Welcome to TIM Talks!

Developing the Business Case for Outsourcing Care Management to a Community Based Organization (CBO)

May 31, 2017

Administration for Community Living

Care Management Recap from Previous TIM TALKS

- Impact of Expanded Care Management on CBOs – December 21, 2016
  - The 2017 Physician Fee Schedule
    - Significant expansion in care management reimbursement
    - Services can be outsourced to a third-party care management company – *The CBO*
  - 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 have an opportunity to expand care management to achieve improved health outcomes and receive compensation for providing the care management resources
  - Recording link here.

Care Management Recap from Previous TIM TALKS

- *Chronic Care Management Contracting Steps with Physician Practices*– March 30, 2017
  - The shift towards financial incentives that align with preventing costs has created new business opportunities
    - MACRA
      - Merit Incentive Payment System (MIPS)
      - Alternative Payment Models (APMS)
  - Population Health
    - Identification of populations that are most at-risk for increasing costs
    - Stratification of the highest risk population
    - Need for programs and services that can address the factors that will lead to increased costs

Business Model for Care Management Services

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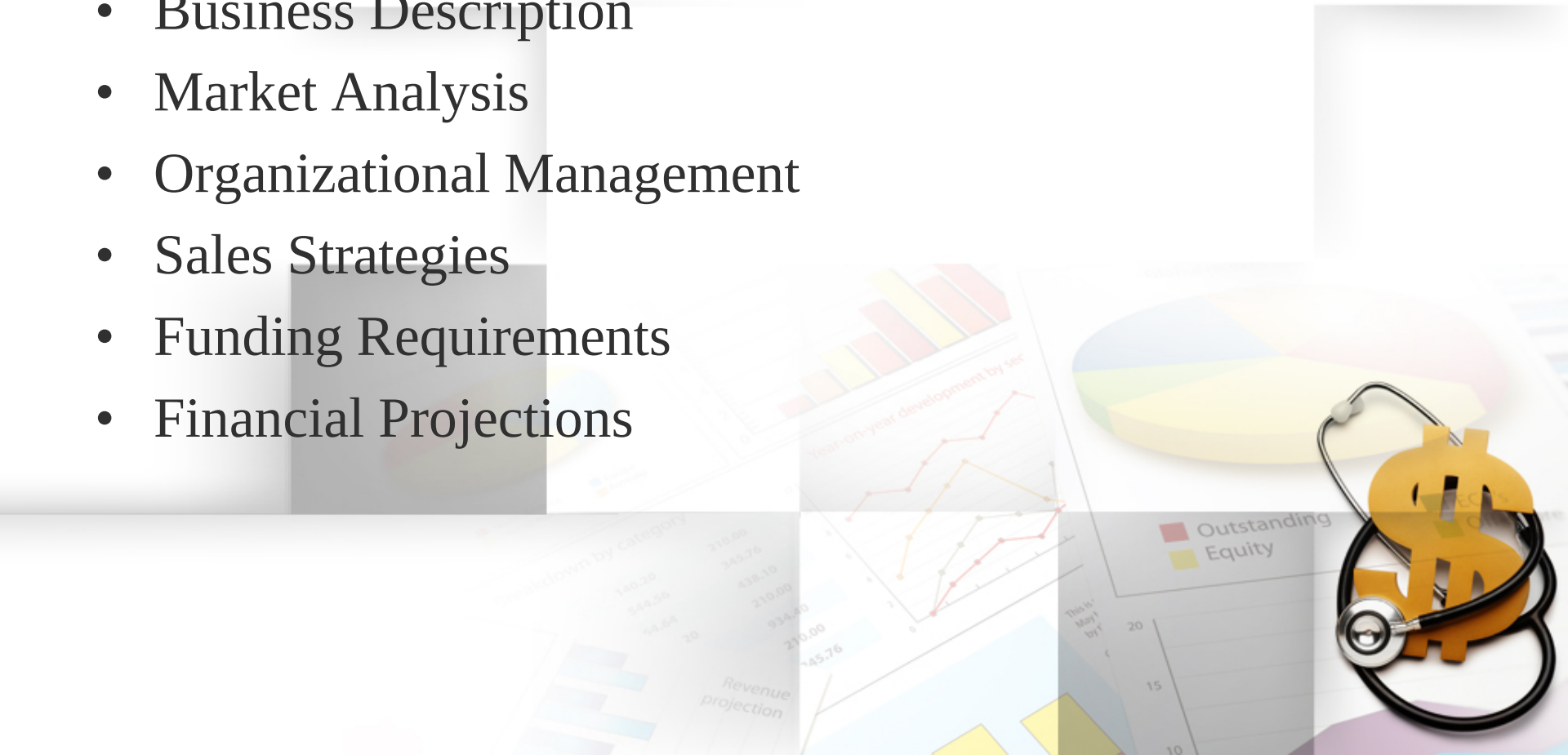
1. Care Management Business Plan
2. Market Opportunity
3. Sample Financial Model
4. Questions

Elements of a Care Management Program Business Plan

- Executive Summary
- Business Description
- Market Analysis
- Organizational Management
- Sales Strategies
- Funding Requirements
- Financial Projections



Business Plan Section:

EXECUTIVE SUMMARY

Why Create an Executive Summary

- Generally written last
- Serves as a one to two page document that summarizes the entire business model
- Introduces the reader to the business model
- Includes goals, objectives and approach
- Outlines the market opportunity and revenue potential

Sample Elements of an Executive Summary

- Our comprehensive care management program will provide the following:
  - Evidence-based disease self-management programs
  - Targeted care coordination
  - Navigation services to assist with maximizing access to eligible social service programs, disease self-management programs, and applicable medical support programs
- The program will enroll 400 participants per year
- Revenue over expenses per 400 participants = $137 K / yr
- New service with large potential for growth beyond Yr 1 Projections

