Idaho Patient Centered Medical Home (PCMH)
Webinar #5 - Chronic Care Management Programs and Solutions: Providing and Getting Paid for Models of Care Management (November 17, 2016)
Transcription

Date: November 17, 2016 **Time:** 2:30 pm E/T

Speaker/Moderator: Nancy Jaeckels Kamp

Notes

Nancy Jaeckels Kamp:

As you see on the learning objective here, what we are doing today is reviewing these new types of payment model opportunities. While I will be touching on care management models and care management requirements, it is all built under the umbrella of some payment model opportunities. I will be reviewing mostly in-depth Chronic Care Management (CCM), but also some on Transitional Care Management (TCM), and the newest Medicare payment codes that have just been approved and will start to be eligible for use in January 2017 around collaborative care.

We will be looking at additional payment model opportunities and understanding the delivery approaches and care team roles that are in these various roles. All of these models are very consistent with things and aligned with things within PCMH in the various standards. You would actually be meeting the standards and more by doing the requirements around many of these models.

The other piece that I do want to mention on that is, before we move on, that just realizing our Medicare payments at this point. Some of you may not have a high Medicare population, but it is pretty significant for CMS to be moving in the direction of these types of bundle payments, or payment around a team approach and a bundle care model verses traditional fee-for-service, where you would have each one of these services or elements broken out into payment models and that it would only be eligible, typically, if it was a billable provider. This is a new approach, a new wave, and typically what happens is when CMS starts these kinds of things it leaves a movement within Medicaid as well as some of the independent payers as well. This is seen as a good sign and useful for you to understand and think about, even if at the end of the day you do not feel as though you have a high enough Medicare population to potentially supply the codes. It is still a model to think about within your own care management and transitions of care integration models.

There are opportunities for some additional funding. We really have to look at our patient population of need; are they eligible, do they meet the criteria, and do we have all of the things in place and can more easily implement this in order to be able to collect that billing for the work that we are doing. As we start looking into this on the first few slides, I just threw in where the actual CMS final rule is, so you could actually see the wording from the final rule and the Current Procedural Terminology (CPT) codes that are now accepted for this. This has been in place for 2015 and 2016; in 2015 it was in place but not eligible with Federally Qualified Health Centers (FQACs) or Rural Health Clinics (RHCs). They did change that in January of 2016; FQACs and RHCs are now eligible for this and there are a few nuances that I will go over in a subsequent slide.

As you see on this particular one, we are talking about the chronic care services; at least 20 minutes of quality care time directed by a physician or quality professional per month. We will go through what that means and what that looks like, and those eligible for this are patients with Medicare and have multiple chronic conditions that are expected to last more than 12 months or until death. These chronic conditions place that patient at significant risk.

For the Medicare payment incentive itself, the average in 2015 was $42.35. I have heard that was relatively close in 2016 and maybe a tad bit higher, maybe around $43 or $44. So maybe, if you look at per Medicaid beneficiary with two chronic conditions or more, there is a potential of $400 a year when you look at those monthly payments, if they were enrolled in a program for 12 consecutive months. You could calculate that amount, and I am going to show you a formula here in a moment.

These CCM payments reimburse the providers for the non-face-to-face services, the nontraditional billable services along care management. This is really a first step looking at different kinds of payment models and risk-based reimbursement in a way to retain and grow Medicare. What are the Benefits to this and why would we do this? Some of the things I already talked about, as far as moving us towards a different type of payment model that is not just paid on a person doing services, but really a team approach in nontraditional ways, or nontraditional billable ways.

Care management is an evidence-based approach to looking at managing your complex patient and your patients that need more than just that periodic ten-minute provider visit. Care management is being done across our organization, and so being able to have at least one payer that is starting to move towards a payment model is going to help us along the way of sustaining the model no matter who we are using that model for. Care management again has been proven in many of the demonstration's projects in other research models and randomized control panels to reduce that costly care for patients with chronic disease.

