Leveraging Medicare Fee-for-Service Reimbursement to Address Social Determinants of Health

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PYA

The $3.5 Trillion Question

What happens when the buyer wants to buy *health* instead of *healthcare*?

Fee-for-Service Reimbursement

INCENTIVES	▪ Maximize patients ▪ Maximize services
MEASURES	▪ DRGs and APCs ▪ CPTs
REGULATORS	▪ Fraud and abuse laws ▪ Reimbursement rules
PROVIDERS	▪ Silos ▪ Destination orientation
PATIENTS	▪ Unmanaged chronic conditions ▪ Uninvolved in care
RISK	▪ Resides with payer ▪ Increasing costs

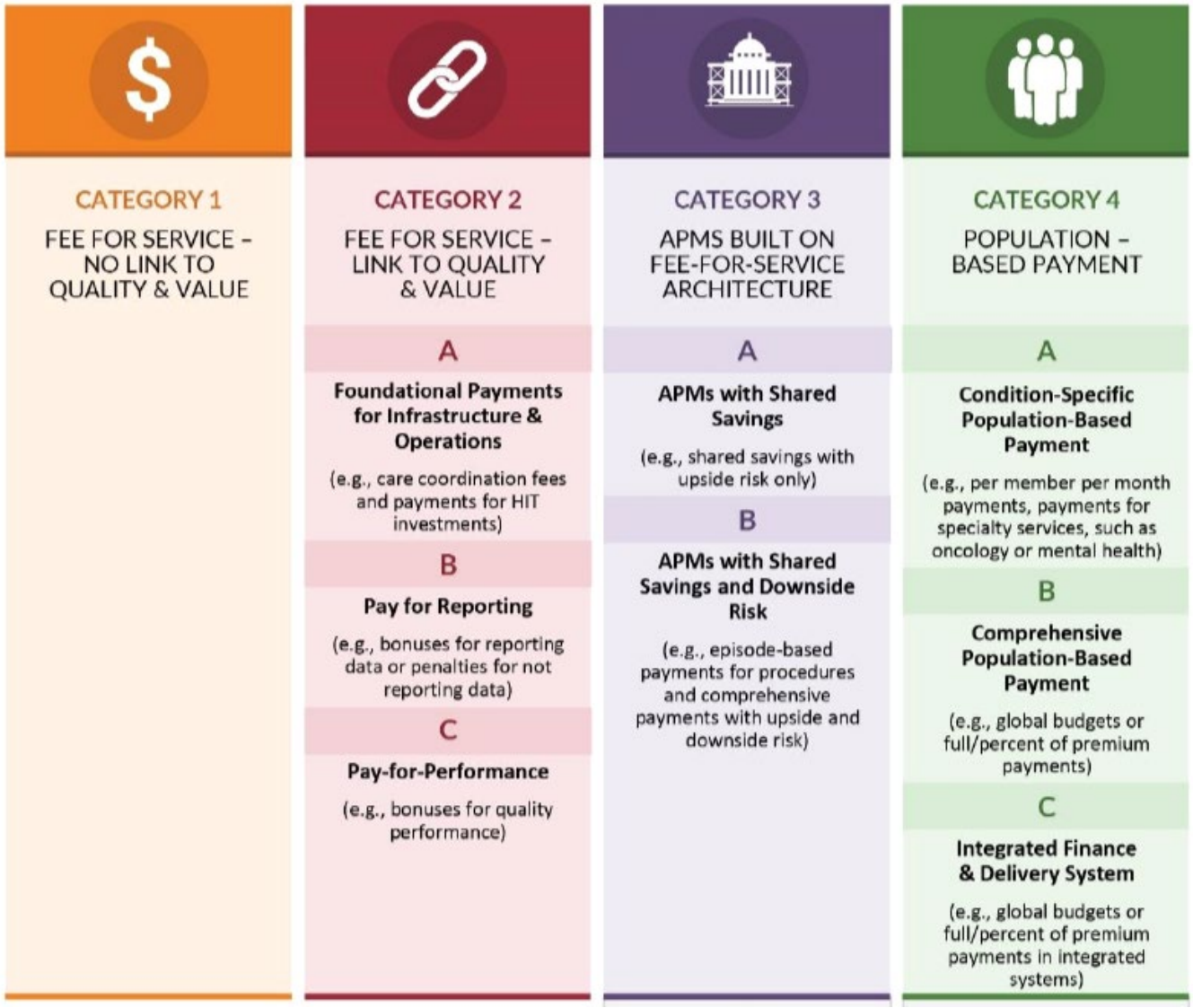
We Get What You Pay For…

- JAMA: Surgical Complications and Hospital Finances (Summer 2013)
  - Analyzed data from 10-hospital system in southern US
  - Surgical complications = higher margins (except Medicaid/self-pay)
  - Substantial adverse near-term financial consequences of reducing overall complication rate
- The CAH and the flu shot clinic