Business Plan Section:

BUSINESS DESCRIPTION

Comprehensive Chronic Care Management Program

- Suite of evidence-based programs and interventions targeting older adults and persons with disabilities.
- Community-based programs and intensive direct care coordination supporting community-dwelling persons to address medical and social needs.
- Program Goals
  - Increased compliance with disease self-management
  - Improved health outcomes
  - Reduced expenditures
  - Improved physician value-based payment
  - Improved patient satisfaction

Care Management Services

- An extensive range of services intended to support a person to improve clinical outcomes and reduce exacerbation of disease
  - Managing Transitions
  - Care Management Services
  - Coordinating community and social support services
  - Coordinating with external agencies supporting the consumer
  - Disease self-management support
  - Health Education
  - Symptom management
  - Medication management

Eligibility

- Chronic Care Management services can be provided to any Medicare FFS beneficiary that meets the following criteria:
  - Must have Medicare Part B benefits
  - Co-Insurance requirements apply
  - Must have two or more chronic conditions that are expected to last at least 12 months
  - Chronic conditions could lead to worse health outcomes or death is not properly managed
- Eligibility for CCM and Complex CCM are the same
  - Intensity of services defines which code to use

Alignment with CMS

- HHS Multiple Chronic Conditions. A Strategic Framework
  - https://www.hhs.gov/sites/default/files/ash/initiatives/mcc/mcc_framework.pdf
- Goal 2: Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions.
  - Facilitate Self-care management
  - Strategy 2.A.1. Continually improve and bring to scale evidence-based, self-care management activities and programs, and develop systems to promote models that address common risk factors and challenges that are associated with many chronic conditions.
  - Strategy 2.A.2. Enhance sustainability of evidence-based, self-management activities and programs.

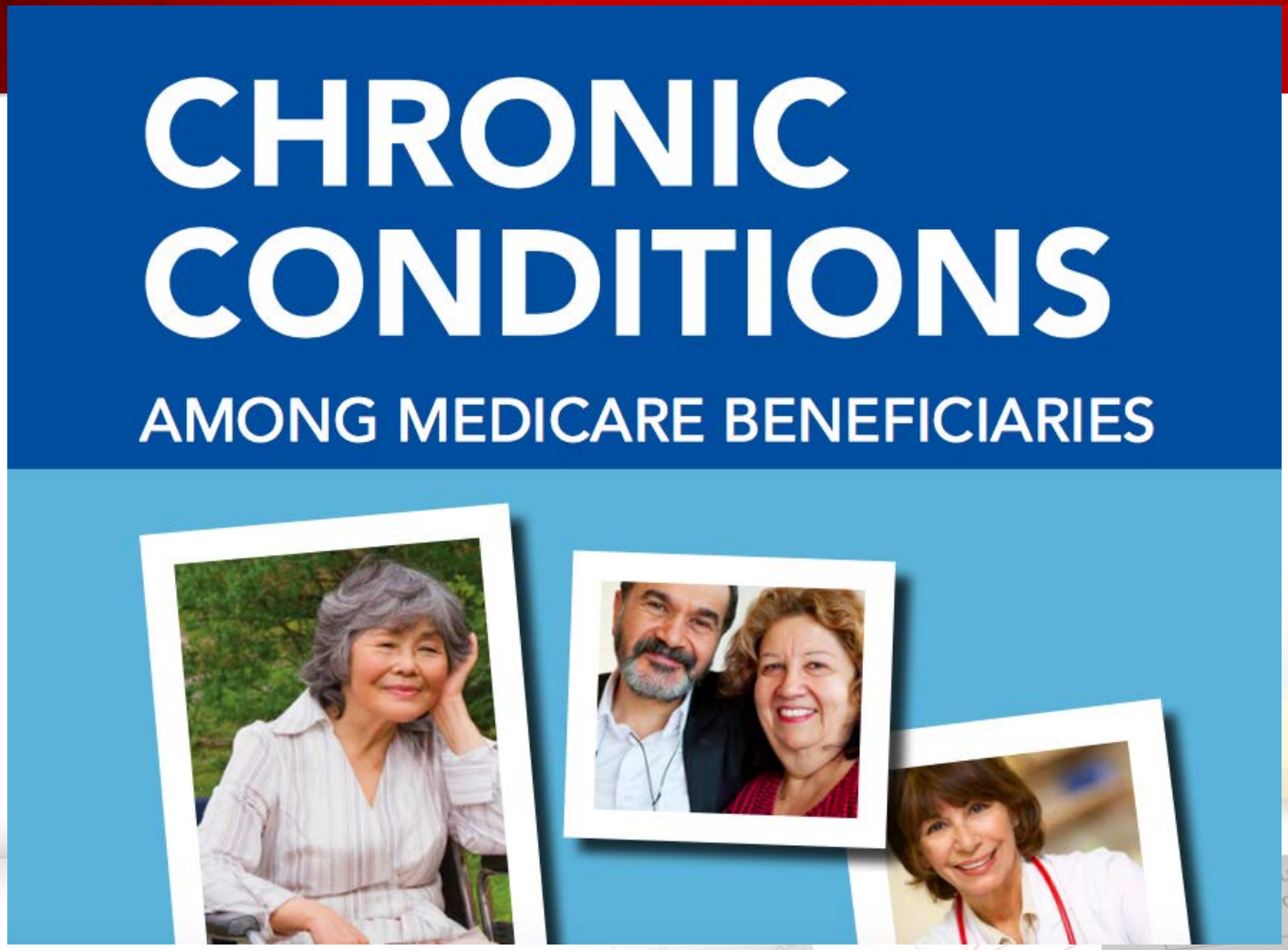
Business Plan Section:

