Welcome to TIM Talks: Chronic Care Management (CCM) - Moving from Planning to Implementation
June 22, 2017
CCM in the Market place

Customers for CCM Services:
- Health Systems that want to reduce readmissions
- ACOs
- Health System-Owned Physician Practices
- Multi-Specialty Practices
- Physician Groups participating in bundled payment
Identify the Win-Win

• Provider
  – Additional care management resources to support the patient population
  – Extending disease self-management and lifestyle changing efforts beyond the clinic to the community
  – Support to address MIPS, ACO Measures, and Cost containment

• CBO
  – Profit center within my organization
  – Direct referral source for evidence-based programs
  – Best practice model that can be replicated to other customers in the market
Target Population: Payer

- **Beneficiaries with Medicare Part B:**
  - Emphasis on Dual Eligible Beneficiaries
    - Data shows significant increase in cost and disease burden associated with dual-eligible status
  - Emphasis on persons with four or more chronic conditions
    - Data shows significant increase in costs for any beneficiary with four or more chronic conditions

- **Medicare Advantage Beneficiaries:**
  - Emphasis on persons receiving a low-income subsidy
    - CMS study shows direct correlation between low-income subsidy status and performance on HEDIS measure outcome
Target Population: Disease Groups

• Diseases that are impacted by lifestyle choices
  – Diabetes
  – Heart Disease / Heart Failure

• Populations impacted by social determinants of health
  – Low-Income
  – Minority
  – Rural

• Populations that have a primary or secondary diagnosis of depression
  – WHO: Depression is the leading cause of disability worldwide
Pilot the Process

- Identify One Provider within the organization to test the process
  - Seek out a champion
  - Develop a model of sharing clinical data
  - Establish a process of targeting the participants
  - CBO and Provider gain knowledge of the culture of the business
  - Embed a health coach within the practice
Key Factors

- Business Associate Agreement
- HIPAA Training of embedded personnel
- HIPAA Training for CBO staff supporting the project
- Health IT system
- Data exchange
- Bi-directional referral patterns
- Person-Centered Planning Process
Financial Considerations

- Total number of eligible patients
- Mutual expectations regarding referral volume
- Break-even point
- Charge capture process
- Revenue cycle management
Tracking Performance: Establish Mutual Expectations

- **Financial**
  - Number of enrolled clients
  - Services provided per beneficiary per month
  - Billing generated per coach
  - Aggregate billing per beneficiary per month
  - Aggregate billing per population
  - Administrative Fees
  - Billing cycle
  - Invoice timeline
Tracking Performance: Establish Mutual Expectations

• Clinical
  – Primary diagnosis
    • Depression status
    • Malnutrition
  – Readiness for change
  – Need for social services
  – Homebound status
  – Dual-eligible status
  – Medicaid Waiver enrollment / Managed LTSS
  – OAA services
  – Veteran Status
    • VA Choice / VD-HCBS
Embedded Health Coach Qualifications

- Develop a personnel file for each Coach
  - Job Description / Resume
  - Background check
  - Training
  - HIPAA / Confidentiality statement
  - TB testing / MMR / Flu

- Recommended Training
  - HIPAA
  - Motivational Interviewing
  - Disease Self-Management skills
  - Abuse, Neglect, Exploitation / Mandatory Reporting
Key Practice Personnel

• Embedded Health Coach and the Program Administrator must establish a relationship with the following key personnel:
  – Practice Manager
  – Front Desk Personnel
  – Scheduler
  – Practice Care Coordinator
  – Billing Staff
Health Coach Routine - Prep

• Review the schedule for the week
  – Appointment Reason
  – Payer / Insurance Status
  – Co-insurance (Medicaid, AARP / UHC, etc.)
• Daily assess the schedule for changes
• Coordinate with Practice Care Coordinator to target patients based on the schedule
• Report the daily list of potential clients to enroll
Health Coach Routine – Daily Operations

