Welcome to TIM Talks: Establishing CBO-Physician Collaborations to Implement Reimbursable Chronic Care Management Services

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Chronic Care Management Contracting Steps with Physician Practices

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2. Role and Responsibilities
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4. How to get started

New Business Opportunities Abound

- 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

Chronic Care Management Opportunity

- Chronic Care Management CCM
  - Benefit established in 2015 targeting Medicare
  - CPT Code: 99490
    - 20 min of clinical staff time
- Complex Chronic Care Management
  - Expanded Benefit beginning January 1, 2017
  - CPT Code: 99487
    - 60 min of clinical staff time
  - CPT Code: 99489
    - Ea. Additional 30 min of clinical staff time

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

Rate and Duration of Services

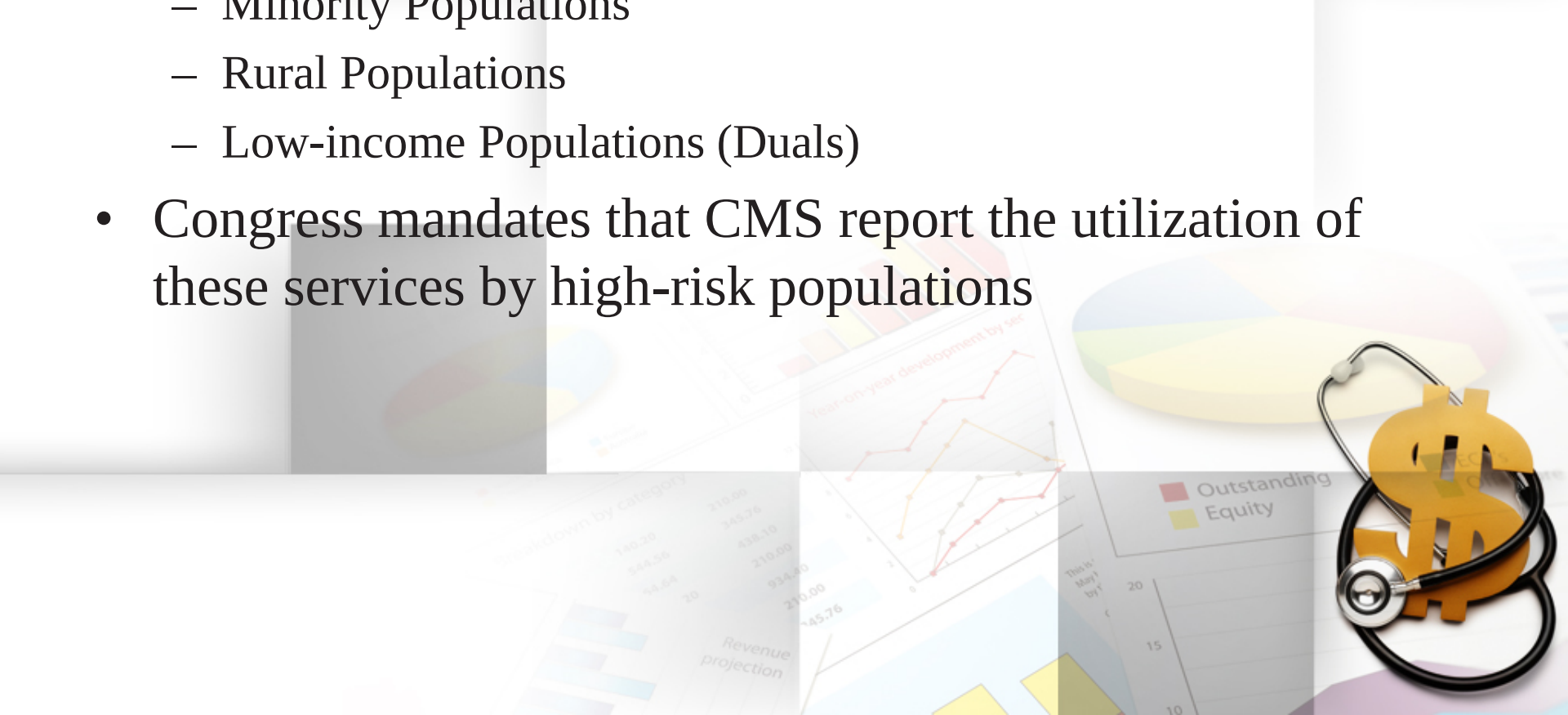
CPT Code	Rate	Duration
99490 - CCM	$42.71	Billed each calendar month
99487 - Complex CCM	$93.67	Billed each calendar month *only one CCM code can be billed per month
99489 – Add on per 30 min	$47.01	Billed for each 30 min of additional services beyond the 99487 - 60 min encounter

