SALIENT® HEALTHCARE

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# Care Management for ACOs

## Presented by: Salient Healthcare


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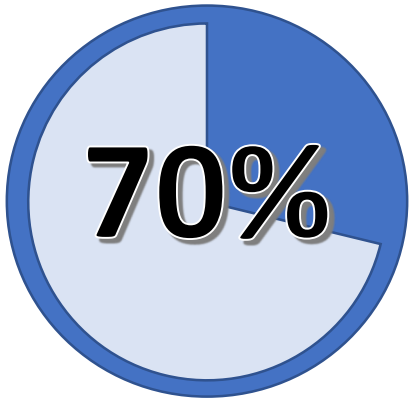
*Senior Business Consultant, Team Lead and Senior Business Consultant*


*DISCLAIMER: All PHI has been cleansed as per HIPAA protocols.*

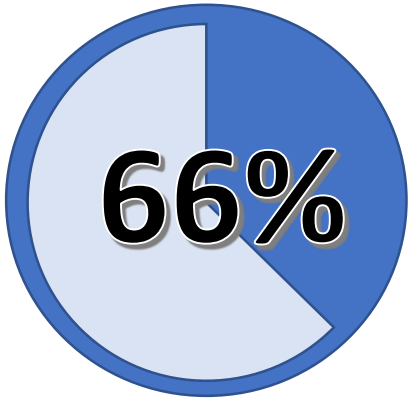
NAACOS National Association of ACOs

BOOT CAMP

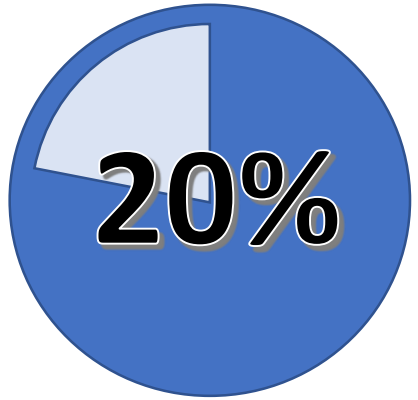
# THE PROBLEM




Of Medicare Patients have MCCs




Of total healthcare spend is associated with care for the top 25% with MCCs




More expenditures when a mental disease is introduced to a chronic condition diagnosis

*https://www.hhs.gov/ash/about-ash/multiple-chronic-conditions/about-mcc/index.html*

# SOCIAL DETERMINANTS OF HEALTH

# THE SOLUTION

- Use a combination of creativeness & known effective methods with a population health foundation to create a care management program.
    - Ensure proper infrastructure
    - Know & understand the programmatic details/scope
    - Create a patient ID process
    - Calculate the ROI

- Get physician buy-in at the beginning

# WHAT IS CHRONIC CARE MANAGEMENT?

- Care Coordination
- Case Management
- Disease management
- Chronic Care Management (CCM)
- Transition Care Management (TCM)
- Telemedicine
- Post-Acute Care (PAC)

# BUILDING AN INFRASTRUCTURE | THE TEAM

## Care Team

- Multidisciplinary teams will help with perspective and wide range

Examples Include…

- Nurses
- Medical Assistants
- Scheduling
- Pharmacy
- Primary Care
- Specialty Care
- Community Stakeholders