MARKET ANALYSIS

Market Opportunity Analysis

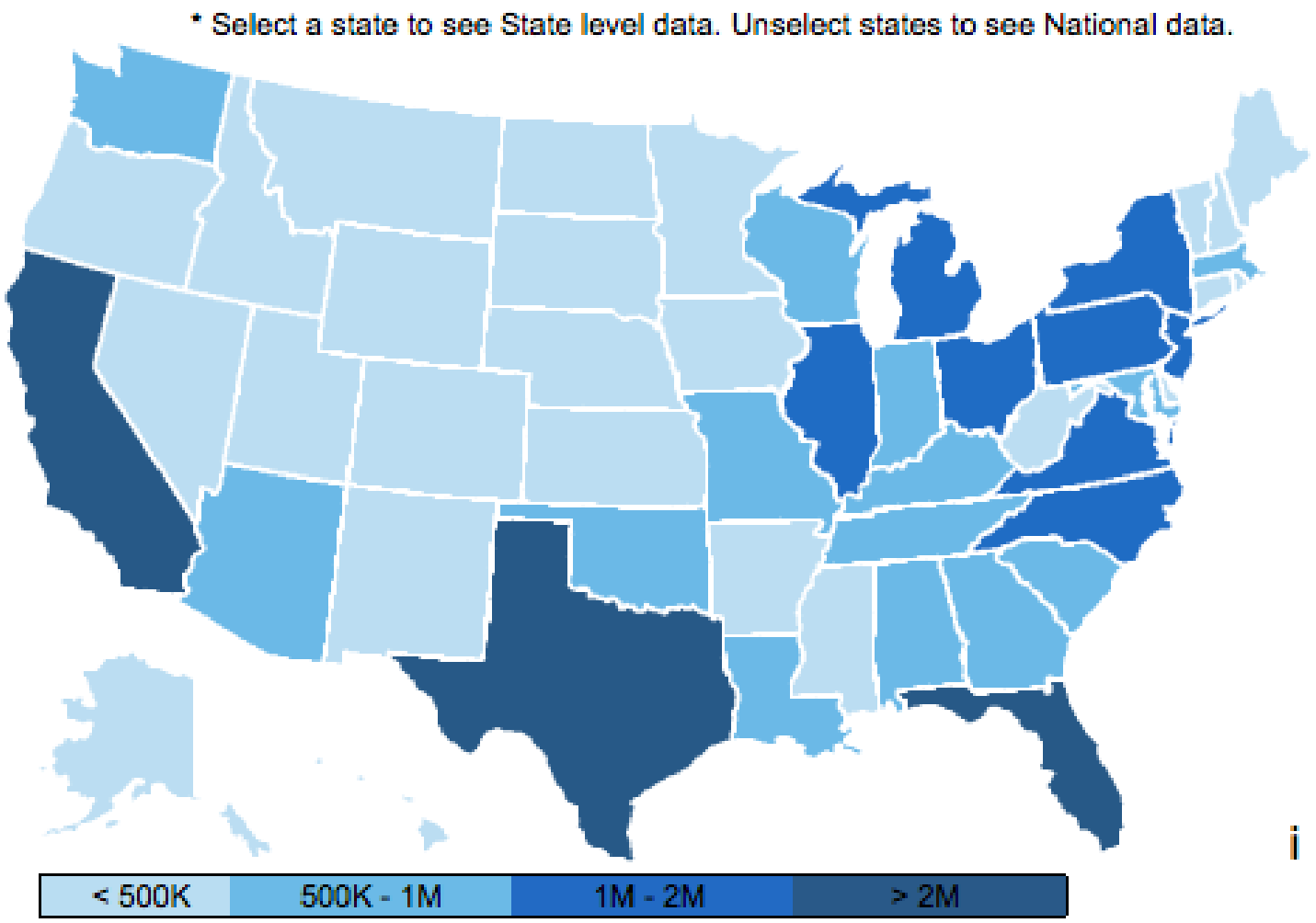
- Hospitals in your market
  - Readmissions / Admissions
  - ER Utilization
  - Post-Acute Care Provider Network
- Physician market
  - Hospital-Owned Practices
  - Independent Practices
  - Specialists vs Primary Care
- Accountable Care Organizations
- Bundled Payment programs
- Medicare FFS Beneficiaries in your market

CMS Medicare Chartbook:



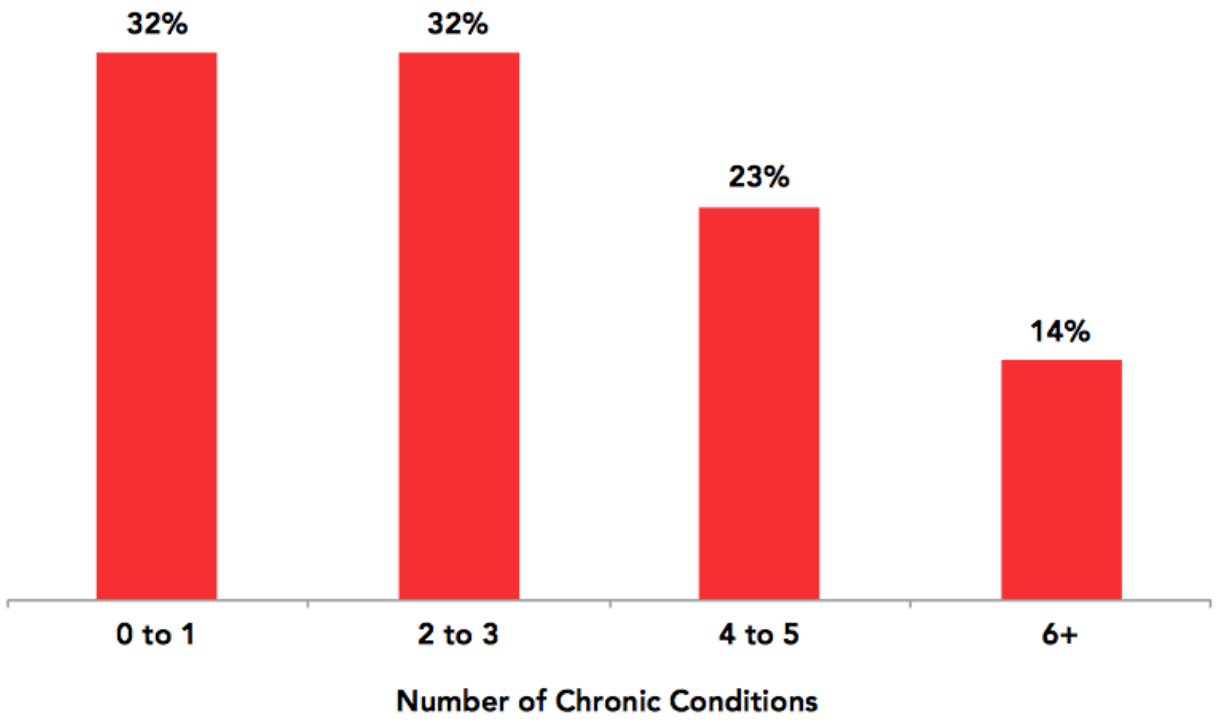
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

