Advisory Board

Medicare (CMS) Patient Activation Strategies

July 25, 2017

ROAD MAP

1. Chronic Care Management Basics - Review
2. Transitional Care Management Basics - Review
3. Patient Liability
4. Strategies for Patient Activation

Chronic Care Management (CCM) Services

Care Coordination for Medicare Beneficiaries

CMS.gov
Centers for Medicare & Medicaid Services

CPT 99490

Chronic Care Management Services

(Non-Complex)

CPT 99487

Complex Chronic Care Management Services

CPT 99489

Each additional 30 minutes of staff time

CCM Program Basics

On January 1st, 2015, Chronic Care Management (CCM) services (CPT 99490) became reimbursable via Medicare.

Patients with 2+ chronic conditions must be provided 20 minutes or more of non-face-to-face CCM services within a 30 day period**.**

Qualifying Conditions

- ✓ Expected to last at least 12 months, or until death of patient
- ✓ Place patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

Qualifying Services

- ✓ Phone calls and emails with patient
- ✓ Coordination of care (by phone or other electronic communication, but not fax) with other clinicians, facilities, community resources, and caregivers
- ✓ Time spent on prescription management and medication reconciliation
- ✓ Time spent reviewing physiologic data from patient monitoring devices (provided it is not billed elsewhere)

Qualifying Providers

- ✓ Physicians
- ✓ Certified Nurse Midwives
- ✓ Clinical Nurse Specialists
- ✓ Nurse Practitioners
- ✓ Physician Assistants
- ✓ …and only one practitioner may be paid for the CCM service for a given calendar month

CCM and Complex CCM Basics

What

- CCM or non-complex, and Complex CCM services share common service elements but differ in the amount of clinical service staff time provided; the involvement and work of the billing practitioner; and the extent of care planning performed

- The CCM service is extensive and includes:
  - ✓ structured recording of patient health information
  - ✓ requires an EHR for a comprehensive electronic care plan
  - ✓ managing transitions of care and other care management services coordinating and sharing patient health information timely within and outside the practice

CCM and Complex CCM Basics

Who

The following health care professionals may furnish CCM services:

- ✓ Physicians - Generally Primary Care
- ✓ Non Physician Providers (NPPs*):
  - ✓ Certified Nurse Midwife
  - ✓ Clinical Nurse Specialists
  - ✓ Nurse Practitioner
  - ✓ Physician Assistants

Supervision

- ✓ CCM codes are assigned as General Supervision under Medicare PFS
- ✓ When service is not provided by the billing practitioner, it is performed under his/her overall direction and control
- ✓ Physical presence is not required

Additional Eligibility Requirements

- ✓ Certain circumstances - specialty practitioners may provide and bill CCM
- ✓ Out of practice scope – limited license physicians i.e. clinical psychologists, dentists, podiatrists
- ✓ CCM services not provided personally by the billing practitioner are provided by the clinical staff employed by and under the direction of the billing practitioner on “incident to” basis

*Applicable to state law, scope of practice, “incident to” rules and regulations. The staff are either employees or working under contract to the billing provider whom MCR directly pays for CCM services

CCM and Complex CCM Basics

When

- CCM services are typically provided **outside of face-to-face patient visits**
  - ✓ Focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team
  - ✓ Patient support for chronic diseases to achieve health goals
  - ✓ 24/7 patient access to care and health information
  - ✓ Receipt of preventive care
  - ✓ Patient and caregiver engagement
  - ✓ Timely sharing and use of health information

CCM and Complex CCM Basics

Patient Eligibility

1

Requirements

- ✓ Multiple chronic conditions (2 or more)
- ✓ Expected to last 12 months or till the death of the patient
- ✓ Places the patient at significant risk of:
  - ➢ Death
  - ➢ Acute exacerbation/ decomposition
  - ➢ Functional decline

2

Identifying Patients

- ✓ Use criteria suggested by CPT
  - ➢ # of illnesses
  - ➢ # of medications
  - ➢ Repeat admissions or ER visits
  - ➢ Identify & engage subpopulations to help reduce disparities in geographical and racial/ethnic arenas