Mainly showing that change in hospitalizations, readmissions, and Emergency Department (ED) visits, which is the bulk of the high cost of care elements. Also, as all of you know, as you are working towards PCMH recognition, care management, care coordination, and transitions of care are all key areas and standards within the PCMH. So you are working on this already and it is an opportunity to think about whether you can meet the requirements for a CCM payment. If you are already taking on any risk within your manage care contracts or thinking about how to do that this can also add to that model.

Who qualifies? We have talked about this already, but just to re-emphasize – for Medicare patients who have two or more chronic conditions, the chronic conditions place them at significant risk and there needs to be consent to those services. Unfortunately, the copays do apply; they are not exempt in this model; that has been one of the downfalls to the groups that have taken this on already. It is really engaging patients that they are paying copays for services that may not be typical. They are coming in to see their physician, and paying a copay to come in and see their care manager or to talk on the phone to their care manager two or three times a month. They have to consent to that service, which is another piece of the eligibility requirement that I will go over in a moment.

The thing to think about even before jumping into some of the required pieces is; does this even make sense to you from a financial standpoint of pure population eligibility? What we did here was just a very quick example and calculation to give you an idea of thinking about this and looking at your own numbers within your own organization. First is looking at your Medicare beneficiary number; how many patients do you have in your current mode that have Medicare? I just put two examples here, 1,000 and 500, these are just two examples of applying the same elements or criteria to two different denominators. If you have 1,000 beneficiaries in your patient panel and you look at how many of those would have two or more chronic conditions.

Hopefully, you have the ability to look in your Electronic Health Record (EHR), claims system, or practice management system to pull that number out. If you do not, what I have put here is just looking at what CMS predicts was their average of their Medicare beneficiaries that have two or more chronic conditions. CMS says that there are 40% to 60% across the country of their beneficiaries that have two or more chronic conditions. We just took the average and made that 50%. If you made an assumption of your 1,000 Medicare patients in your panel, 500 of them have two or more chronic conditions. Then you go and apply the new filter of gaining consent for the program and you have to have written consent. We have example consent forms that we have written as we have helped

organizations put this model into place. You have that consent and can walk the patient through it and have them sign it, and we have to have permanent and retrievable capability of that signed consent.

You are going to have some folks that are going to say “I do not want this, I am not signing up for this, and I am not going to pay the copays.” We just looked at an assessment of 70% of the eligible patients that we were talking about with this program are going to consent; that would be 350 of the 500. Then we simply applied the average 2015 monthly billing, which was $42.64; you can calculate it as a six-month or a twelve-month. Thinking that not everyone is going to join in January, they are going to join in different times of the year. Just giving you a feel for what would be the range of potential reimbursement totals that you could bring in for those patients. This formal is just there to help explain that and for you all to use this to think about your own populations, calculating your own numbers, estimating what you can, and saying does this make sense for us to do.

Of course, everything is not just about the reimbursement that you are bringing in, but you also have to consider the cost going out. That range of reimbursement totals that I just listed at the bottom of the last page needs to cover these costs, and the two main costs would be making sure that your EHR has the capabilities to meet the requirements of billing, collecting the information that needs to be collected in the 20 minutes-a-month and tracking that time element, and having an electronic care plan. That care manager is going to provide that engagement of the patient, getting the consent signed, and then continuing to contact them and provide that 20 minutes of care management a month. So you are thinking about who could fill that role; what are your average salaries for those roles and what do you think about that in terms of your potential reimbursement that you figured out in the previous table? Really think about if this model makes sense to you from a financial standpoint.

There are a few billing nuances here to show you; there is a specific CPT code that will need to be turned on. There are four different types of providers that can bill for this; they are listed here. Billing for that means that if the code gets billed under their provider code, they do not have to perform the work. The nuance there is that the care manager on their team is taking care of those 20 minutes plus of that care management per month. We will talk through what 20 minutes of care management looks like as well. You can only bill one CCM fee a month per patient, so it is really a bundled reimbursement in a bundled payment for a month of services. You may not do all 20 minutes at a time with a patient, you may call that patient twice in that month or have two ten-minute sessions and that would meet that requirement. You are still billing once a month for that patient.