Chronic Care Management Opportunity

- Medicare Providers can deliver this service or contract with a third-party care management company to provide the service
- Services can be provided by “General Supervision”
  - Incident To rules have been changed to include Transitional Care Management and Chronic Care Management Services as services that can be rendered under General Supervision
- Requires development of a Person-Centered Care Management Plan

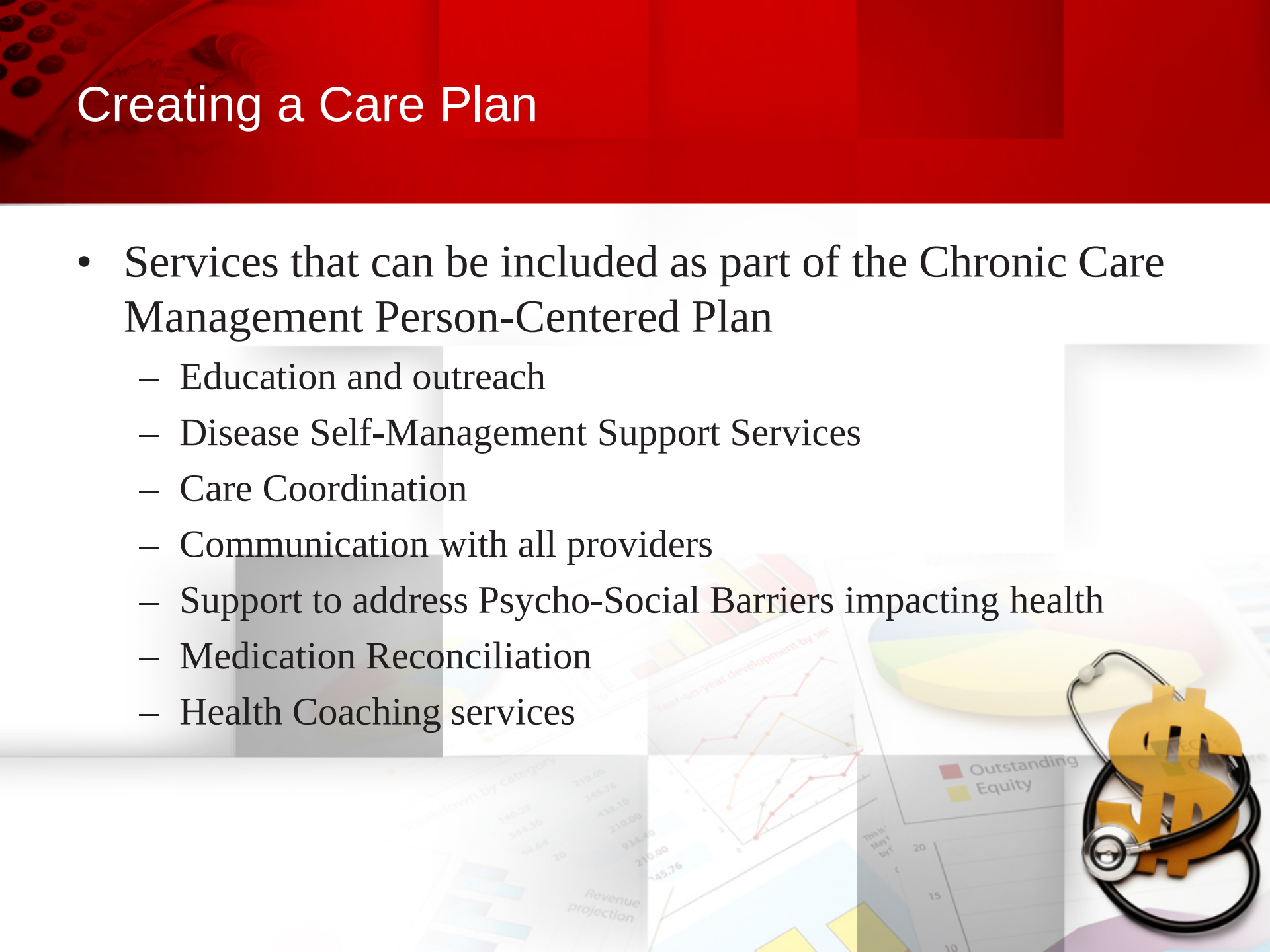
Target Population

