Welcome to TIM Talks:
Chronic Care Management (CCM) - Moving from Planning to Implementation
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1. CCM Operations Process
2. Contract Models
3. Value-Added Benefits
4. Questions

CCM in the Market place

- Customers for CCM Services:
  - Health Systems that want to reduce readmissions
  - ACOs
  - Health System-Owned Physician Practices
  - Multi-Specialty Practices
  - Physician Groups participating in bundled payment

Identify the Win-Win

- Provider
  - Additional care management resources to support the patient population
  - Extending disease self-management and lifestyle changing efforts beyond the clinic to the community
  - Support to address MIPS, ACO Measures, and Cost containment
- CBO
  - Profit center within my organization
  - Direct referral source for evidence-based programs
  - Best practice model that can be replicated to other customers in the market

Target Population: Payer

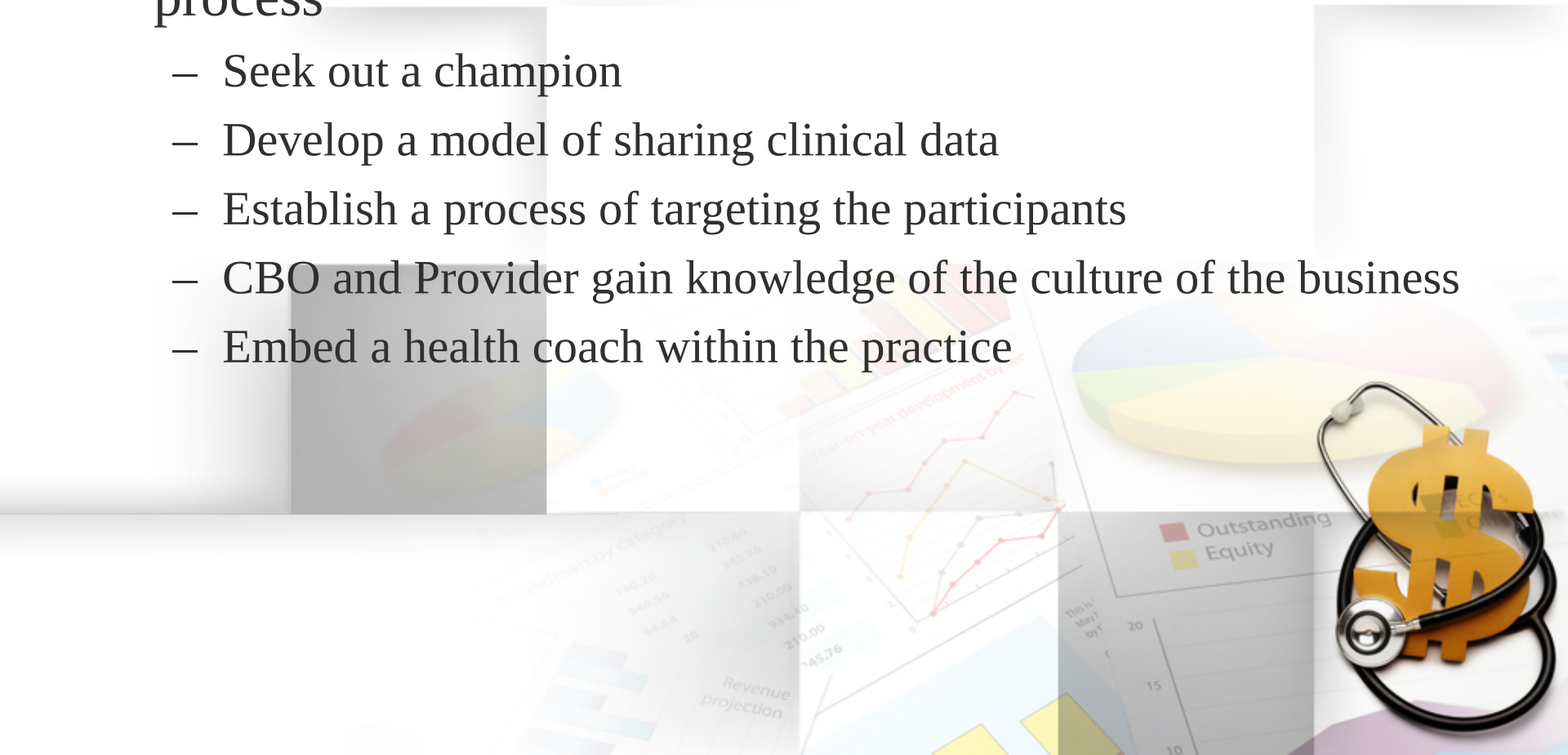
- Beneficiaries with Medicare Part B:
  - Emphasis on Dual Eligible Beneficiaries
    - Data shows significant increase in cost and disease burden associated with dual-eligible status
  - Emphasis on persons with four or more chronic conditions
    - Data shows significant increase in costs for any beneficiary with four or more chronic conditions
- Medicare Advantage Beneficiaries:
  - Emphasis on persons receiving a low-income subsidy
    - CMS study shows direct correlation between low-income subsidy status and performance on HEDIS measure outcome