Distribution of Fee-For-Service Medicare Beneficiaries



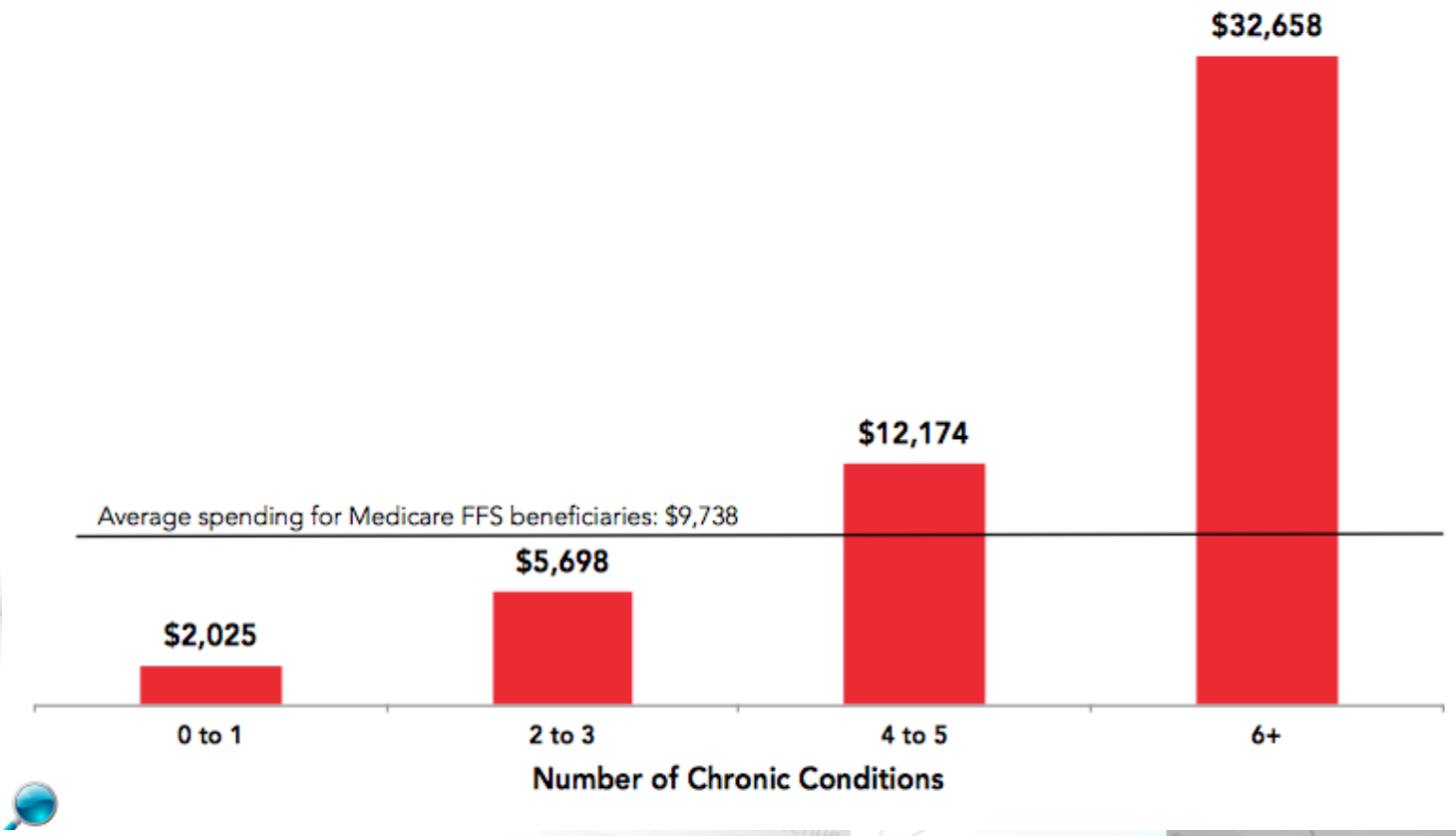
Nearly 70% of FFS Medicare has 2 or more chronic conditions

Figure 1.2a *Percentage of Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010*



Per Capita Expenditures increase as the conditions increase

Figure 3.1a *Per Capita Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010*



Which Population has the most chronic disease?