Value-Based Reimbursement

INCENTIVES	▪ Manage patient population ▪ Optimize health
MEASURES	▪ Quality ▪ Efficiency
REGULATORS	▪ Network participation
PROVIDERS	▪ Continuum of care ▪ Retail orientation
PATIENTS	▪ Educated ▪ Engaged
RISK	▪ Moves to providers

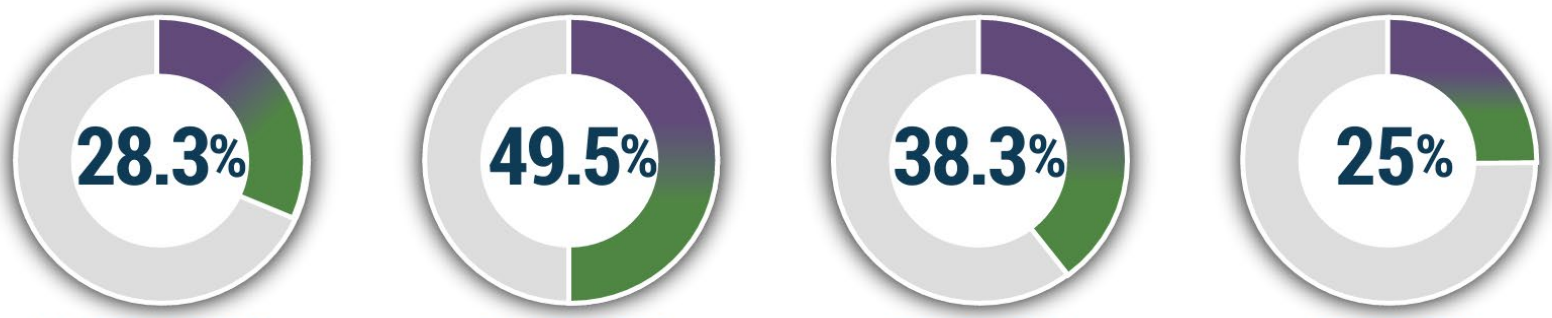
Alternative Payment Models



In **2017,**

34% of U.S. health care payments, representing approximately **226.3 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:



Representativeness of covered lives:
Commercial - 63%
Medicare Advantage - 70%
Medicare FFS - 100%
Medicaid - 50%

HCP LAN
Health Care Payment Learning & Action Network

What Do Payers Think about the Future of APM Adoption?

90% think APM activity will increase

9% think APM activity will stay the same

0% think APM activity will decrease

1% not sure or didn't answer

Categories Payers Feel Will Be Most Impacted

3B **48%**

3A **25%**

Will APM adoption result in...	Strongly Agree/ Agree	Strongly Disagree/ Disagree	Unsure
...better quality of care?	99%	0%	1%
...more affordable care?	89%	2%	9%
...improved care coordination?	97%	1%	2%
...more consolidation among health care providers?	59%	18%	23%
...higher unit prices?	6%	73%	21%

*Top 3 Barriers:

1. Willingness to take on financial risk
2. Ability to operationalize
3. Provider interest/readiness

Top 3 Facilitators:

1. Health plan interest/readiness
2. Purchaser interest/readiness
3. TIE: Provider interest/readiness and government influence

*Please see the Methodology and Results Report and the LAN Insights Report for more information.

Impact on Community Health

- Risk-taking providers focus on high-cost patients
  - Identify through data analytics
- Low hanging fruit
  - Deliver more effective care in more efficient manner
  - Avoidable ER visits and admissions, readmissions, post-acute care
  - *Providers believe they can harvest this fruit on their own*
- Long-term success: keep people healthy
  - *Providers appreciate this will require new partners*

Clinical Integration

Providers accountable to each other and to community to deliver *value* – high-quality care in efficient manner

- Collectively define and enforce standards of care
- Coordinate and manage patient care across the continuum

Clinically Integrated Network

Lean infrastructure to support provider accountability

- Governance
- Management
- Participation

Core Functions

- Evidence-Based Medicine
- Care Coordination
- Care Management

Accountable Care Organization

ACO = entity through which CIN contracts with payers

- Legal structure and administrative operations to satisfy payer requirements
- ACO participants (those bound by payer contract) may include all or subset of CIN participants

