Welcome to TIM Talks:

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

May 31, 2017
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

Timothy P. McNeill, RN, MPH
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
HHS Multiple Chronic Conditions. A Strategic Framework


- 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.
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:

CHRONIC CONDITIONS
AMONG MEDICARE BENEFICIARIES

Distribution of Fee-For-Service Medicare Beneficiaries
Nearly 70% of FFS Medicare has 2 or more chronic conditions.
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

- **0 to 1 Chronic Conditions**: $2,025
- **2 to 3 Chronic Conditions**: $5,698
- **4 to 5 Chronic Conditions**: $12,174
- **6+ Chronic Conditions**: $32,658

Average spending for Medicare FFS beneficiaries: $9,738
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
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
Figure 1: Distribution of Medicare Beneficiaries by Coverage Type, 2012

- Medigap: 21%
- Medicare Advantage: 17%
- Medicaid: 27%
- Employer-sponsored insurance: 23%
- Other public insurance: 11%
- Medicare FFS alone: 1%
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

MIPS Overview

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
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

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<thead>
<tr>
<th>CPT Code</th>
<th>Rate</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490 - CCM</td>
<td>$42.71</td>
<td>Billed each calendar month</td>
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</tbody>
</table>
| 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 |
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
• 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

<table>
<thead>
<tr>
<th>Labor Category</th>
<th>FTE</th>
<th>Rate</th>
<th>Hours</th>
<th>Subtotal</th>
<th>Total + Fringe</th>
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</thead>
<tbody>
<tr>
<td>Health Coach/Lay Leader</td>
<td>1.0</td>
<td>$25.00</td>
<td>2,080</td>
<td>$52,000.00</td>
<td>$62,400</td>
</tr>
<tr>
<td><strong>Monthly Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$4,333.33</strong></td>
<td><strong>$5,200.00</strong></td>
</tr>
</tbody>
</table>
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