# BUILDING AN INFRASTRUCTURE | THE TECH

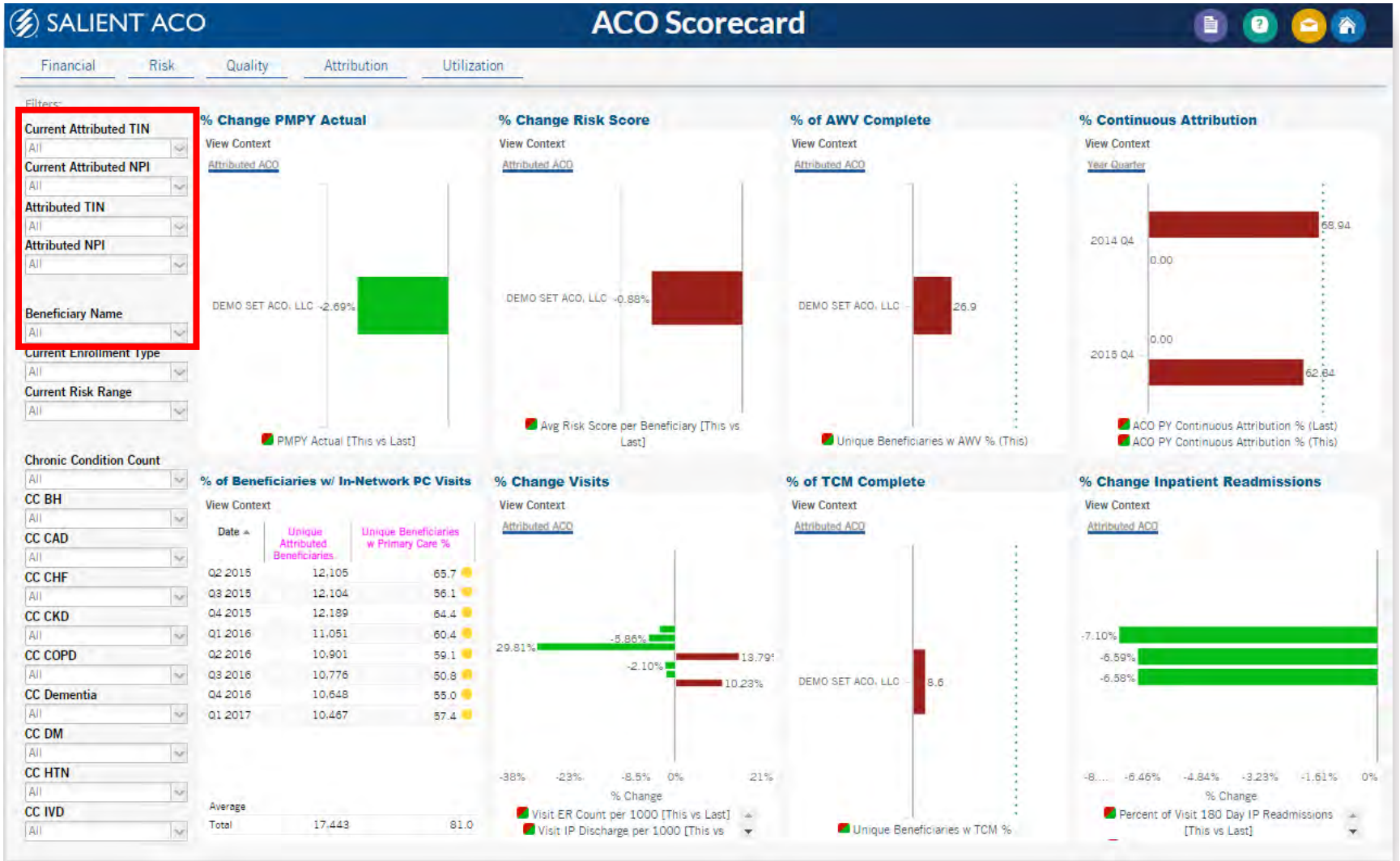
## Performance Management Software

- Must Haves…
  - Cost & Utilization Metrics
  - Aggregate to the Beneficiary Level & in-Between
  - Narrow Cohorts by Chronic Condition
  - HIE/ADT Integration
  - Other Data Sources

- Telemedicine or Other Clinical Devices*
  - Bluetooth Monitors: Glucose, Scales, BP, $O^2$, and Exercise
  - Online Food Journals

** Currently for rural beneficiaries, but will be for all beneficiaries in prospective assignment ACOs in 2020*

# Dashboard Sample

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# BUILDING AN INFRASTRUCTURE | TOOLS

- Call-Me-Cards/ VIP cards
- PAC cards/preferred providers
- Marketing Tools
- Education for Providers, Office Staff, and Beneficiaries
- Patient Surveys
- Physician Surveys
- Scheduling for Process Improvement and Combined Work Effort