- Coordinate with front desk to greet clients prior to their provider appointment
- Introduce the program using defined script agreed upon by the practice administrator and the CBO
- Assess consumer willingness to participate
- Support the development of a person-centered plan
- Report the enrollment and person-centered plan to the provider
- Obtain endorsement from the provider for client engagement
- Document
  - Person-Centered Plan
  - Verbal Consent
Person-Centered Planning Key Elements

• Person-Centered Plan should span 12 Months

• Needs
  – Medical
  – Social
  – Psycho-social

• Interventions
  – Preventive Health appt. schedule
  – Evidence-based programs
  – Individual Health Coaching

• Cultural Factors impacting health

• Social Determinants
Health Coach Routine – End of Day

• Record number of enrolled compared with potential eligible
• Compare enrollment to daily enrollment quota target
• Record financial and clinical quality measures
  – Primary Diagnosis
  – Depression Status
  – Dual-Eligible Status
  – Veteran Status
  – Social Service Needs
  – Zip Code or residence
  – Enrollment in Medicaid Waiver / Managed LTSS
CBO Administrator Tasks - Administrative

- Daily assess status of meeting enrollment goals
- Identify barriers to enrollment and discuss them with the practice manager
- Assess the demographics of the population enrolled to determine if the program is reaching the target population
- Assess for monthly services provided to each beneficiary
- Monitor enrollment in programs provided by the CBO
  - Evidence-based programs
  - OAA Services
  - Senior Center Programs
  - Social Service Programs
CBO Administrator Tasks - Financial

- Monitor billing
  - Billing per beneficiary
  - Aggregate billing for the program
  - Billing compared to costs
  - Reconciled billing
  - Revenue-Cycle timeline
  - Daily enrollments
  - Productivity of embedded coach
  - Cost of the embedded coach compared to enrollment numbers
12-Month CCM Service Plan

• In-Home Assessment to determine risk
  – Assess for Fall Risks
  – Review Medications and document findings
    • OTC
    • Use of Herbal Medication
    • Adherence to Prescribed Medication Regimen
• Enrollment in scheduled Evidence-based programs
• Preventive Health appt. schedule
• Coordination with specialists
• Person-Centered Plan should support the person with completing all applicable evidence-based programs
• Health Coaching model supports the consumer with completion of planned participation in evidence-based programs
• Health coaching and individual participation in monthly evidence-based programs must be documented for each individual consumer – even if participant attends a group intervention
Sample Plan Using Evidence-based Interventions

- 68 y/o female. Widow and lives alone. Dual-Eligible. Dx Diabetes, CHF, Depression. Not receiving Medicaid waiver. Hx of recent fall
  - Enhanced Wellness – Evidence-Based Health Coaching Program
  - Fall Prevention Program (Matter of Balance, Stepping On, etc.)
  - In-Home assessment for fall-risk and medication review
  - CDSMP
  - PEARLS – Depression management
  - Enrollment in Medicaid Waiver for home-delivered meals and adult day-health
  - Coordination of transportation to a DSMT / MNT class

- MNT / DSMT will be billed separately from CCM
• CCM and Behavioral Health Integration services can be billed on the same consumer, during the same month

• Eligibility for Behavioral Health Integration
  – Any Behavioral Health Condition
  – WHO: Depression is the leading cause of disability worldwide
  – Depression is a common co-morbidity of diabetes and heart disease

• Services must be documented separately for each intervention
Track Value-Added Benefits to the Practice

- Adherence to Medical Office Visit Prevention Schedule
  - Four Preventive Health Visits per year + sick visits ($$$)
  - Annual Wellness Visit ($175 first year, $99 thereafter)
    - Health Coach can support completion of Annual Wellness Visits
- CCM Support of Tele-Health Services
  - Geographic Restrictions on Tele-Health are lifted for the following beneficiaries:
    - Participants in a bundled payment program, during the episode of care
    - Consumers in a Next Generation ACO
Is there a Bundled Payment Program Near You?