Target Population: Disease Groups

- Diseases that are impacted by lifestyle choices
  - Diabetes
  - Heart Disease / Heart Failure
- Populations impacted by social determinants of health
  - Low-Income
  - Minority
  - Rural
- Populations that have a primary or secondary diagnosis of depression
  - WHO: Depression is the leading cause of disability worldwide

Pilot the Process

- Identify One Provider within the organization to test the process
  - Seek out a champion
  - Develop a model of sharing clinical data
  - Establish a process of targeting the participants
  - CBO and Provider gain knowledge of the culture of the business
  - Embed a health coach within the practice



Key Factors

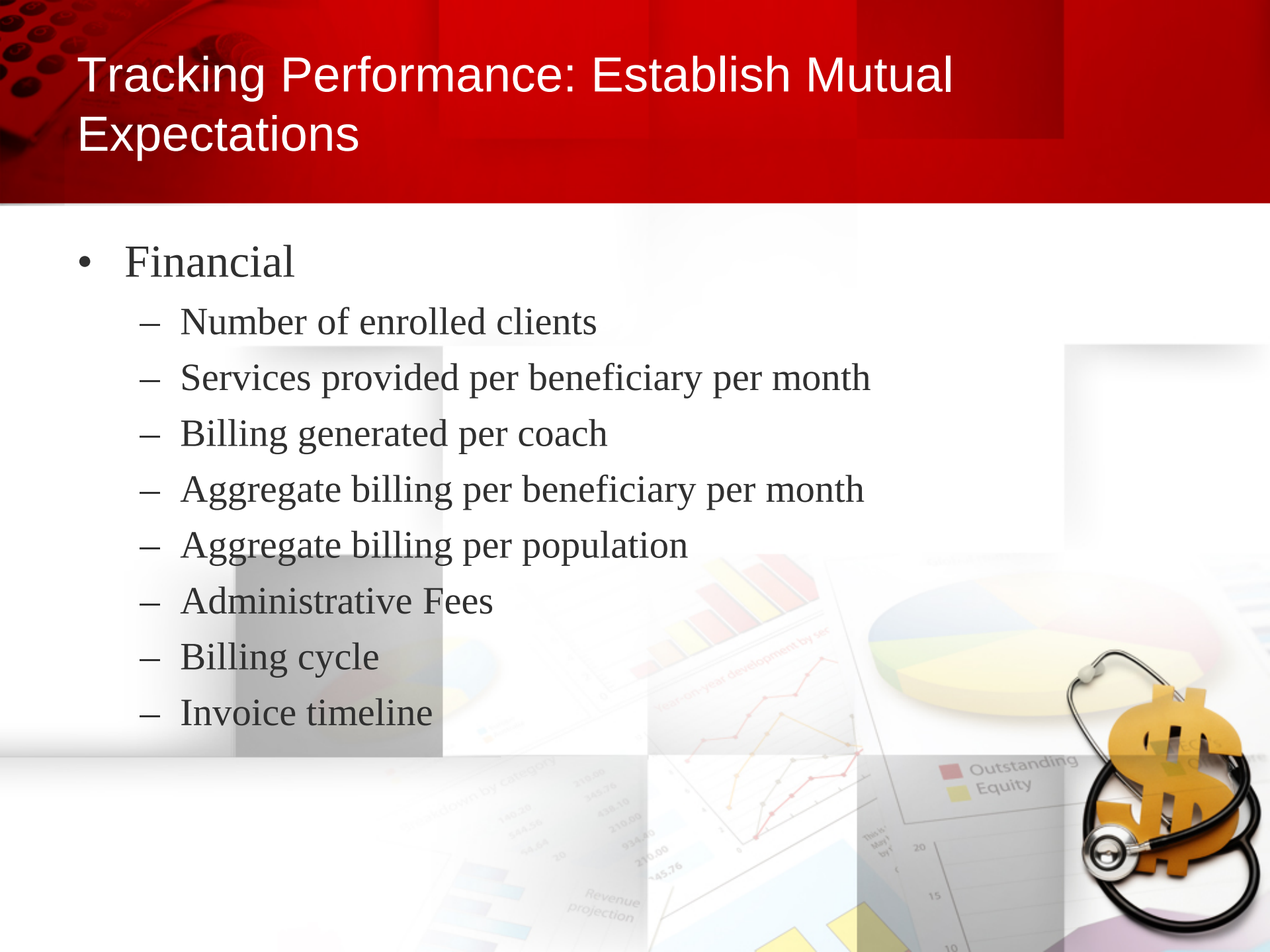
- Business Associate Agreement
- HIPAA Training of embedded personnel
- HIPAA Training for CBO staff supporting the project
- Health IT system
- Data exchange
- Bi-directional referral patterns
- Person-Centered Planning Process