3

Examples of Chronic Illnesses

- ✓ Alzheimer's disease and related dementia
- ✓ Arthritis (osteoarthritis and rheumatoid)
- ✓ Asthma
- ✓ Atrial fibrillation
- ✓ Autism spectrum disorders
- ✓ Cancer
- ✓ Cardiovascular disease
- ✓ Chronic Obstructive Pulmonary Disease
- ✓ Depression
- ✓ Diabetes
- ✓ Hypertension
- ✓ Infectious diseases i.e. HIV/ AIDS

*Illnesses not limited to those identified

1. Chronic Care Management Basics - Review
2. **Transitional Care Management Basics - Review**
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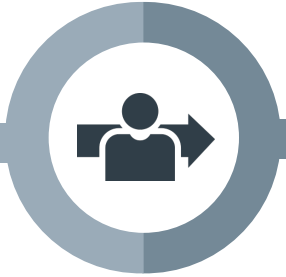
Transitional Care Management Basics

What

Services provided to patients whose medical and/or psychosocial problems require moderate to high complexity medical decision making during transition of care



Transitioning From

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital Outpatient Observation or Partial Hospitalization
- Partial Hospitalization at Community Mental Health Center

Transitioning To

- Home
- Domiciliary
- Rest Home
- Assisted Living

Transitional Care Management (TCM) Services

Care Coordination for Medicare Beneficiaries

CMS.gov
Centers for Medicare & Medicaid Services

CPT 99495

- Communication with patient or caregiver within 2 business days of discharge
- Medical Decision Making - Moderate
- Face-to-face* visit within 14 calendar days of discharge
- **Average Reimbursement - $165**

CPT 99496

- Communication with patient or caregiver within 2 business days of discharge
- Medical Decision Making - High
- Face-to-face* visit within 7 calendar days of discharge
- **Average Reimbursement - $233**

*Face-to-face visits may be in the office or another location where the patient resides

Transitional Care Management Basics

Who & When

The following health care professionals may furnish TCM services

- ✓ Physicians (any specialty)
- ✓ Non Physician Providers (NPPs*):
  - ✓ Certified Nurse Midwife
  - ✓ Clinical Nurse Specialists
  - ✓ Nurse Practitioner
  - ✓ Physician Assistants
  - ✓ *Face-to-Face provided with minimum of direct supervision*
  - ✓ *Non Face-to-Face provided under general supervision*

- ✓ Post discharge from facility setting without a gap
- ✓ Within 30 business days of discharge from hospital

*Applicable to state law, scope of practice, “incident to” rules and regulations

Transitional Care Management Basics

Interactive Contact

- Made within 2 business days following discharge to community setting
- Telephonic, electronic, or face-to-face
- Made by clinical staff with capacity for prompt interactive communication
- Addresses patient status and needs beyond scheduling follow-up care
- Communication attempts should continue after first 2 days until successful contact is made

Provider Communication

- Obtain and review discharge information
- Review need of or follow-up on pending testing or treatment
- Interact with other clinicians who will assume or resume care of the patient's system-specific conditions
- Educate the patient and / or caregiver
- Establish or re-establish referrals for specialized care
- Assist in scheduling follow-up with other health services

Clinical Staff Communication

- Communication with the patient or caregiver (telephonic, electronic, or in-person)
- Communication with a home health agency or other community service that the patient needs
- Educate the patient and / or caregiver to support self-management and activities of daily living
- Provide assessment and support for treatment adherence and medication management
- Identify available community and health resources
- Facilitate access to services needed by the patient and / or caregivers

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3. **Patient Liability**
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Chronic Care Management (CCM) Services

Care Coordination Liability for Medicare Beneficiaries

CCM can be initiated by the billing practitioner during a “comprehensive” E/M visit, initial preventive physical exam (IPPE) or annual wellness visit (AWV)

CPT 99490

Chronic Care Management Services

(Non-Complex)

- *Average Reimbursement of $42.*

CPT 99487

Complex Chronic Care Management Services

- *Average reimbursement of $93*

CPT 99489

Each additional 30 minutes of staff time

- *Average Reimbursement of $47*

Patient Liability

- Patients must consent to the services once every 12 months, as they are subject to a 20% copay which is an estimated $8 per month.
- If enrolled for the entire 12 months, this would leave a patient on the hook for an annual copay of up to **$96**.

Cost Sharing for CCM Services

CCM payment rules were initially finalized in the CY 2014 and CY 2015 PFS final rules, and were significantly revised to reduce administrative burden and improve payment accuracy in the CY 2017 PFS final rule.