# PROGRAM DETAILS | CCM

## Chronic Care Management | CPT 99490

Minimum of 20 mins. Clinical staff time directed by a physician or other qualified healthcare professional each month (bill incident to under general supervision)

Patient must have 2+ chronic conditions

Establish a comprehensive care plan with ongoing meetings to revise, monitor, and implement initiatives

*https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*

# PROGRAM DETAILS | CCM

## Complex CCM | CPT 99487 & 99489

| | | | |
|---|---|---|---|
| Same as CPT 99490, plus… | Substantial revision to the comprehensive care plan | Moderate or high complexity medical decision making required | 60 minutes of clinical staff time each month |

## Complex Initiation for CCM | HCPCS G0506

*https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*

# PROGRAM DETAILS | TCM

## Transition Care Management | CPT 99495 & 99496

Patient is discharged from the inpatient, observation, or SNF setting

Patient is discharged to the home setting, with or without care at home, or assisted living

Only a physician, or qualified non-physician practitioner, can render the service i.e., nurse-midwife, clinical nurse specialist, nurse practitioner, or physician assistant

*https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf*

# PROGRAM DETAILS | TCM

## Transition Care Management | CPT 99495 & 99496

An interactive contact within 2 business days of discharge to address immediate needs & scheduling a face-to-face visit

Address discharge plan, ensure referrals are arranged, medication reconciliation, and ensure proper plan of care*

Cannot overlap with CCM

** Bill incident to under direct supervision and/or general supervision for non-face-to-face*

*https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf*

# PROGRAM DETAILS | IMPLEMENTATION

Annual Wellness Visit | HCPCS G0402, G0438, & G0439

Set up a care plan and ensure annual adjustments are made

In-Home / On-Site Visits | CPT 99341 - 99350

Must meet requirements such as: home-bound or caregiver dependent

Mental Health

Rehab Facility / PT / OT

# PROGRAM DETAILS | IMPLEMENTATION

## Community Assistance

- Meals on Wheels
- Centers of Religious Worship
- Community Center
- Silver Sneakers

## Scheduling and Taper Method

# CCM PATIENT IDENTIFICATION

- 2+ Chronic Conditions
- Increase in Spend over Time (Rising Risk)
- High Utilization of ER and IP
- Overutilization of Primary Care and/or Anxiety Dx
- Just Discharged from the Hospital or SNF
- Depression Dx
- Polypharmacy