Financial Considerations

- Total number of eligible patients
- Mutual expectations regarding referral volume
- Break-even point
- Charge capture process
- Revenue cycle management

Tracking Performance: Establish Mutual Expectations

- Financial
  - Number of enrolled clients
  - Services provided per beneficiary per month
  - Billing generated per coach
  - Aggregate billing per beneficiary per month
  - Aggregate billing per population
  - Administrative Fees
  - Billing cycle
  - Invoice timeline



Tracking Performance: Establish Mutual Expectations

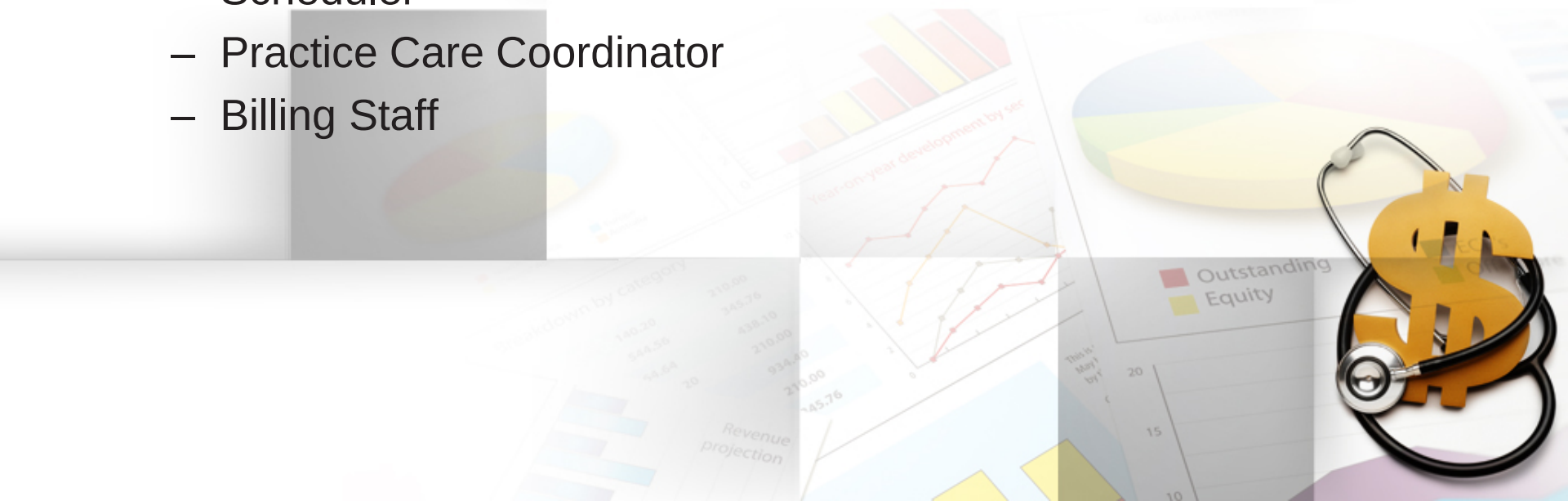
- Clinical
  - Primary diagnosis
    - Depression status
    - Malnutrition
  - Readiness for change
  - Need for social services
  - Homebound status
  - Dual-eligible status
  - Medicaid Waiver enrollment / Managed LTSS
  - OAA services
  - Veteran Status
    - VA Choice / VD-HCBS