If, in your organization, you have a larger organization and you are using some sort of centralized CCM so that the care managers are not in the practice itself, that can still apply for the CCM payment if there is documentation and coordination connected into the practice. The billing still has to be generated from that billable provider within the practice. Later on, I will state this here too, because many of you are FQHC or RHC this does not apply. You have to have your care management within the practice in a FQHC or RHC in order to bill for it. If you are part of a Medical Shared Savings Plan (MSSP), you can still bill for CCM but it does apply to your total amount spent in your MSSP contract. If you are a MSSP contract, you will know what I am talking about. You do not need to be PCMH recognized to bill for CCM either, but clearly meeting CCM requirements helps you to get to your PCMH standard requirements. We will talk about CCM in a moment, because there is a separate code for that.

What needs to be done, and this is just a high level overview, we will go over each one. We need that eligible beneficiary to sign a written consent and keep that. We have five capabilities of CCM that I was talking about in high level detail earlier: your certified EHR; you are maintaining your electronic care plan with 24-hour access; facilitation of any transitions for that patient and coordination of care. In addition to those capabilities, you have that 20-plus minutes, but it does not have to be face-to-face; it can be telephonic or televideo with a care manager and all of this work with monitoring and documentation and tracking of these patients over time. If you are working within your PCMH recognition and your MU standards, you already have most of this or are working towards getting most

of this in place. So your EHR is certified for MU, again maintaining a comprehensive electronic care plan, which we will talk a little bit through regarding what needs to be on that care plan. But the point of this capability is that it has to be electronic and we have to be able to have access to that and have access from the beneficiary to their care plan, as well as other providers of care. To facilitate transitions of care for those beneficiaries and coordinate their care, which dives into the 20 minutes of care management documentation of that within that EHR.

Again, storing the signed eligibility consent permantly and retreavably is an important aspect to this document and retreaving the notes; so if we are calling that patient and doing that care management by the phone, how are we documenting those none visits and tracking that with a time connected with that? Having that full assessment and care plan created into the EHR and applying to submit that electronically for purposes of coordination. If the hospital or ED calls and says “we have x, y, and z patient here,” we have the ability to send over that patient’s most up to date care plan to the ED and that can help the ED provider better access that patient. Electronic care plan in a little more detail: let’s have this developed and regularly updated.

Accessible, like we talked about before, and the plan needs to include a list of your practionaries that are regularly involved in providing medical health care for this patient and also an assessment of their functional status related in proven medical health care for this patient and to those chronic health conditions that they have. We are working on within the care management model and an assessment whether limitations or health conditions would impair self-management and an assessment of prevent care needs. Care plans should address all health issues not just their chronic conditions. When you think about this, this is very consistent with the PCMH standard and requirement around the health risk assessment question and the health risk assessment is not just about preventive care needs. It is not just about their diabetes care needs. We have to look across and look at other social determinates, behavioral health amongst daily functions that could impair their ability to self-manage and fulfill whatever the care planner treatment is that the provider is working on with them. Then provide the paper electronic availability to the patient. So, if you have a portal, that is a great way to do it and again consistent with much of what is under those PCMH standards as well.

Access to care: we have talked about this a couple different times; it is just listed out here very specifically to the CCM and access to the member of the care team 24/7. Continuity of successive appointments with designated provider or member of the care team. If I need to get in with five days of this last ED visit, I want to see the provider that I have been seeing so that there is continuity in that care, and not just access to whoever has an opening on their schedule. Then that person may not have that full picture of the patient and may not have a relationship with that patient. This is really enhancing that access model and then also having enhanced opportunities for the patient to have communication. So alternative methods for the patient to have communication.

Transition of care in the CCM: it talks about how the provider must have capabilities to follow up after an emergency room visit and a discharge, coordinating referrals to other clinicians if that was part of that discharge or part of the next step needs, share information electronically with any of the other clinicians that the patient has been referred to or has seen, and coordinate with home and any community-based clinical services, provided to meet their needs. Part of these pieces need to be coordinated, and part of that CCM role, and there is also a TCM role that we will talk about that takes these components and dives much deeper into a 30-day follow-up with those patients that have just been discharged from the hospital.

