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"The CMS Proposed Rule - What's the CBO role?"

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The CMS Proposed Rule Changes and the Potential Impact on CBOs

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Rule Setting Process – Provider Fee Schedule Changes

- Proposed Ruling
  - Posted July 15, 2016
  - Federal Register / Vol. 81, No. 136
  - Available: https://www.gpo.gov/fdsys/pkg/FR-2016-07-15/pdf/2016-16097.pdf
- Comments
  - Due no later than 5pm. On September 6, 2016
  - In commenting, refer to file code CMS-1654-P
- Final Ruling
  - Anticipated release of Final Rules in November 2016

Proposed Rules Applicable to CBOs

- DSMT Billing Accuracy
- Chronic Care Management (CCM) and Transitional Care Management (TCM)
- Diabetes Prevention Program (DPP)

DSMT

- Diabetes Self-Management Training
- CMS Notes that only 5% of Medicare Beneficiaries with newly diagnosed diabetes used DSMT services
- Input requested on how to overcome barriers to provide the service for eligible beneficiaries

DSMT Issues

- Concerns regarding claims being rejected because of confusion about the credentials of the individuals furnishing DSMT services vs the accredited organization
- Settings about where services are furnished
  - Alternate locations for the delivery of DSMT
- Is the current payment for services adequate?
- Other barriers that CMS is not aware of

Diabetes Prevention Program (DPP)

- DPP is a structured lifestyle intervention that includes
  - Dietary coaching
  - Lifestyle intervention
  - Moderate physical activity
- 16 intensive ”core” sessions in a group-based setting
- Proposed expansion of DPP beginning January 1, 2018
- The CMS proposes to allow CDC-Recognized DPP Organizations to enroll as a Medicare Supplier of DPP beginning January 1, 2017

DPP Eligibility

- A beneficiary having a body mass index (BMI) of 25 or greater (a BMI of 23 or greater for Asian beneficiaries) in addition to a hemoglobin A1c test with a value of 5.7-6.4 percent, or a fasting plasma glucose of 110-125 mg/dL within the last 12 months, or 2-hour plasma glucose of 140-199 mg/dl after the 75 gram oral glucose tolerance test, and no previous diagnosis of diabetes

Site of Service

- CMS seeks comment on allowing service delivery in-person or virtually
- The service would not be considered part of a current telehealth benefit and therefore not submit to current telehealth regulations

Chronic Care Management

- A comparison of Medicare claims data shows that for CY 2015, 275,000 unique Medicare beneficiaries received a CCM service.
  - The average number of services provided is 3
- CCM (Chronic Care Management) - benefit established CY 2015 – Reducing administrative burden
  - CPT Code 99490
  - At least 20 min of clinical staff time per calendar month
  - Beneficiaries must have two or more chronic conditions
  - Must have a comprehensive care plan to address their needs
  - A new G-Code will be established for the provider time

Proposed Changes for CCM

- Recognition and pay for three levels of CCM
  - CPT 99490 – Chronic care management
  - CPT 99487 – Complex chronic care management services
  - CPT 99489 – Each additional 30 min of clinical time during a calendar month providing care management for the beneficiary
- Transitional Care Management
  - The face-to-face visit for TCM qualifies as a “comprehensive” visit for CCM initiation

Behavioral Health Integration (BHI)

- Care Coordination for persons with a behavioral health diagnosis
- Established a new set of proposed G – Codes:
  - GPPP2: Subsequent psychiatric collaborative care management
  - GPPPX: Care management services for behavioral health conditions
  - GPPP1: Initial psychiatric collaborative care management
    - Outreach and engagement
    - Initial assessment
    - Review
    - Development of patient registries

Advancing Care Coordination through Episode Payment Models (EPMs)

- Acute care hospitals in selected MSAs will all participate with few exceptions
- 3 new EPMs
- Cardiac Care Bundles
  - Acute Myocardial Infarction
  - CABG
- SHFFT Model
  - Surgical hip/femur facture treatment episodes

Rule Setting Process – Expanded Bundled Payment

- Proposed Ruling
  - Posted August 2, 2016
  - Federal Register / Vol. 81, No. 148; Part II
  - Available: https://www.gpo.gov/fdsys/pkg/FR-2016-08-02/pdf/2016-17733.pdf
- Comments
  - Due no later than 5pm EDT. On October 3, 2016
  - In commenting, refer to file code CMS-5519-P
- Final Ruling
  - Anticipated release of Final Rules in November 2016

EPMs Will Move Hospitals to Redesign Care

- Increase post-hospitalization follow-up
- Coordinate care across inpatient and post-acute care settings
- Conduct appropriate discharge planning
- Improve adherence to medication regimen
- Reduce readmissions
- Manage chronic conditions that may be related to the EPM
- Choose the appropriate care setting
- Coordinate between all members of the care team to include HCBS providers

Proposed Implementation

- 5 year model - 97 MSAs (Proposed)
- Impact analysis projects the EPMs will result in $170 Million in savings to the Medicare program
- First performance year is proposed to begin July 1, 2017
- Retrospective payment model
- Year 1 – No repayment required
- Years 2 & 3: progressively increasing repayment when the costs exceed the target price (downside risk)
- Years 4 & 5: Move from hospital-based target pricing to regional pricing

Waivers

- SNF 3-day admission rule
  - SNF must be rated 3-stars or higher
  - Beneficiary must be able to exercise their freedom of choice
- Home Visits
  - “Incident to” rule for physician services
  - Licensed staff can provide a home visit in the beneficiary home
- Telehealth
  - Waives the geographic site requirement and permits visits in the home

Eligible Beneficiaries

- Must be enrolled in Medicare Part A and Part B
- Must not have End Stage Renal Disease
- Must not be enrolled in any managed care plan for Medicare benefit coverage
- Beneficiary participates by selecting a participating provider for care

Achieving the Projected Savings

- $170 Million projected in savings to the Medicare program
- Shifting of expenditures from institutional care to home-based care
- Targeting of services to the most appropriate level of need

Key Takeaways

- Hospitals and Providers will be participating in more risk-based contract models
- As providers take on more risk, the more likely they are to engage in a different care delivery model
- Success with these models will require a redesign of standard care
- There will be a shifting towards the greater utilization of home and community-based services
- Prevention of disease and disease-complications are increasingly important

The Potential Role of the CBO

- Prevention
  - DSMT
  - DPP
- Care Coordination / Care Management
  - TCM
  - CCM
  - CCoM – Behavioral Health Integration
- Providers can contract directly with CBOs to support the delivery of these services
- CBOs can become a direct supplier of services or support the provider to deliver these services

Questions