Embedded Health Coach Qualifications

- Develop a personnel file for each Coach
  - Job Description / Resume
  - Background check
  - Training
  - HIPAA / Confidentiality statement
  - TB testing / MMR / Flu
- Recommended Training
  - HIPAA
  - Motivational Interviewing
  - Disease Self-Management skills
  - Abuse, Neglect, Exploitation / Mandatory Reporting

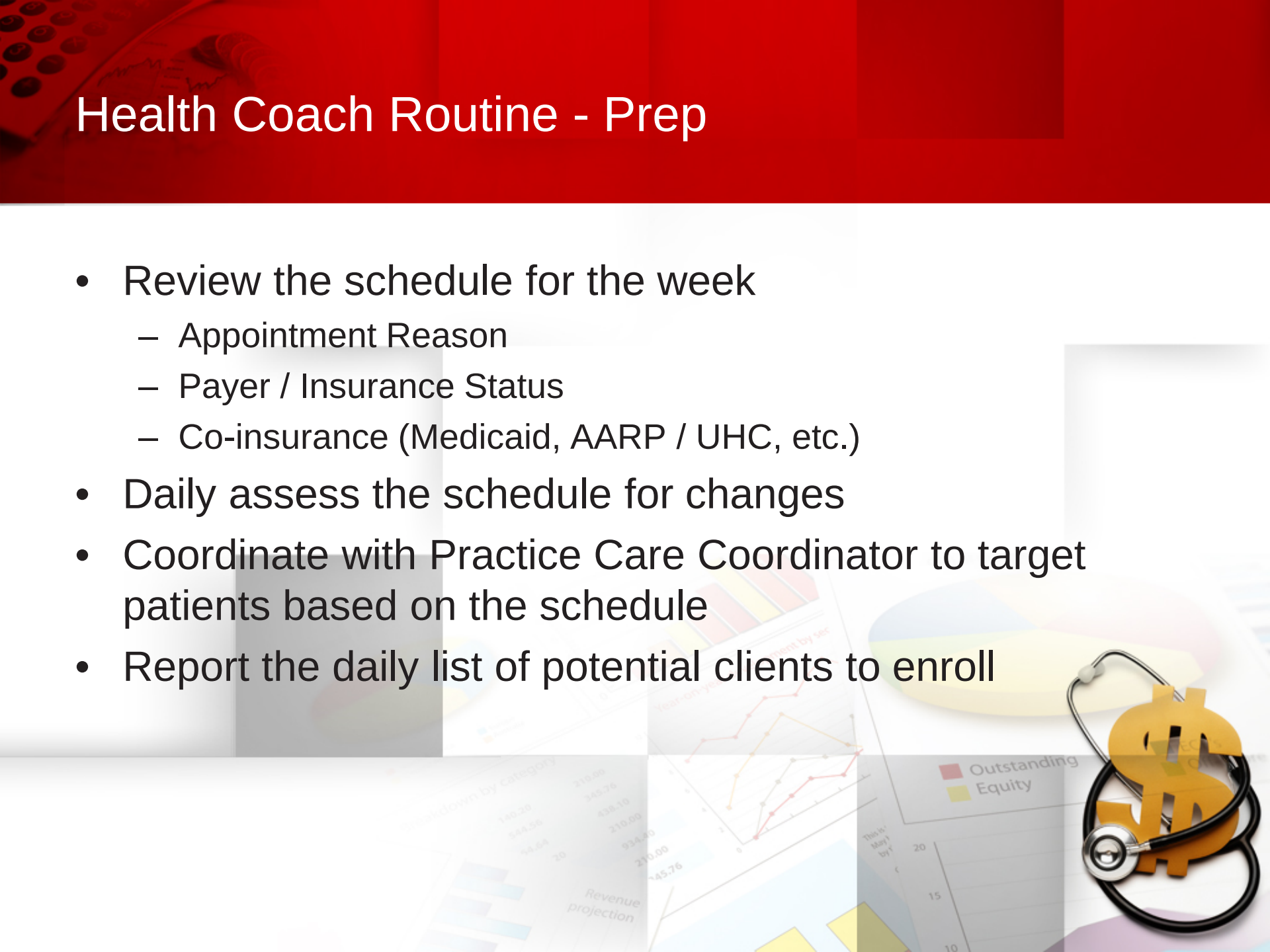
Key Practice Personnel

- Embedded Health Coach and the Program Administrator must establish a relationship with the following key personnel:
  - Practice Manager
  - Front Desk Personnel
  - Scheduler
  - Practice Care Coordinator
  - Billing Staff



Health Coach Routine - Prep

- Review the schedule for the week
  - Appointment Reason
  - Payer / Insurance Status
  - Co-insurance (Medicaid, AARP / UHC, etc.)
- Daily assess the schedule for changes
- Coordinate with Practice Care Coordinator to target patients based on the schedule
- Report the daily list of potential clients to enroll



Health Coach Routine – Daily Operations

- Coordinate with front desk to greet clients prior to their provider appointment
- Introduce the program using defined script agreed upon by the practice administrator and the CBO
- Assess consumer willingness to participate
- Support the development of a person-centered plan
- Report the enrollment and person-centered plan to the provider
- Obtain endorsement from the provider for client engagement
- Document
  - Person-Centered Plan
  - Verbal Consent

Person-Centered Planning Key Elements

- Person-Centered Plan should span 12 Months
- Needs
  - Medical
  - Social
  - Psycho-social
- Interventions
  - Preventive Health appt. schedule
  - Evidence-based programs
  - Individual Health Coaching
- Cultural Factors impacting health
- Social Determinants

Health Coach Routine – End of Day

- Record number of enrolled compared with potential eligible
- Compare enrollment to daily enrollment quota target
- Record financial and clinical quality measures
  - Primary Diagnosis
  - Depression Status
  - Dual-Eligible Status
  - Veteran Status
  - Social Service Needs
  - Zip Code or residence
  - Enrollment in Medicaid Waiver / Managed LTSS