Does *Medigap* cover the beneficiary cost sharing for CCM Services?

- If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract.

Does *Medicaid* cover the beneficiary cost sharing for CCM for dually eligible beneficiaries?

- The majority of dually eligible beneficiaries (approximately 64%) are Qualified Medicare Beneficiaries who will not be responsible for CCM cost sharing.

Does *Medicare Advantage* cover the beneficiary cost sharing for beneficiaries?

- Physicians treating patients enrolled in Medicare Advantage plans cannot bill for services using CCM codes unless the contract between the plan and the physician specifically provide for such coverage.
- If a Medicare Advantage beneficiary chooses an out-of-network physician to provide CCM services, then that physician can bill for those services using the CCM code. In this scenario Patients would be responsible for the out-of-Network cost-sharing.

Transitional Care Management (TCM) Services

TCM Billing Services per Medicare Cost Report Guidelines

Billing Requirements

- Codes apply to both new and established patients
- Same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However the required face-to-face visit may not take place on the same day your report discharge day management services.
- Subsequent E/M services outside the required face-to-face report separately
- TCM services may not be billed by the same practitioner if you are within a global period
- TCM services are subject to co-insurance and deductibles under Medicare
- TCM CPT codes 99495 and 99496 can be furnished through tele-health

Patient financial responsibility:

- TCM codes 99495 and 99496 are subject to Medicare deductible and copay. This copay is dependent on individual payer plan

! TCM services are not applicable for every patient that has a follow-up appointment after discharge. TCM codes were designed to reimburse providers for significant extra work on the complex multidisciplinary patient

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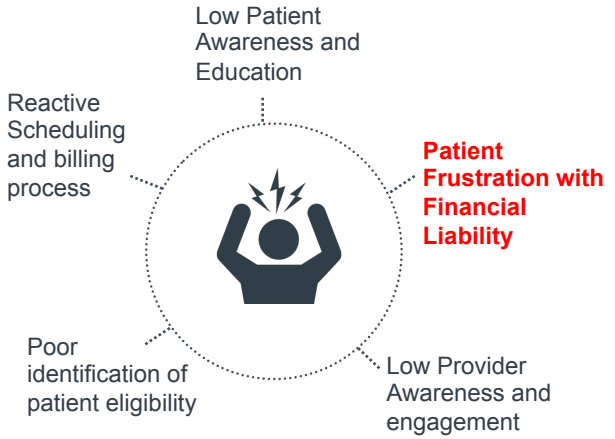
Why is Participation So Low?

Overcoming Barriers in Patient Activation & Enrollment

Common Challenges:



Keys to successful Patient Activation:

Understanding each patients chronic complexity and what their copay would look like should they decide to enroll.

Educating patients on the value of ongoing monitoring in their care plan as well as what these services mean from a financial liability perspective.

Reinforcing education by having providers and staff over communicate the program purpose/ expectation.

Strategies for Effective Patient Communication

Helping Patients Better Understand Program Complexity

Educating prior to an appointment

- Deploying Service-focused staff to outreach helps ensure patients understand their care, make active decisions, and adhere to the care pathway
- Different Outreach mechanisms include:
  - Phone calls
  - Patient Portal
  - Mailers