That care coordination and care management that we have talked about, that 20 minutes of non-face-to-face - one of the things that Medicare says can be part of those 20 minutes. So we can think about if we are talking with patients that have multiple chronic conditions, one of the typical things that we are going to do is view their medications with them and find out how they are taking their meds and if they have questions about their meds. That is a routine kind of piece to continue to do during those care management calls or contacts. Always reviewing to see if they are doing any kind of preventive

services and also doing any kind of regular monitoring of their chronic conditions. If they have diabetes when was their last A1C level done? Are they in need of that? If they just had it done a few months ago, what were the results and how do we help them move forward? Are they doing their daily blood sugars and what are those looking like? What is their latest blood pressure, what was their latest PHQ9? So a general monitoring of the patient's condition. As well as part of this 20 minutes could be things like education, addressing questions of the patients and family. Helping them arrange other community resources and communications and coordination with referrals of other providers.

Those pieces in the last two slides emcompass a lot of different task that can be expected in the 20 minutes plus each month. Some people get anxious about that 20 minutes and what can they do and what is legitimate about documenting what you did. As you can see from those bulletins on the previous two slides, it is a broad array of things that we would talk about with our chronic diease patients. It really is around having a good documentation system, a registry or some kind of care management documentation that you can document both your time and what was discussed during that time. That will meet that requirement of documentation and time.

They are really going to look at how you spent that 20 minutes, and in my experience, in any type of care management that I have done, have not been tough to do, to meet that time requirement and covering those types of topics. The FQHC and RHC eligibility that started in January 2016: identifying your eligible populations, you probably have a lower Medicare or dual eligible patient population. You still need to obtain consent and include an HRA, but that needs to be done during the annual wellness visit if you are an FQHC or RHC. The 20 minutes of care management has to be done in the organization itself under the supervision of the provider. So that you can have that sort of centralized care management model and documentation and connection back to the primary practice or primary provider in the practice but it actually has to be in that practice under the supervision of the provider. The 20 minutes needs to include establishing, implementing, and revising the care plan, which is also very consistent.

What does TCM look like and how does it relate to CCM? Some of you that I have talked to have implemented TCM and chose to implement that versus the CCM. Some are looking to do both, and thinking about which one to start with. I do not think there is a magic answer per se; I think there are some pros and cons to organizations that have done it both ways. TCM is purely a transitional care management, so it is purely time limited to the 30 days post discharge. There are different codes for TCM and CCM; the patients also need to be at a moderate or high risk for these services in use for these codes to be used. You may have patients that have two chronic conditions and are Medicare beneficiaries; so they are eligible for CCM, but they might be quite well managed within their chronic diseases and not have other social disorders or any behavioral health conditions. They may go into the hospitals for an elective knee replacement and not be at that need for moderate or high risk abound discharge.

Also you cannot code a CCM in the same month as that 30-day post discharge if the TCM is being billed. If you are doing both, you need to think about what you are billing the first 30 days and meeting those requirements for TCM. Ater those 30 days are up, if this patient is qualified for CCM, there can be a warm hand off for transition to the CCM coordinator or, if the CCM is the same person, they would continue on with the CCM requirements as I just reviewed them and the following month you could start billing the CCM fee. Caution people on making sure that your hospital is not going TCM and billing for the TCM rate already. They sometimes have transition nurses or navigators and then they are doing this and billing TCM as source revenue for their transitions work and Medicare will only accept one TCM bill on that patient. Knowing what is going on within your hospitals is a good thing before you are embarking on your own TCM model.

There are additional benefits to thinking through all of these different payment models. As I said before, it puts an increased focus on your Medicare patients, and it helps to build steps towards eventual risk-based payments and thinking about alternative payment methodologies; not just thinking

that all of these patients have to come in and see Nurse Practionar (PA) or the Physician. This service is a service that can be part of your team base care and can be perfectly delivered and probably bettered delivered by folks that are specifically skilled and in trained to doing this kind of behavioral health activation and motivational interviewing, self-management, and goal settings. It retains patients with more costumer services or costumer needs. This also gives you the opportunity if you have not looked at alternate payment models yet and have not started thinking or talk with your manage care organization or any other contracts or types of payers. When you start looking at those you are going to want to have leverage in those negotiating discussions to say we have some of this already in place and we could serve your patients and your patient population better.