CBO Administrator Tasks - Administrative

- Daily assess status of meeting enrollment goals
- Identify barriers to enrollment and discuss them with the practice manager
- Assess the demographics of the population enrolled to determine if the program is reaching the target population
- Assess for monthly services provided to each beneficiary
- Monitor enrollment in programs provided by the CBO
  - Evidence-based programs
  - OAA Services
  - Senior Center Programs
  - Social Service Programs

CBO Administrator Tasks - Financial

- Monitor billing
  - Billing per beneficiary
  - Aggregate billing for the program
  - Billing compared to costs
  - Reconciled billing
  - Revenue-Cycle timeline
  - Daily enrollments
  - Productivity of embedded coach
  - Cost of the embedded coach compared to enrollment numbers

12-Month CCM Service Plan

- In-Home Assessment to determine risk
  - Assess for Fall Risks
  - Review Medications and document findings
    - OTC
    - Use of Herbal Medication
    - Adherence to Prescribed Medication Regimen
- Enrollment in scheduled Evidence-based programs
- Preventive Health appt. schedule
- Coordination with specialists

12-Month CCM Service Plan – Evidence-Based Programs

- Person-Centered Plan should support the person with completing all applicable evidence-based programs
- Health Coaching model supports the consumer with completion of planned participation in evidence-based programs
- Health coaching and individual participation in monthly evidence-based programs must be documented for each individual consumer – even if participant attends a group intervention

Sample Plan Using Evidence-based Interventions

- 68 y/o female. Widow and lives alone. Dual-Eligible. Dx Diabetes, CHF, Depression. Not receiving Medicaid wavier. Hx of recent fall
  - Enhanced Wellness – Evidence-Based Health Coaching Program
  - Fall Prevention Program (Matter of Balance, Stepping On, etc.)
  - In-Home assessment for fall-risk and medication review
  - CDSMP
  - PEARLS – Depression management
  - Enrollment in Medicaid Waiver for home-delivered meals and adult day-health
  - Coordination of transportation to a DSMT / MNT class
    - MNT / DSMT will be billed separately from CCM