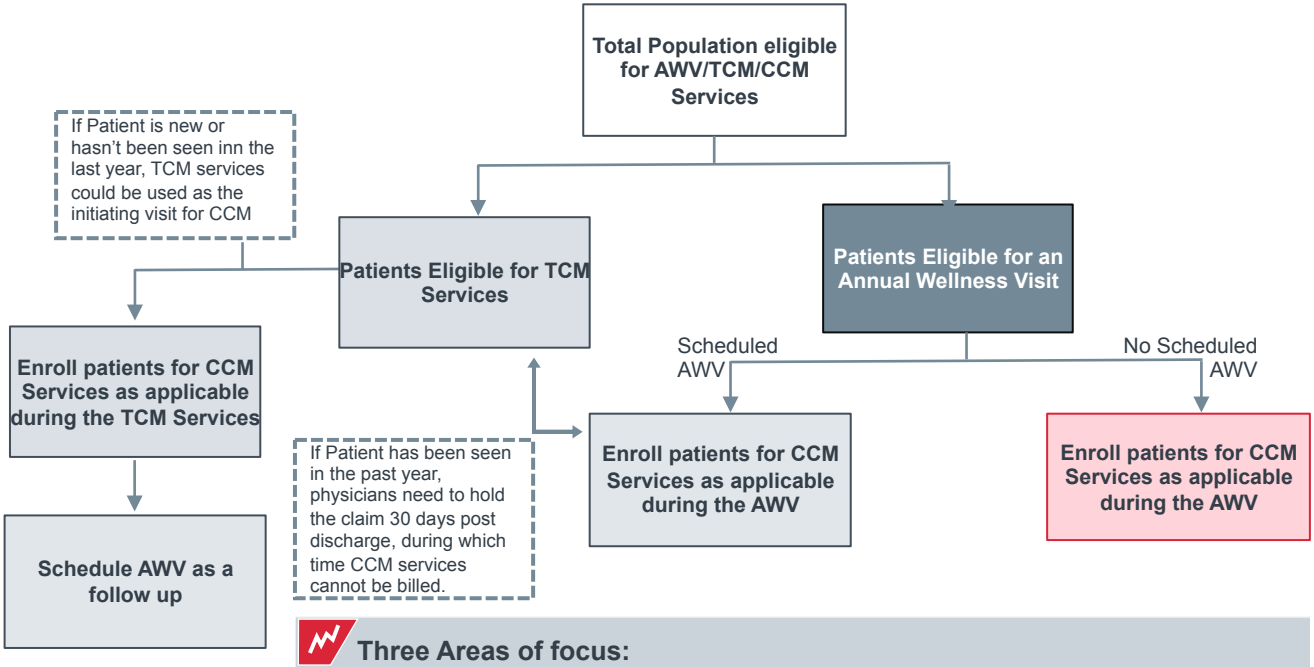
Patient Facing Marketing Content

- Targeted marketing materials ensure patients are informed and active decision makers in their care.
- On average, patients who understand the purpose of their care and the importance and the importance of adhering to their prescribed care pathway experience better outcomes.

Engagement during the AWV

- Utilizing the AWV to engage and enroll patients in CCM service will provide patients a venue to discuss the services with their provider.
- These services will increase convenience for patients in care plan management. Higher levels of activation will lead to increased patient satisfaction.

Identify and Prioritize Patient Activation



Three Areas of focus:

1. Active management of Inpatient discharges to ensure TCM services are given to appropriate patients
2. Leverage the Annual Wellness Visit as a part of the patients continued care plan
3. Prioritize signing eligible patients up for CCM services as a part of the Annual Wellness visit

AWV Visit Types

1 Initial Preventive Physical Exam (IPPE)

- G0402
- Once in a lifetime benefit, no later than 12 months after the effective date of the first Medicare Part B Coverage
- Approximate Reimbursement: $160.00
- wRVU Value per Unit: 2.43

2 Initial Annual Wellness Visit (AWV)

- G0438
- Once in a lifetime benefit, no longer in the 12 month window after covered under Medicare Part B and have not received an AWV or IPPE in the past 12 months
- Approximate Reimbursement: $165.00
- wRVU Value per Unit: 2.43

3 Subsequent Annual Wellness Visit (AWV)

- G0439
- Annual benefit. Have not received an AWV in the past 12 months
- Approximate Reimbursement: $111.00
- wRVU Value per Unit: 1.50

Initial Preventative Physical Exam (IPPE)

The Initial Preventative Physical Examination (IPPE) is also known and the "Welcome to Medicare Preventative Visit". The goal of the IPPE is health promotion and disease prevention and detection. Medicare pays for one IPPE per beneficiary per lifetime for beneficiaries within the first 12 months of the effective date of the beneficiary's first Medicare Part B coverage period.

Components of an IPPE

Acquire Beneficiary Information	*Requirement Elements*
Review the beneficiary's medical and social history	At a minimum, Collect information about • Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries and treatments) • Current Medications and Supplements • Family History (review of medical events, including diseases that may be hereditary or place the beneficiary at risk) • History of alcohol, tobacco, and illicit drug use • Diet and Physical Activity
Review the beneficiary's potential risk factors for depression and other mood disorders	Use any appropriate screening instrument for beneficiary's without current diagnosis of depression from various available screening tests recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders

Initial Preventative Physical Exam (IPPE)

Acquire Beneficiary Information	*Requirement Elements*
Review the beneficiary's functional ability and level of safety	Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas • Hearing impairment • Activities of daily living • Falls risk • Home Safety

Begin Examination & Discussion	*Requirement Elements*
Exam	Obtain the following: • Height, weight, Body Mass Index and Blood Pressure • Visual Acuity screening • Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards
End-of-Life Planning, on agreement of the beneficiary	End-of-life planning is verbal or written information provided to the beneficiary about: • The beneficiary's ability to prepare an advanced directive in case of injury or illness causes the beneficiary to be unable to make health care decisions • Whether or not the provider is willing to follow the beneficiary's wishes as expressed in the advanced directive.

