharing clinical information with third party for this purpose

Seize the Opportunity – “My AAA is the Premier Care Mgmt organization serving high-risk duals in our area”

- MACRA will impose penalties on physicians based on health outcomes
- CMS Data shows that dual-eligible status has a statistically significant impact on health outcomes
- Increased risk in the market will require a different approach to delivering care
- Define the target population and/or geographic coverage area
- Have a clear contract model
  - Who is the responsible party on the contract?
  - Existing agency or network of CBOs
  - One contract to cover region

Questions