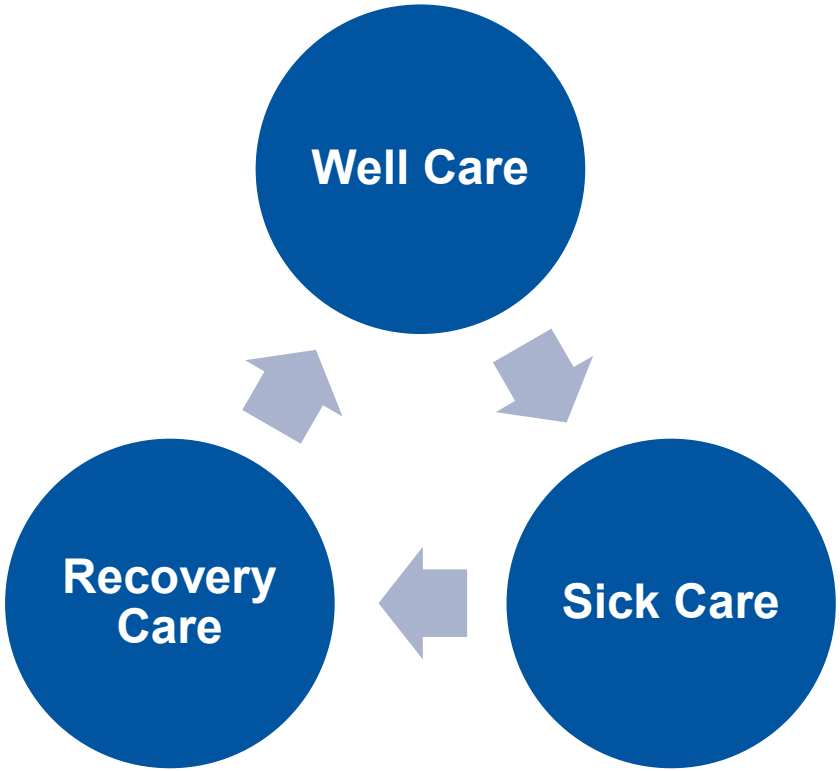
Key ACO functions

- Network adequacy
- Credentialing
- Performance monitoring
- Contract management

Promote Evidence-Based Medicine

- EBM = integrating individual clinical expertise with the best available external clinical evidence from systematic research
- Network provider-approved clinical guidelines
  - Identify (prioritize)
  - Implement (education, technology solutions)
  - Incentivize (financial consequences)
  - Monitor (reporting on quality and efficiency measures)
  - Remediation (including punitive measures)

Facilitate Care Coordination



- Right head in right bed
- Seamless transitions through continuum of care
- Shared health record

Enable Care Management

Identify high-risk and rising-risk patients

- Disease registries
- Data analytics

Aggressive interventions

- Practice transformation
- Ambulatory care management
- Remote patient monitoring

Utilize patient engagement strategies for low-risk patients

Fee-For-Service Population Health Management Services:
Getting Paid Now to Prepare for the Future

Medicare FFS Care Management

Date	Service	Codes	Nat'l Payment Rate
01/01/2013	Transitional Care Management	CPT 99495 CPT99496	$167.04 $236.52
01/01/2015	Chronic Care Management	CPT 99490	$42.84
01/01/2017	Complex CCM Care Plan Development	CPT 99487 CPT 99489 G0506	$94.68 & $47.16 $64.44
01/01/2018	RHC & FQHC billing for CCM	G0511	$62.28
01/01/2019	Remote Patient Monitoring	CPT 99453 CPT 99454 CPT 99457	~$21 ~$69 $51.54

What about Medicare Advantage?

- Must provide same level of benefits
- May provide benefits in two ways
  - Furnish service directly
  - Contract with enrolled provider to deliver service
- Plans providing telephonic support not required to pay for TCM, CCM