- Most chronic conditions were more prevalent for dual-eligible beneficiaries
  - 72% of dual-eligible beneficiaries had two or more conditions
  - Dual eligible beneficiaries were 1.7 times as likely to have 6 or more chronic conditions
- 98% of readmissions, in 2010, were for Medicare beneficiaries with two or more chronic conditions
  - *CMS Chronic Conditions Among Medicare Beneficiaries, Chartbook – 2012 Edition. Available Online:* ***https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf***

What are the characteristics of Duals?

- Nationally, there were **9.6 million dual-eligible** beneficiaries
  - 3.9 million were under age 65
  - 5.7 million were aged 65 and older

  Data book: Beneficiaries dually eligible for Medicare and Medicaid — January 2015 MedPAC
- As of Nov 2016, the total population receiving care management services = 517,000
  - 72% of 9.6 million = 6,912,000
  - 1 hour per year delivered to Duals = $647 Million

Business Plan Section:

ORGANIZATIONAL MANAGEMENT

Medicare Part B

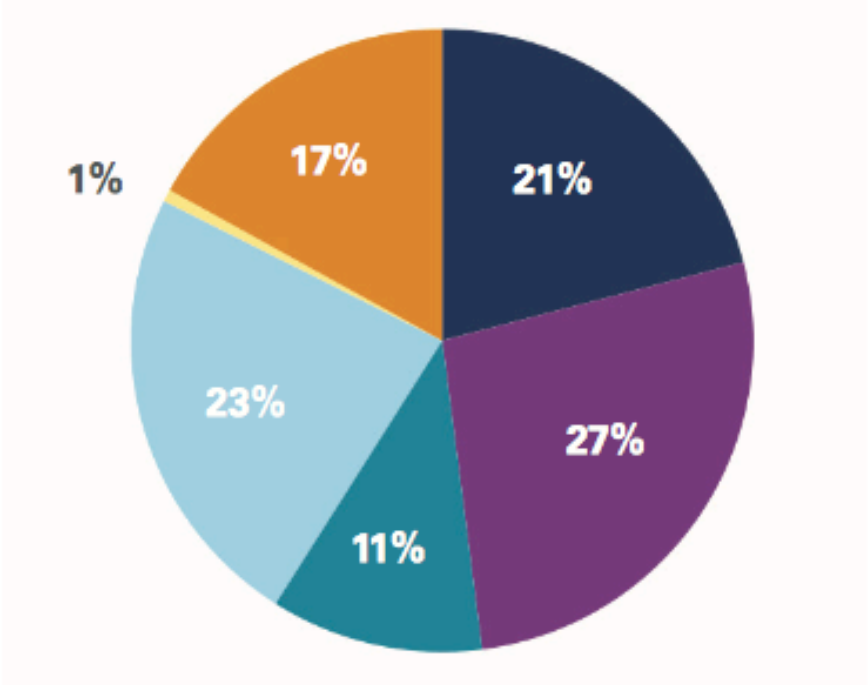
- Part B: Care Management Services are a Part B benefit
  - Part B services have a co-insurance requirement of 20%
  - Organization must attempt to collect co-insurance
- Co-Insurance: Part B covers 80% of charges and the beneficiary is responsible for the co-insurance amount (20%)
- Medigap policies cover the 20% co-insurance
  - Medicaid is the Medigap for Duals
  - Tricare for Life is the Medigap for Military Retirees
  - State Employee retirees often have their State insurance as their Medigap
  - Retired workers have their company revert to Medigap

Medigap Market

- Medicare Part B beneficiaries can purchase a Medigap or supplemental policy to cover the 20% coinsurance requirements
- A Medigap policy defined
  - Health insurance sold by private insurance companies to fill gaps in Original Medicare coverage
    - Coinsurance, copayments, deductibles
    - If a beneficiary elects Medicare Advantage, they cannot be sold or use a Medigap policy
    - Beneficiaries with Medicaid (Duals) generally cannot buy a Medigap policy

When Medicare Isn't Enough….Supplement

Figure 1: Distribution of Medicare Beneficiaries by Coverage Type, 2012



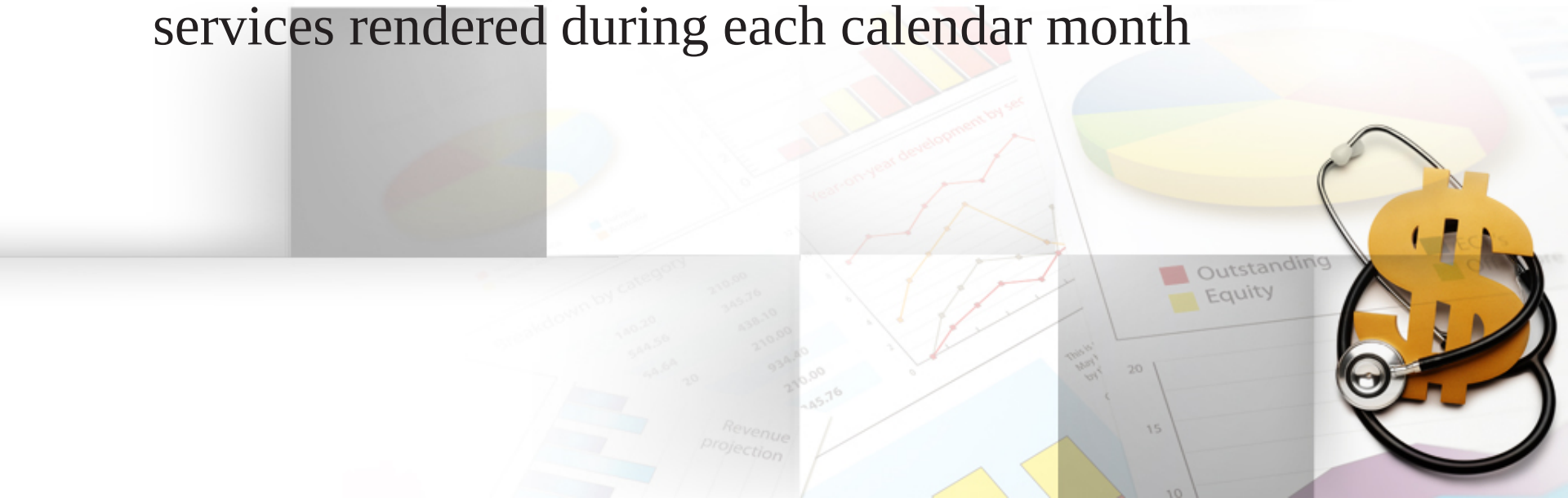
AHIP: BENEFICIARIES WITH MEDIGAP COVERAGE