Initial Preventative Physical Exam (IPPE)

Counsel Beneficiary	*Requirement Elements*
Educate, counsel, and refer based on the previous five components	Based on the results of the review and evaluation services in the previous five components, provide education. counseling, and referral as appropriate.
Educate, counsel, and refer for other preventative services	Includes a brief written plan, such as a checklist, for the beneficiary to obtain • A once-in-a lifetime screening electrocardiogram (EKG/ECG), as appropriate • The appropriate screenings and other preventative services that Medicare covers.

Who Can Conduct the IPPE?

Medicare covers an IPPE when performed by a:

- Physician (a doctor of medicine or osteopathy) or
- Qualified non-physician practitioner (PA, NP or certified nurse specialist)

IPPE Coding, Diagnosis & Billing

Coding

IPPE HCPCS Codes	*Billing Code Description*
G0402	Initial preventative physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventative physical examination with interpretation and report
G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventative physical examination.
G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only; performed as a screening for the initial preventative exam.

Diagnosis

Since CMS does not require a specific diagnosis code for the IPPE, you may choose any appropriate diagnosis code. You must report a diagnosis code.

Initial Annual Wellness Visit

Beneficiary's are eligible for the Initial AWV if they are not within the first 12 months of their first Medicare Part B coverage period and have not received an initial preventative physical examination (IPPE) or AWV within the past 12 months.

Components of an Initial AWV

Acquire Beneficiary Information	*Requirement Elements*

Administer the Health Risk Assessment (HRA)	• Collect self-reported information from the beneficiary. You, your staff or the beneficiary **can complete the HRA before or during the AWV** encounter
	• Accounts for the communication needs of the underserved populations, persons with limited English proficiency, and persons with health literacy needs and is appropriately tailored to their needs
	• Takes no more than 20 minutes
	• At a minimum address the following:
	  • Demographic data
	  • Self assessment of health status
	  • Psychosocial risks
	  • Behavioral risks
	  • Activities of Daily Living (ADLs), including but not limited to: dressing, bathing and walking
	  • Instrumental ADL's, including, but not limited to: shopping, housekeeping, managing own medications and handling finances.

Initial Annual Wellness Visit

Acquire Beneficiary Information	*Requirement Elements*
Establish a list of current providers and suppliers	Include a list of current providers and suppliers regularly involved in providing medical care to the beneficiary, i.e. Cardiologist, Chiropractor, Urologist etc.
Establish the beneficiary's medical/family history	At a minimum, collect and document the following: • Medical events in the beneficiary's parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk. • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments • Use of, or exposures to, medications and supplements, including calcium and vitamins
Review the beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders.	Use any appropriate screening instrument for beneficiary's without current diagnosis of depression from various available screening tests recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders
Review the beneficiary's functional ability and level of safety	Use direct observation of the beneficiary, or select appropriate screening questions or a screening questionnaire, from various available screening questions or standardized questionnaires recognized by national professional medical organizations to assess at a minimum, the following topics: • Ability to successfully perform ADLs • Fall Risk • Hearing impairment • Home Safety

Initial Annual Wellness Visit

Begin Assessment	*Requirement Elements*
Assess	Obtain the following measurements: • Height, weight, body mass index (or waist circumference, if appropriate) and BP. • Other routine measurements as deemed appropriate based on medical and family history.
Detect and cognitive impairment the beneficiary may have	Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others

Counsel Beneficiary	*Requirement Elements*
Establish a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years as appropriate	Base written screening schedule on: • Age appropriate preventative services Medicare covers • Recommendations from the United States Preventative Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP) • The beneficiary HRA, health status and screening history
Establish a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary	Include the following • Any mental health conditions or any risk factors or conditions identified through an IPPE; and • A list of treatment options and their associated risks and benefits

Initial Annual Wellness Visit

Counsel Beneficiary	*Requirement Elements*
Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventative counseling services or programs	Include referrals to programs aimed at: • Community-based lifestyle interventions to reduce health risks and promote self-management and wellness • Fall prevention • Nutrition • Physical Activity • Tobacco-use cessation • Weigh Loss

Subsequent Annual Wellness Visit

Beneficiary's are eligible for the Subsequent AWV every year if they are not within the first 12 months of their first Medicare Part B coverage period and have not received an initial preventative physical examination (IPPE) or AWV within the past 12 months.