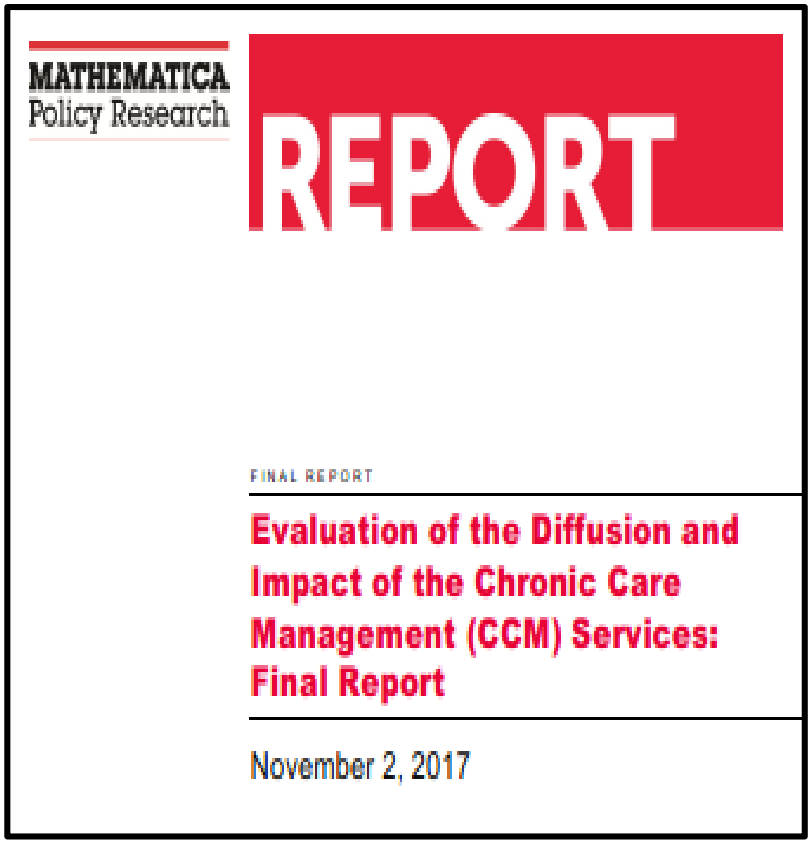
Transitional Care Management

Billing Code	99495 or 99496
Timeline	Face-to-face visit within 7 or 14 days of discharge (billing practitioner)
Patient Eligibility	Discharge from eligible facility (Part A stay)
Required Service Elements	- Communicate within 2 days of discharge - Medication reconciliation and management - Non-face-to-face care management - Medical decision making of moderate or high complexity
Supervision	General

Medicare CCM

CMS' evaluation contractor, Mathematica, analyzed CCM's impact

1. Provider experience
2. Beneficiary experience
3. Total cost of care



Provider Experience

Qualitative interviews with CCM providers

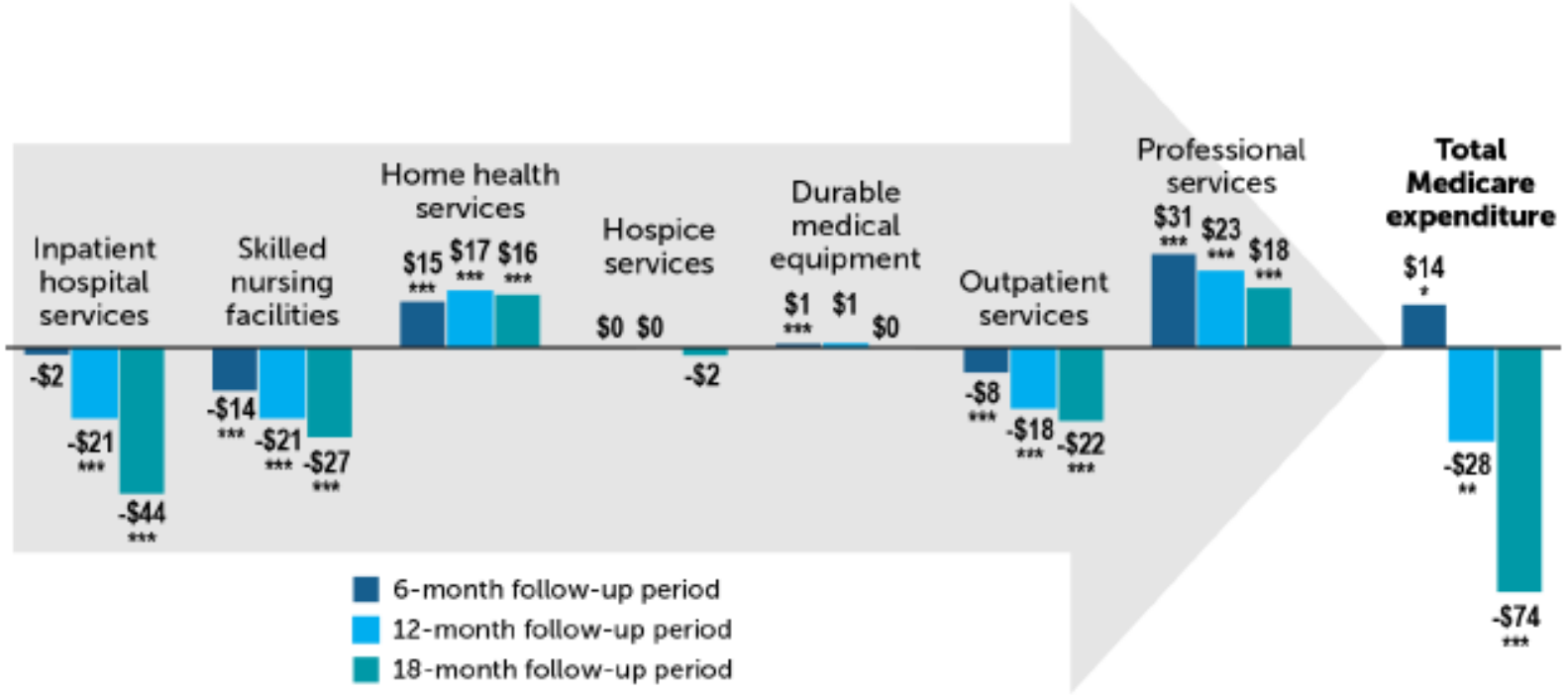
- Enables practice to devote resources necessary to properly manage complex patients
- "[P]atients who consented to CCM have overwhelmingly positive views of CCM services"
- Improved patient satisfaction and compliance
- Decrease in ER visits and hospitalizations