- Concerns have be raised that certain populations will have limited access to these services
  - Minority Populations
  - Rural Populations
  - Low-income Populations (Duals)
- Congress mandates that CMS report the utilization of these services by high-risk populations



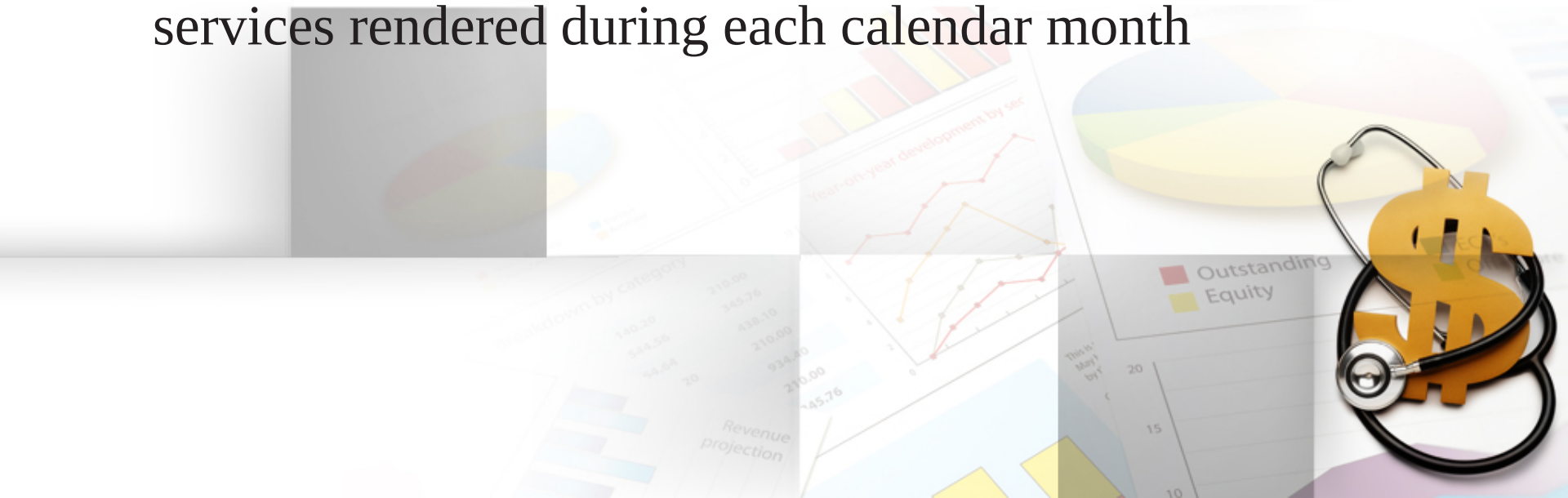
Creating a Care Plan

- Services that can be included as part of the Chronic Care Management Person-Centered Plan
  - Education and outreach
  - Disease Self-Management Support Services
  - 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