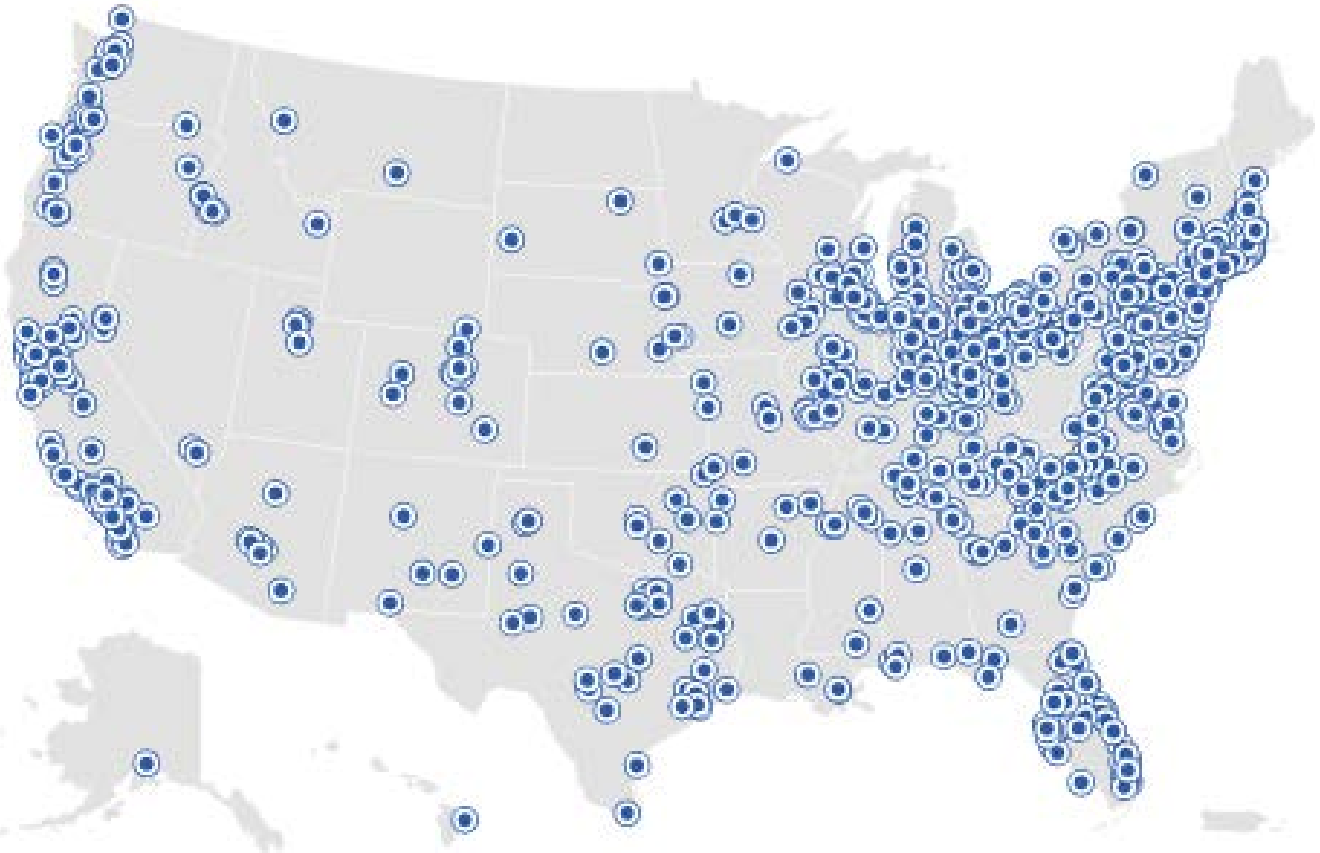
CCM / Behavioral Health Integration

- CCM and Behavioral Health Integration services can be billed on the same consumer, during the same month
- Eligibility for Behavioral Health Integration
  - Any Behavioral Health Condition
  - WHO: Depression is the leading cause of disability worldwide
  - Depression is a common co-morbidity of diabetes and heart disease
- Services must be documented separately for each intervention

Track Value-Added Benefits to the Practice

- Adherence to Medical Office Visit Prevention Schedule
  - Four Preventive Health Visits per year + sick visits ($$$)
  - Annual Wellness Visit ($175 first year, $99 thereafter)
    - Health Coach can support completion of Annual Wellness Visits
- CCM Support of Tele-Health Services
  - Geographic Restrictions on Tele-Health are lifted for the following beneficiaries:
    - Participants in a bundled payment program, during the episode of care
    - Consumers in a Next Generation ACO

Is there a Bundled Payment Program Near You?