Creating a Care Plan

- Support the completion of a person-centered plan
- Services that can be included as part of the Care Management Person-Centered Plan
  - Education and outreach
  - Disease Self-Management Support Services / Classes
  - Care Coordination
  - Communication with all providers
  - Support to address Psycho-Social Barriers impacting health
  - Medication Reconciliation
  - Health Coaching services

Role of the Clinician

- Obtain Beneficiary Consent
- Review and authorization of the Person-Centered Plan
- Provide General Supervision for the services rendered in accordance with the Person-Centered Plan
- Submit reimbursement claims based on the totality of services rendered during each calendar month



Role of the CBO

- Support the development of a Person-Centered Plan
- Provide services in accordance with the Person-Centered Plan
- Provide face-to-face AND/OR non-face-to-face services to each identified beneficiary each calendar month
- Document services to include start and stop times
- Submit documentation and time totals to the provider each calendar month

Business Plan Section:

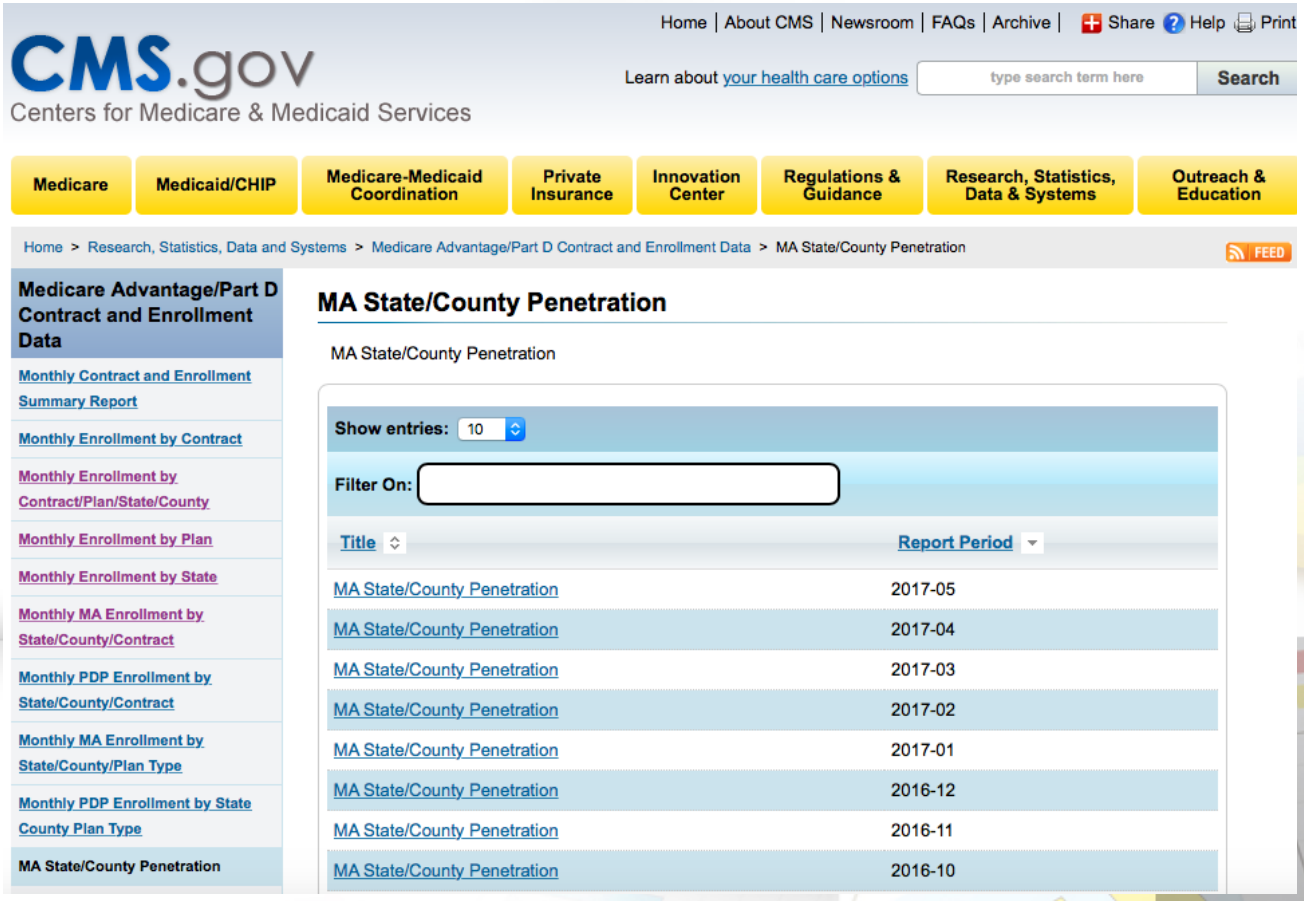
SALES STRATEGIES

Alignment with Value-Based Payment Models

- Medicare FFS beneficiaries have a profound impact on physician performance in value-based payment models
  - Quality and Cost measures are directly correlated with the number of persons with two or more chronic conditions
- MACRA
  - Merit Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)
    - ACOs
    - Bundled Payment
- Costs
  - Admissions/Readmissions
  - Post-Acute Care Utilization (Rehab, SNF, etc.)