Beneficiary Experience

- Qualitative telephone interviews
  - Improved coordination among providers
  - Improved access to primary care provider
- Data suggests reduction in potentially preventable admissions - diabetes, COPD, CHF, UTI, dehydration, pneumonia

Impact on Total Cost of Care

Figure III.7. Estimated PBPM impact of CCM on total expenditures and by expenditure category: 6-, 12-, and 18-month follow-up periods

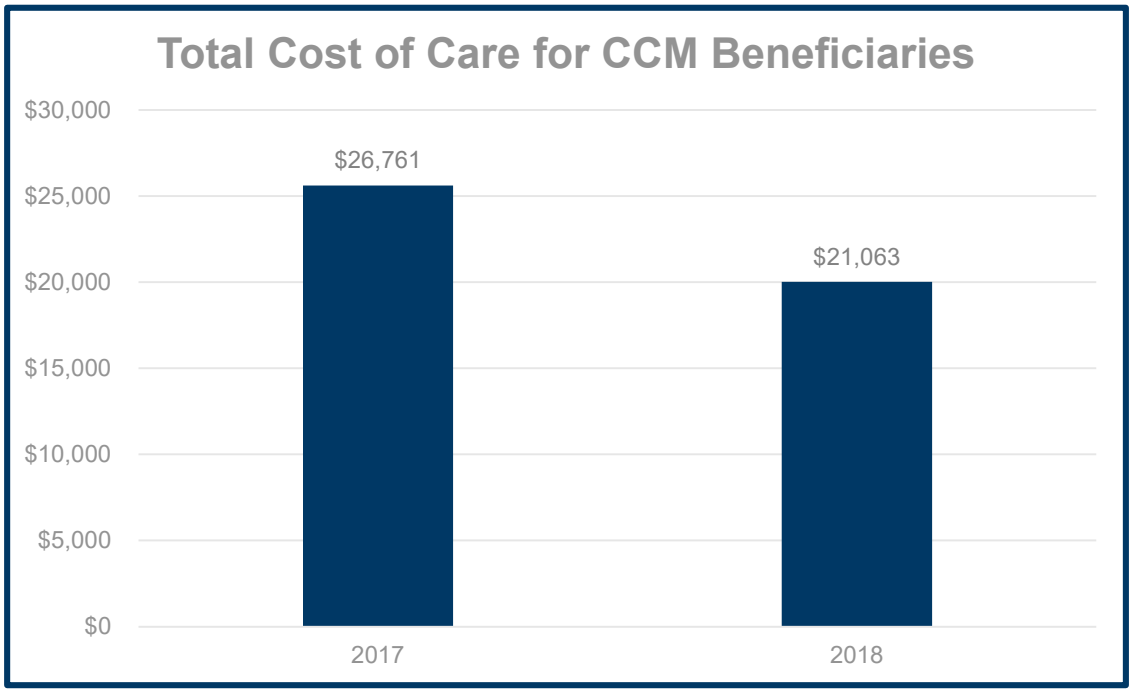


Source: Medicare 2014–2016 enrollment and FFS claims data.