We are willing to take on some risk in that and we are willing to say we can accomplish so kinds of goals. You cannot do that if you do not have these kinds of models in place and you have started some of the piloting of that. Using the TCM and CCM models, requirements, and reimbursement to help build that program and withstand it and show some impact of it. Then that helps to give you some negotiating leverage when you are talking with your payers as well. As I have said all along, it is in total alignment with what you would need to build within your PCMH recognition. It is only going to get more intense on care management models and behavioral health integration models when you are looking at 2017 PCMH standards.

This last slide is around the latest Medicaid codes or collaborative care and behavioral health integration. This is really exciting to me because it is an area I have worked in for a very long time and have worked on alternative payment care models in individual states, because there is such a plethora of this kind of collaborative care model, showing great impact on patient outcome. For us not to have a billing code and a way to reimburse for this highly effective evidence based model has been something that I have been frustrated with and been working with for a decade. I was very excited when Medicare had a focus group working on this. Experts have really been leading these studies and working this past decade plus. They came up with these definitions that are very close to the collaborative care model and now have two sets of codes that can be used as of January 1, 2017.

Mainly, the first code is an initial assessment in care management, and the reason it talks about initial psychiatric collaborative care management because this is the collaborative care model where you have a care manager that is not a billable provider. Just like in TCM and CCM, that person is doing regular outreach and engagement with patients with behavioral health needs. In addition to those ongoing outreaches to the patients is also making routine connections with the psychiatric consultant and talking through the patients on their registry that are not making improvements. Much of that can be med-managed, which is why we have a psychiatrist of NP consultation. It also helps to guide the PCPs in learning much more about how to treat these kinds of conditions and be comfortable with those kinds of treatment interventions.

That initial month has a higher billing code, a higher amount of reimbursement in that billing code than that initial billing code used to have. That initial contact and initial care management with that patient. It takes more time that first month. The next slide shows the ongoing subsequent month; it is a different code; it is a smaller amount but I will tell you that the folks on the panel that were advising CMS were pushing very hard to keep this number still high. There is still a lot of work going on that the care manager is doing more than 20 minutes a month and also connecting with that consulting psychiatrist about things every month, too. Which also adds into their reimbursement amount.

So it is not just direct patient and care management time, but it is that whole team time? These bullets on the slide came right out of the state registry; we are actually summarizing them down to a smaller white paper, which I think I shared with some of you previously in my coaching but it was not finalized yet. Now it is finalized and we are working on shrinking that down into a more manageable white paper.

Questions	Answers
Wanda – At the very beginning of the presentation, you were talking about CCM and I was wondering about a good example or maybe you could give us some advice on how we would actually build for that copay? If the CCM worked non-face-to-face are we expected to send out a bill and then talk that through with the patient at the time of the consent signature, or how is that expected to be billed?	Nancy Kamp – So you are going to bill Medicare that CPT code, but you do have to bill a copay just like you have any other copays at the time of the visit and you definitely want to talk that through. That is going to be part of the consent process that they sign. I do not know, Wanda, did I ever share that with you, a draft of a consent?
Wanda – Yes and we have that. I guess my wording was just that any of our patients that do qualify for the CCM work, I would be worried that they were really surprised that they got a bill in the mail for something that they did not see the provider or nurse for. I know that we would review that at the time that they signed the consent. I am just envisioning that monthly copay going out and I do not know how that would be received.	Nancy Kamp – Yes, it is the stickler of this whole thing and there is no doubt about it. I have worked in a model like this where we had to implement the copays for Medicare and some groups tried not to wave the copay and you cannot; that is illegal. Some tried to fund it through charity fund and Medicare said “no” to that. The collaborative codes that just came out, again, that advisory group tried to push so hard with CMS to let go of the copay, especially in those behavioral health patients and they would not do it.
To bill for the BHI, do they have to be enrolled in CCM too?	Nancy Kamp – No, two different programs.