Benefits to the Clinician

- Increased compliance with prescribed treatment regimen
- Increased revenue resulting from increased E/M visits and preventive health visits
- Additional support for moderate-high risk patients without building the chronic care management delivery system
- Improved quality measures
  - Alternative Payment Models
  - Merit Incentive Payment System (MIPS)

Benefits to the CBO

- Clinical Integration with community providers
- Incorporation of preventive health programs into the treatment regimen
- Program sustainability pathway by operating as a contact case management organization serving moderate-high risk Medicare beneficiaries with 2 or more chronic conditions
- Reliable revenue source to support program expansion

Path to Sustainability

- Identify local providers participating in alternative payment models
- Identify small to medium size physician practices that lack infrastructure to build a chronic care management program
- Meet with the practice manager and/or medical director to present the model
- Outline the potential revenue and the benefits to each organization along with expected health outcomes

Process Steps

- Express your interest in providing chronic care management services as a contracted CBO partner
- Define the services that your organization would provide
- Provide a sample care management plan that includes the services you will provide
- Outline how you will provide the necessary staff to implement the program and the frequency
- Define how your services will integrate with the clinical services provided by the clinic
- Define the methods that will be employed to increase revenue to the practice

Contract Model Anywhere USA AAA

- Provide Person-Centered Planning support services
- Define a person-centered plan that incorporates the strength of the organization
- Execute the person-centered plan
  - Assess for social determinants of health
  - Define a plan to address defined psycho-social barriers
  - Provide linkages to community resources
  - Enroll participant in relevant evidence-based programs
    - CDSMP
    - Fall Prevention
    - PEARLS, etc.

Evidence-Based Program Model

- Define your evidence-based programs as part of an overall Chronic Disease Care Management Program
- Participants will receive health coaching to support them with completing all relevant EB programs according to the menu of services you provide
- Health Coaching and EB program delivery will occur at-least monthly over a 12 month period
- Develop a business model that incorporates revenue over the year per beneficiary in comparison to your costs

Revenue Model - Physician

Code	Service Description	Rate
G0506	Development of CCM Person-Centered Plan	**$63.88**
G0438	Annual Wellness Visit/PPPS	**$173.70**
99497	Advanced Care Planning	**$82.90**
99213	Level 3 E/M Visit once per quarter for prevention	**$73.93 X 4 = $295.72**
99214	Level 4 E/M Visit to address medical needs – 2 per Year	**$108.74 X 2 = $217.44**
99489	Add-On Complex CCM for physician office staff x 3	**$47.01 X 3 = $141.03**
Grand Total		**$974.67 per person/year**

Revenue Model - CBO

Code	Service Description	Rate
99487	Complex Chronic Care Management	**$93.67 X 12 = $1,124.04**
Grand Total		**$1,124.04 per person/year**

Creating a Win Win for both organizations

- Physician
  - Improved patient compliance
  - Dedicated care management staff to provide additional support to patient population
  - Access to community resources
  - Access to Medicaid-funded LTSS provider resources and staff that are experts in serving older adults and persons with disabilities
- CBO
  - Clinical Integration
  - Sustainable Revenue
  - Partnership that supports MCO contracting

How to Get Started

- Identify a target population to start with
- Identify a physician in the practice that will pilot the intervention
- Start with populations that we may be mutually serving
  - Duals
  - HUD Funded Senior Housing
  - Assisted Living Populations
  - Waiver participants
  - Senior Center participants

Scope of Work

- Establish a well defined scope of work
- Outline roles and responsibilities of each party
- Determine a start date
- Obtain commitment from management, physicians, and support staff

Questions