Source: Centers for Medicare & Medicaid Services

Background

CCM Implementation:

CONTRACT MODELS

Contract Models

- **Model #1:** Clinical Integration with one individual Medicare Provider

- **Model #2:** Contract with a organization that can bill Medicare and support multiple providers in a market

- **Model #3:** Become a direct Medicare provider with the appropriate infrastructure to deliver CCM services

MODEL #1:
CLINICAL INTEGRATION WITH ONE INDIVIDUAL MEDICARE PROVIDER

Contract Model

- Individual Contract with an individual provider / group practice to provide CCM services as a third-party care management organization
- Contract defines the services, cost of services, and expected payment schedule
  - Admin costs should be limited to 10% or less
- CBO provides the services and documents in the E.H.R of the provider
- Provider submits claims to insurance
- Provider and CBO reconcile with the collections department on a regular schedule.

Pros vs Cons

- Pros
  - Ability to quickly start
  - Ready source of consumers
  - Sets precedence and marketing material for other practices
- Cons
  - Agreement is limited to one individual provider and will require separate agreements with every other individual provider
  - Embedded Health Coaches and staff will have to learn and adopt the E.H.R for each contracted provider
  - Increased administrative costs to manage and track services with multiple systems and multiple providers

Financial Considerations

- Agreement limited to one practice and the billing is limited to that provider's capacity
- Track claims submission, denials, aging report
- Increased administrative costs to the CBO if this contract model is replicated to multiple practices in the market
- Training costs associated with staff use of multiple IT systems

MODEL #2:
CONTRACT WITH A ORGANIZATION THAT CAN BILL MEDICARE AND SUPPORT MULTIPLE PROVIDERS IN A MARKET

Contract Model

- Contract with an established Medicare Provider or Management Service Organization (MSO) that has the capacity to work with multiple providers in the market
- MSO should provide
  - E.H.R platform that integrates with multiple providers
  - Revenue Cycle Management
  - Reporting / Population Health Mgmt.
- MSO will take an administrative fee
  - Range is 20% - 45%
  - MSO accepts the risk, liability, and IT costs

Pros vs Cons

- Pros
  - Ability to integrate with multiple providers in the market using one IT system platform
  - Risk and liability are borne by the MSO
  - Lower administrative costs related to the use of one IT platform, one tracking system, one claims management process, and one reporting venue
- Cons
  - Increased costs associated with the MSO fee
  - MSO must be flexible and agreeable to modify IT platform to meet the needs of the provider and CBO