Kansas Clinical Improvement Collaborative

- MSSP ACO including 30+ rural Kansas counties
  - Only KS ACO to earn shared savings in 2017
- Provides centralized CCM services (10 FTE health coaches)
- Have served 2,200 unique traditional Medicare beneficiaries since 2015
  - Analyze MSSP claims data to identify high-risk/high-cost patients
  - Utilize Cerner HealtheIntent to manage patient panels
  - Access practice EHR for documentation and reference

Impact on Total Cost of Care



21.3%
reduction year over year

Compare total cost of care for 2017 and 2018 for 1,579 beneficiaries initiating CCM in 2016 or 2017

Risk Stratification

Category	Value	Score
Age of patient	Less than 65=0, 65-80=1, >80=2	
Number of chronic conditions (minimum of 2)	One point for each condition Max of 5 points	
Hospitalization in the last 12 months – any reason	0 hospitalizations = 0 1-4 inpatient stays = 1 >4 inpatient stays = 2	
ER visits in the last 12 months – any reason	0 Visits = 0 1-5 visits = 1 >5 visits = 2	
Chronic condition diagnosis within the last 2 years	No new diagnosis = 0 1-2 new diagnoses = 1 >3 new diagnoses = 2	
Number of prescription medications taken daily	0-3 prescriptions = 0 4-6 prescriptions = 1 >6 prescriptions = 2	
Number of new daily prescription medications in the last 12 months	1 new prescription = 0 2-3 new prescriptions = 1 >4 new prescriptions = 2	
Hospitalizations in the last 12 months with chronic condition diagnoses	1 point for each primary diagnosis Max of 5 points	
ER visits in the last 12 months with chronic condition diagnoses	1 point for each primary diagnosis Max of 5 points	
Complex social situation creating barriers to treatment plan	None = 0 Complex social situation(s) = 1	
Inpatient rehabilitation stay in the last 12 months	No = 0 Yes = 1	

Total Score _____

Risk Score	Acuity Level
2-7	Low
8-16	Moderate
17-29	High

CPT 99490 – Long Descriptor

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

Key Considerations

1. Billing providers
2. Eligible beneficiaries
3. Consent to receive CCM
4. Five specified capabilities
5. Care management services

1. Billing Providers

- Physician (any specialty), APRN, PA, CNS/CNMW
- Rural Health Clinic
- FQHC

No “Double Dipping”

- Cannot bill for CCM and any of the following during same 30-day period
  - Transitional care management (99495 and 99496)
  - Home health care supervision (G0181)
  - Hospice care supervision (G0182)
  - ESRD services (90951-90970)
- CMS will not pay for more than one provider to furnish CCM in each calendar month

2. Eligible Beneficiaries

- 2+ chronic conditions
  - No definitive list
  - CMS Chronic Condition Warehouse
- Expected to last at least 12 months, or until the death of the patient; place patient at significant risk of death, acute exacerbation/decompensation, or functional decline

Initiating Visit

- If patient has not been seen in the practice in the last 12 months, must discuss CCM as part of a face-to-face visit
  - Not a component of CCM; may be billed separately
- No initiating visit required if patient seen in last 12 months (consent still required)

3. Consent

- Provider cannot bill for CCM unless and until secures beneficiary's consent
  - Documented verbal consent
- If beneficiary revokes consent, cannot bill for CCM after then-current calendar month

Elements of Consent

- **Beneficiary must acknowledge provider has explained:**
  1. **Nature of CCM services and how they are accessed**
  2. **Only one provider at a time can furnish CCM**
  3. **Beneficiary may stop CCM services at any time by revoking consent, effective at end of then-current calendar month**
  4. **Beneficiary responsible for copayment/deductible**

4. Five Specified Capabilities

- Provider must demonstrate following capabilities:
  - A. Use of certified EHR for specified purposes
  - B. Electronic care plan
  - C. Beneficiary access to care
  - D. Transitions of care
  - E. Coordination of care
- Submission of claim = attestation of capabilities

Care Plan Development

- Separate reimbursement under G0506 (~$65.00)
- Clinical staff participates in development; review, revision, and approval by billing practitioner
- No specific time requirement
- Time and effort reported under G0506 cannot be counted toward any other billable service (e.g., monthly CCM service)
- Billed once by billing practitioner when CCM initiated

5. Care Management Services

- Types of services (non-exclusive)
  - Performing medication reconciliation, oversight of beneficiary self-management of medications
  - Ensuring receipt of all recommended preventive services
  - Monitoring beneficiary's condition (physical, mental, social)
- Documentation
  - Date and time (start/stop?)
  - Person furnishing services (with credentials)
  - Brief description of services