Medicare Beneficiary Data: State/County Penetration

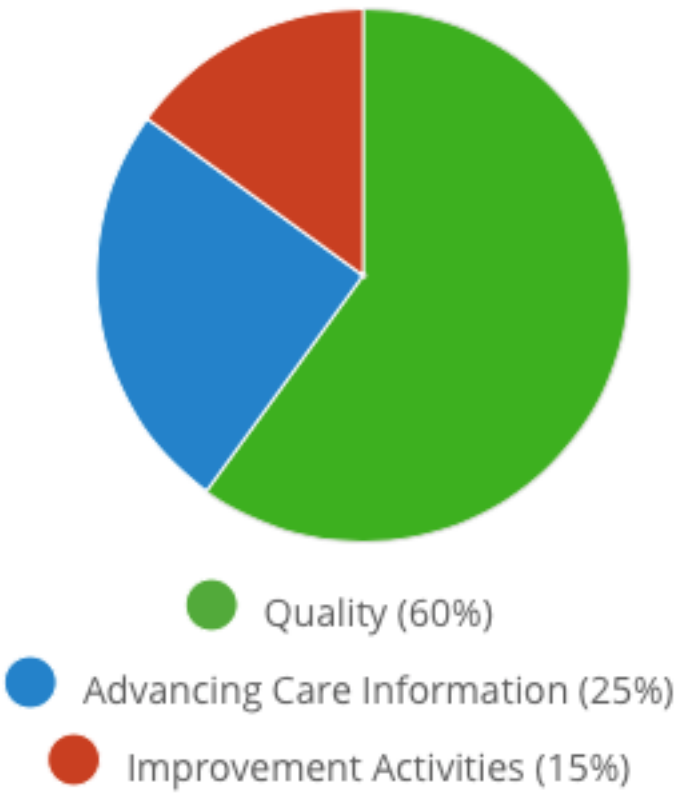
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration.html



Provider Merit Incentive Payment System

MIPS Overview

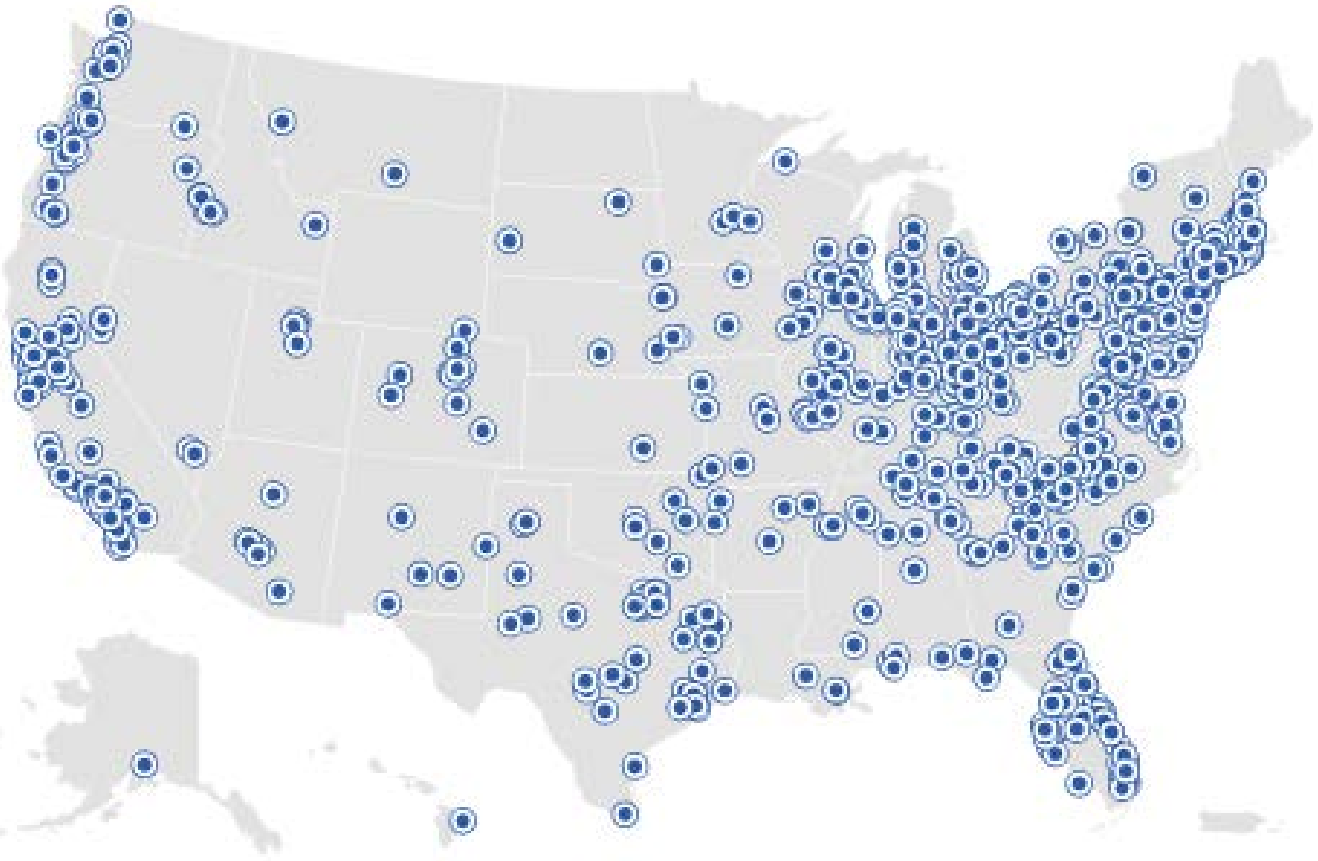
2017 MIPS Performance



Provider MIPS Categories applicable to CBOs

- Quality
  - Diabetes outcomes
  - Depression screening
  - Fall risk
- Advancing Care Information
  - Referrals to community programs
  - Send a summary of care
- Improvement Activities
  - Care transitions documentation
  - Engagement of community for health status improvement
  - Evidence-based interventions to promote self-management
  - Chronic care and preventive care management

Is there a Bundled Payment Program Near You?