Components of a Subsequent AWV

Acquire Beneficiary Information	*Requirement Elements*

Update the Health Risk Assessment (HRA)	• Collect self-reported information from the beneficiary. You, your staff or the beneficiary **can complete the HRA before or during the AWV** encounter
	• Accounts for the communication needs of the underserved populations, persons with limited English proficiency, and persons with health literacy needs and is appropriately tailored to their needs
	• Takes no more than 20 minutes
	• At a minimum address the following:
	  • Demographic data
	  • Self assessment of health status
	  • Psychosocial risks
	  • Behavioral risks
	  • Activities of Daily Living (ADLs), including but not limited to: dressing, bathing and walking
	  • Instrumental ADL's, including, but not limited to: shopping, housekeeping, managing own medications and handling finances.

Subsequent Annual Wellness Visit

Acquire Beneficiary Information	*Requirement Elements*
Update the list of current providers and suppliers	Include a list of current providers and suppliers regularly involved in providing medical care to the beneficiary, i.e. Cardiologist, Chiropractor, Urologist etc.
Update the beneficiary's medical/family history	At a minimum, collect and document the following: • Medical events in the beneficiary's parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk. • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments • Use of, or exposures to, medications and supplements, including calcium and vitamins

Begin Assessment	*Requirement Elements*
Assess	Obtain the following measurements: • Weight (or waist circumference, if appropriate) and BP. • Other routine measurements as deemed appropriate based on medical and family history.
Detect and cognitive impairment the beneficiary may have	Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others

Subsequent Annual Wellness Visit

Counsel Beneficiary	*Requirement Elements*
Update the written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years as appropriate	Base written screening schedule on: • Age appropriate preventative services Medicare covers • Recommendations from the United States Preventative Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP) • The beneficiary HRA, health status and screening history
Establish and update the list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary	Include the following • Any mental health conditions or any risk factors or conditions identified through an IPPE or AWV; and • A list of treatment options and their associated risks and benefits

Counsel Beneficiary	*Requirement Elements*
Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventative counseling services or programs	Include referrals to programs aimed at: • Community-based lifestyle interventions to reduce health risks and promote self-management and wellness • Fall prevention • Nutrition • Physical Activity • Tobacco-use cessation • Weigh Loss

Who Can Conduct the Annual Wellness Visits?

Medicare covers AWVs when performed by a:

- Physician (doctor of medicine or osteopathy);
- Physician assistant;
- Nurse practitioner;
- Clinical nurse specialist;
- OR medical professional* (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals **working under the direct supervision of a physician** (doctor of medicine or osteopathy)

*CMS does not assign particular tasks or restrictions for specific members of the team. They believe it is better for the supervising physician to assign specific tasks to qualified team members (as long as they are licensed in the State and working within their state scope of practice). This approach gives the physician and the team the flexibility needed to address the beneficiary's particular needs on a particular day (CMS FAQ3317)

Initial & Subsequent AWV Coding, Diagnosis & Billing

Coding

AWV HCPCS Codes	*Billing Code Description*
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPPS). Initial visit.
G0439	Annual wellness visit; includes a personalized prevention plan of service (PPPS). Subsequent visit.

Diagnosis

Since CMS does not require a specific diagnosis code for the IPPE, you may choose any appropriate diagnosis code. You must report a diagnosis code.

Investing in AWV Optimization

Patient Engagement

Clinicians engage patients in their own care. Annual preventative focused visits complimented by ongoing CCM services create a trusted relationship and value for the patient

Preventative Care

The AWV allows clinicians to identifying care gaps to keep patient populations healthier, longer

Quality Performance

Yearly capture and tracking of preventative services improve quality metric performance

Populations Health Initiative Funding

An effective AWV strategy can create a foundation for other population health strategies(CCM, TCM)

Questions for Q&A Hours?