Welcome to TIM Talks:
Establishing CBO-Physician Collaborations to Implement Reimbursable Chronic Care Management Services
March 30, 2017
Chronic Care Management
Contracting Steps with Physician Practices

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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

<table>
<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>
</tr>
<tr>
<td>99487 - Complex CCM</td>
<td>$93.67</td>
<td>Billed each calendar month *only one CCM code can be billed per month</td>
</tr>
<tr>
<td>99489 – Add on per 30 min</td>
<td>$47.01</td>
<td>Billed for each 30 min of additional services beyond the 99487 - 60 min encounter</td>
</tr>
</tbody>
</table>
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
• 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.
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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99487</td>
<td>Complex Chronic Care Management</td>
<td>$93.67 \times 12 = $1,124.04</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>$1,124.04 per person/year</td>
</tr>
</tbody>
</table>
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
• 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