Source: Centers for Medicare & Medicaid Services

Background

Business Plan Section:

FINANCIAL PROJECTIONS

Rate and Duration of Services

CPT Code	Rate	Duration
99490 - CCM	$42.71	Billed each calendar month
99487 - Complex CCM	$93.67	Billed each calendar month *only one CCM code can be billed per month
99489 – Add on per 30 min	$47.01	Billed for each 30 min of additional services beyond the 99487 - 60 min encounter

Projected Labor Expenses

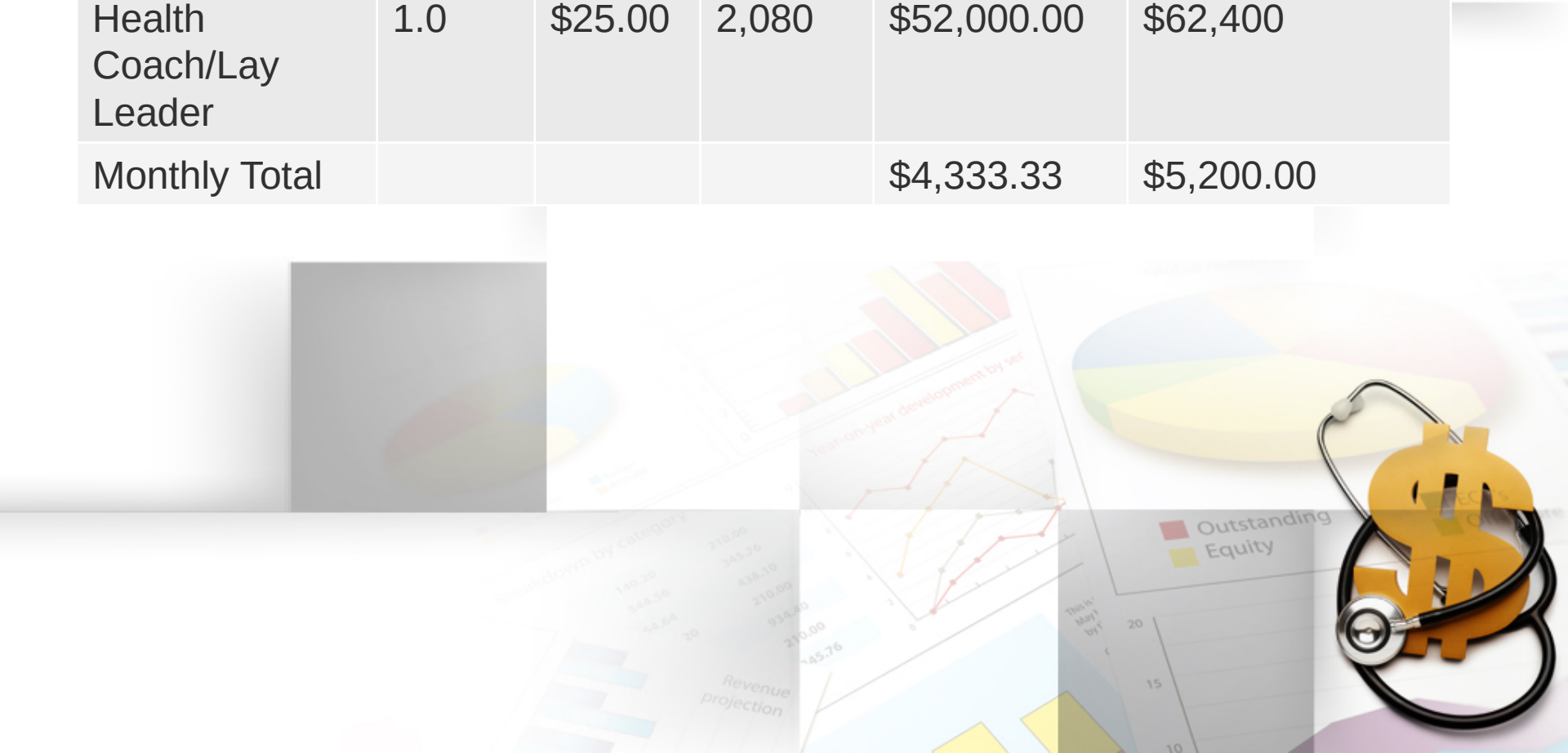
- A full-time Health Coach works 40 hrs per week / 160 hrs per month / 2,080 hrs per year
- Complex CCM requires 1 hour per month/beneficiary
- 80 beneficiaries will require 80 hours of complex CCM time

Projected Labor Expenses

- Provide care management to up to 80 beneficiaries
- Support the delivery of monthly evidence-based programs
- Organize and implement monthly disease self-management support groups
- Provide individual care coordination services as needed

Projected Labor Expenses

Labor Category	FTE	Rate	Hours	Subtotal	Total + Fringe
Health Coach/Lay Leader	1.0	$25.00	2,080	$52,000.00	$62,400
Monthly Total				$4,333.33	$5,200.00



Projected Revenue

- Complex CCM Rate = $93.67
- Beneficiaries = 80
- Monthly Collection = $7,493.60
- Annual Collection = $89,923.20
- Revenue Over Expenses: $89,923.20 - $62,400.00 = +$27,523.20 / 80 participants
- 5 Health Coaches supporting 400 participants:
  - +$137,616.00
  - Target the top 5 providers in each market