Source: Centers for Medicare & Medicaid Services
CCM Implementation:

CONTRACT MODELS
Contract Models

- **Model #1**: Clinical Integration with one individual Medicare Provider

- **Model #2**: Contract with an organization that can bill Medicare and support multiple providers in a market

- **Model #3**: Become a direct Medicare provider with the appropriate infrastructure to deliver CCM services
MODEL #1:  
CLINICAL INTEGRATION WITH ONE INDIVIDUAL MEDICARE PROVIDER
Contract Model

- Individual Contract with an individual provider / group practice to provide CCM services as a third-party care management organization
- Contract defines the services, cost of services, and expected payment schedule
  - Admin costs should be limited to 10% or less
- CBO provides the services and documents in the E.H.R of the provider
- Provider submits claims to insurance
- Provider and CBO reconcile with the collections department on a regular schedule.
Pros vs Cons

• Pros
  – Ability to quickly start
  – Ready source of consumers
  – Sets precedence and marketing material for other practices

• Cons
  – Agreement is limited to one individual provider and will require separate agreements with every other individual provider
  – Embedded Health Coaches and staff will have to learn and adopt the E.H.R for each contracted provider
  – Increased administrative costs to manage and track services with multiple systems and multiple providers
Financial Considerations

• Agreement limited to one practice and the billing is limited to that provider’s capacity
• Track claims submission, denials, aging report
• Increased administrative costs to the CBO if this contract model is replicated to multiple practices in the market
• Training costs associated with staff use of multiple IT systems
MODEL #2: CONTRACT WITH A ORGANIZATION THAT CAN BILL MEDICARE AND SUPPORT MULTIPLE PROVIDERS IN A MARKET
Contract Model

• Contract with an established Medicare Provider or Management Service Organization (MSO) that has the capacity to work with multiple providers in the market

• MSO should provide
  – E.H.R platform that integrates with multiple providers
  – Revenue Cycle Management
  – Reporting / Population Health Mgmt.

• MSO will take an administrative fee
  – Range is 20% - 45%
  – MSO accepts the risk, liability, and IT costs
Pros vs Cons

• Pros
  – Ability to integrate with multiple providers in the market using one IT system platform
  – Risk and liability are borne by the MSO
  – Lower administrative costs related to the use of one IT platform, one tracking system, one claims management process, and one reporting venue

• Cons
  – Increased costs associated with the MSO fee
  – MSO must be flexible and agreeable to modify IT platform to meet the needs of the provider and CBO
Financial Considerations

- MSO entity provides at least one qualifying visit with the beneficiary
  - Annual Wellness Visit
  - TCM
  - In-home primary care / Preventive Health visit
- MSO enrolls the consumer
- CBO supports the completion of the person-centered plan
- CBO implements the person-centered plan
- CBO and MSO work collaboratively to increase client compliance with primary and specialty care appts. and preventive health appt. schedule
MODEL #3: BECOME A DIRECT MEDICARE PROVIDER WITH THE APPROPRIATE INFRASTRUCTURE TO DELIVER CCM SERVICES
Contract Model

- CBO becomes the provider
- CBO bears 100% of the risk and costs of the program
- CBO keeps 100% of collections
- CBO must establish a process to complete a qualifying visit for each consumer and have the appropriate personnel that are eligible to deliver the qualifying visit
Pros Vs Cons

- **Pros**
  - CBO keeps 100% of collections
  - CBO does not have to negotiate with third parties for program
  - CBO can immediately target current client base for services

- **Cons**
  - CBO bears 100% of the risk and liability
  - CBO must establish a process for revenue-cycle management
  - CBO must bear 100% of the costs of the Health IT system and system integration costs
  - Higher upfront costs and risk to the CBO
  - Lack of economies of scale
Financial Considerations

- Malpractice liability
- Cyber Insurance
- Health IT system costs
- Revenue-cycle management costs
- HIPAA compliance
- Referral sources
- IT integration with providers in the marketplace