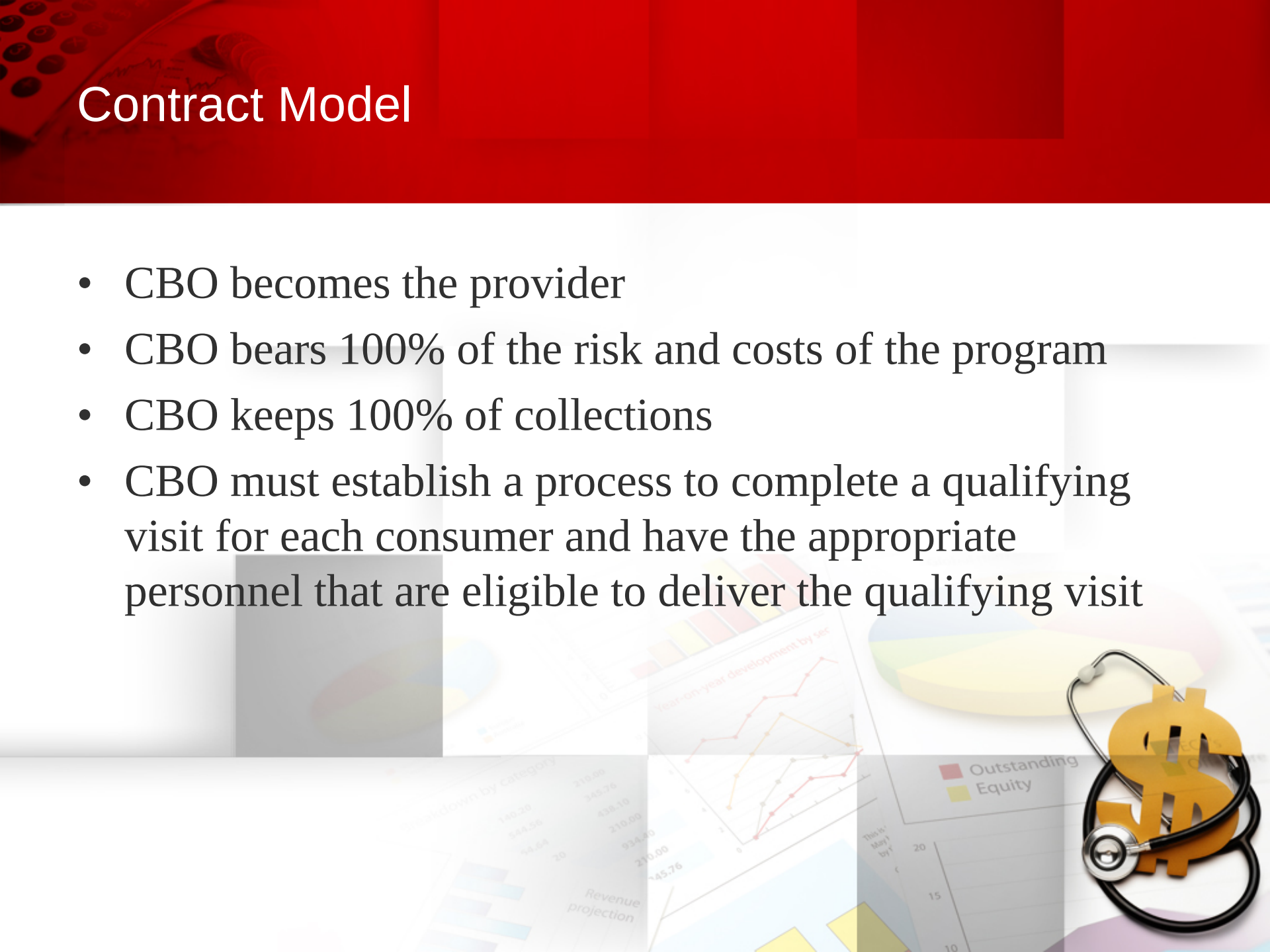
Financial Considerations

- MSO entity provides at least one qualifying visit with the beneficiary
  - Annual Wellness Visit
  - TCM
  - In-home primary care / Preventive Health visit
- MSO enrolls the consumer
- CBO supports the completion of the person-centered plan
- CBO implements the person-centered plan
- CBO and MSO work collaboratively to increase client compliance with primary and specialty care appts. and preventive health appt. schedule

MODEL #3:
BECOME A DIRECT MEDICARE PROVIDER WITH THE APPROPRIATE INFRASTRUCTURE TO DELIVER CCM SERVICES

Contract Model

- CBO becomes the provider
- CBO bears 100% of the risk and costs of the program
- CBO keeps 100% of collections
- CBO must establish a process to complete a qualifying visit for each consumer and have the appropriate personnel that are eligible to deliver the qualifying visit



Pros Vs Cons

- Pros
  - CBO keeps 100% of collections
  - CBO does not have to negotiate with third parties for program
  - CBO can immediately target current client base for services
- Cons
  - CBO bears 100% of the risk and liability
  - CBO must establish a process for revenue-cycle management
  - CBO must bear 100% of the costs of the Health IT system and system integration costs
  - Higher upfront costs and risk to the CBO
  - Lack of economies of scale

Financial Considerations

- Malpractice liability
- Cyber Insurance
- Health IT system costs
- Revenue-cycle management costs
- HIPAA compliance
- Referral sources
- IT integration with providers in the marketplace