20+ Minutes

- 20+ minutes non-face-to-face care management services per calendar month
- Furnished by clinical staff under physician/mid-level general supervision
  - No physical presence requirement
  - Not required to sign notes
- 20 minutes can be aggregated but not rounded up
- May be provided by different individuals, but cannot count double for two staff members providing services at the same time

Complex CCM

- Same as CCM except:
  - Beneficiary's condition necessitates moderate-to-high complexity medical decision making
  - 60 minutes per month, plus add-on code for each additional 30 minutes
    - Cannot bill 99490 in same month

Remote Patient Monitoring

- New in 2019 to reimburse for remote monitoring of beneficiary's physiologic parameters
  - CPT 99453– initial set-up and patient education
  - CPT 99454 – monthly monitoring fee
  - CPT 99457– management services
    - 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
    - Requires direct supervision of clinical staff (vs. general supervision for CCM)
- Rapid advancements in technology

Shared Staffing

- CMS acknowledges providers may not have internal capacity to provide CCM
- Arrangements with 3rd parties permitted
  - Sufficient integration (e.g., use of EHR)
  - Responsibility for key components allocated between parties; billing provider ultimately responsible

Example

Billing Provider

- Secure patient consent
- Provide LHD with remote access to patient's EHR
- Validate care managers' qualifications and competencies
- Respond to care managers' specific inquiries
- Review/approve patient care plan and any revisions
- Address transitions of care
- Provide coordination of care
- Bill and collect; pay negotiated rate to LHD

HCBS Staff

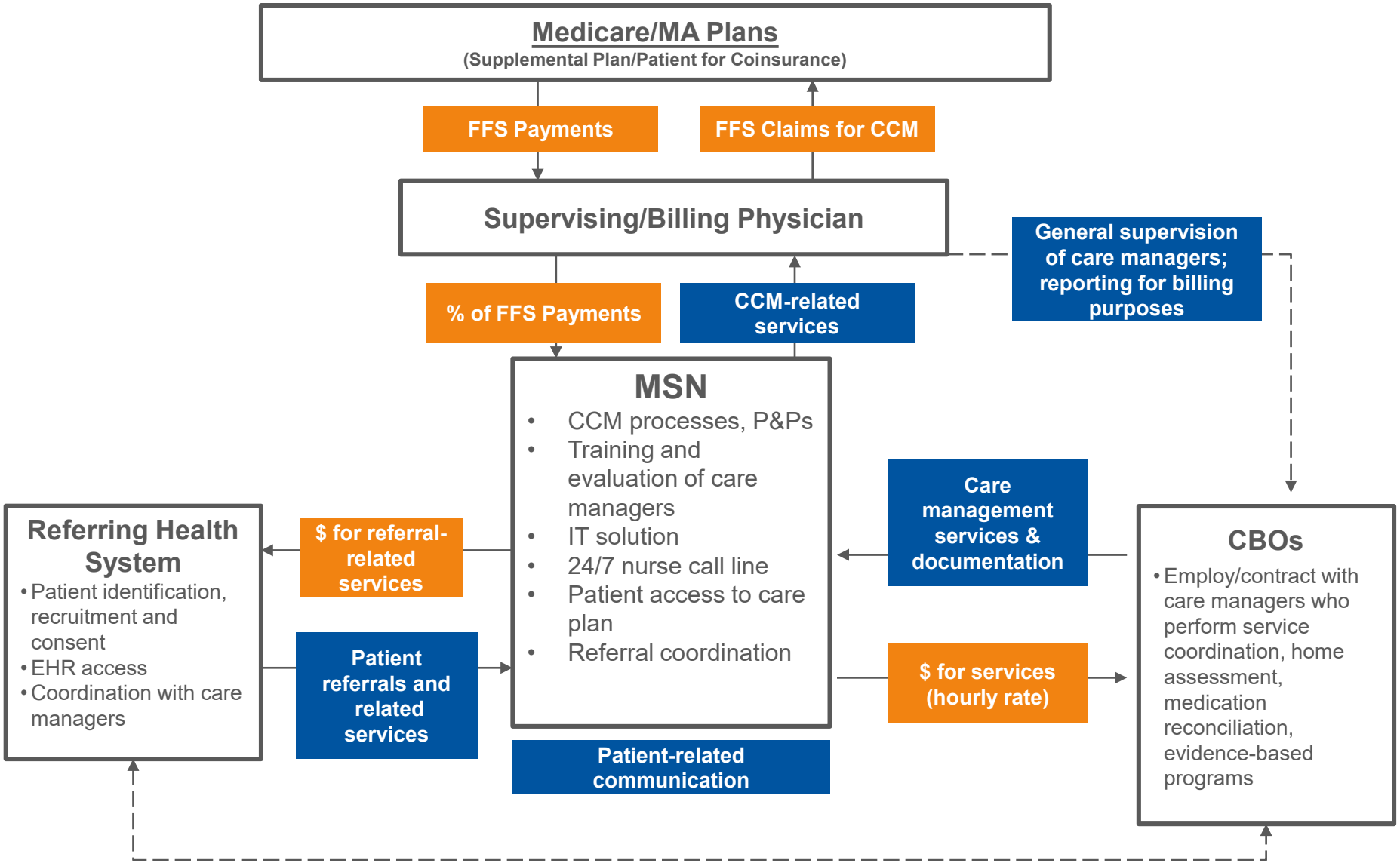
- Provide information sufficient for billing provider to validate qualifications and competencies
- provider's EHR
- Develop draft electronic care plan in provider's EHR
- Deliver ongoing care management services; document in provider's EHR

Sample Agreement

- Contract between HCBS provider and physician practice
  - Independent or hospital-owned
  - RHC or FQHC
- Key assumptions
  - Compliance with Medicare CCM billing rules
  - Practice bills and collects
  - HCBS provider furnishes 20 minutes of care management service under billing practitioner's general supervision
  - Practice pays HCBS provider % of billings

Other Opportunities

- Contracts with payers
  - Medicare Advantage plans
  - Medicaid MCOs
  - Commercial payers
  - Direct employer contracting
- HCBS providers as managed services network
  - Connecting point between providers and community-based organizations


Medicare/MA Plans
(Supplemental Plan/Patient for Coinsurance)
FFS Payments
FFS Claims for CCM
Supervising/Billing Physician
General supervision of care managers; reporting for billing purposes
% of FFS Payments
CCM-related services
MSN
• CCM processes, P&Ps
• Training and evaluation of care managers
• IT solution
• 24/7 nurse call line
• Patient access to care plan
• Referral coordination
Referring Health System
• Patient identification, recruitment and consent
• EHR access
• Coordination with care managers
$ for referral-related services
Patient referrals and related services
Care management services & documentation
$ for services (hourly rate)
Patient-related communication
CBOs
• Employ/contract with care managers who perform service coordination, home assessment, medication reconciliation, evidence-based programs

MA SSBCI

- Medicare Advantage - Special Supplemental Benefits for Chronically Ill
  - MA plan may tailor non-medical benefits to specific needs for beneficiaries with chronic conditions who meet specified criteria
  - Examples: home modification, transportation, nutrition, respite care
- Effective 2020, but plans moving cautiously

Medicaid Health Homes

- Under ACA, states initially receive 90% FMAP for health home program
- Six core services for patients with chronic conditions
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional supports
  - Individual and family supports
  - Referral to community and social supports
- Providers typically paid PMPM for assigned beneficiaries


Next Steps in
Chronic Care
Expanding Innovative
Medicare Benefits
JULY 2019
BIPARTISAN POLICY CENTER

Improving Chronic Care Services in FFS Medicare

- As MA plans gain experience offering SSBCIs, data collected could prove useful in increasing evidence base to support expansion of services to Medicare FFS.
- Expansion of non-medical benefits to Medicare FFS would require congressional action.
- Give HHS authority to pay for evidence-based non-medical benefits for patients with chronic conditions, if:
  - The chronic condition is being managed by an ACO, a comprehensive primary care model, through CCM, or through other payment of delivery models that include a care management component.
- Link to case-management services is critical.
- Recommend HHS consider modifications to risk-adjustment model to better predict medical expenses of Medicare beneficiaries with functional limitations.
- Eliminate beneficiary co-pay for CCM services.

Community-Based Suppliers

- For any new evidence-based benefits for the chronically ill, give Medicare providers a list of suppliers in their area.
- Expand list of qualified providers that can bill for CCM services to include licensed clinical social workers.
- HHS would establish criteria (set standards) for organizations that would be eligible to provide non-medical services.

Function

- Role of functional assessment getting increased attention. Report points out increasing evidence that diagnosis alone does not give a full picture of patient's need for services or cost of providing care.
- CMS would require use of a uniform functional assessment tool to capture chronic conditions and functional status, including cognitive function.
- There are tools available but there is no uniform assessment tool in use across providers or payers.
- BPC report encourages CMS to look to existing tools, such as the California health risk assessment used by Medicaid managed care plans. (10 core questions that address functional and social needs)

Thank You!

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