# TCM PATIENT IDENTIFICATION

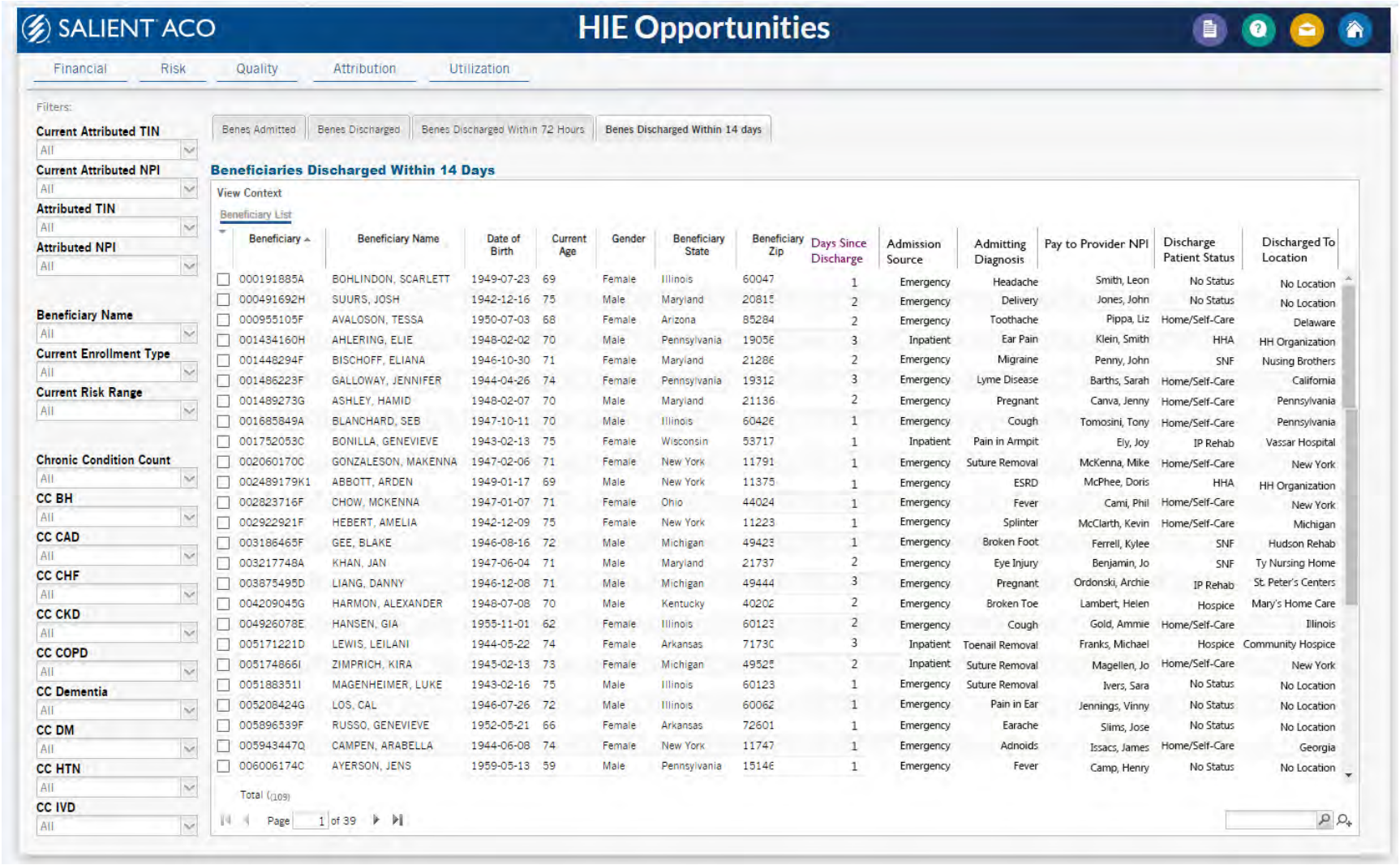
## Notification of Discharge

- HIE, ENS, or ADT Feeds

## The Clock is Ticking

- 2 Business Days for the Initial Contact
- 1-2 Weeks for Visit

# Dashboard Sample

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# TCM PATIENT IDENTIFICATION

## Prioritize by Condition and Level of Need (Risk)

- High HCCs
- Multiple Rx
- CHF/COPD Related
- Dual Enrollment Status
- Admission Record
- Cancer, Renal, or Lung Disease

# GENERAL PATIENT IDENTIFICATION

- Disease Specific
- Socioeconomic Factors
- Alcohol and/or Drug Dependencies
- Caregiver Dependent
- Caregiver
- Anxiety or Behavioral Health

# CALCULATING ROI | CCM

Average Reimbursement = $40 PMPM

- **Sunk Cost(s):** System purchase, personnel, education, vehicle(s)/insurance
- **Reoccurring Cost(s):** Any licensing of system, personnel, education
- **Savings:** The % change of IP visits, ER visits, and PMPM spend
- **Patient Benefits:** Decreased anxiety, motivation, decreased "never events," and perceived control of disease

# CALCULATING ROI | TCM

TCM Average Reimbursement = $150-250 per Visit

- **Sunk Cost(s):** System purchase, personnel, education
- **Reoccurring Cost(s):** Any licensing of system, personnel, education
- **Savings:** The difference in Avg. Cost in 90 days post-discharge between patients with the TCM and patients without the TCM
- **Patient Benefits:** Decrease in acute PTSD, increased patient satisfaction, decreased duplicative/unnecessary spending, adjusted care plan, more developed physician-patient relationship

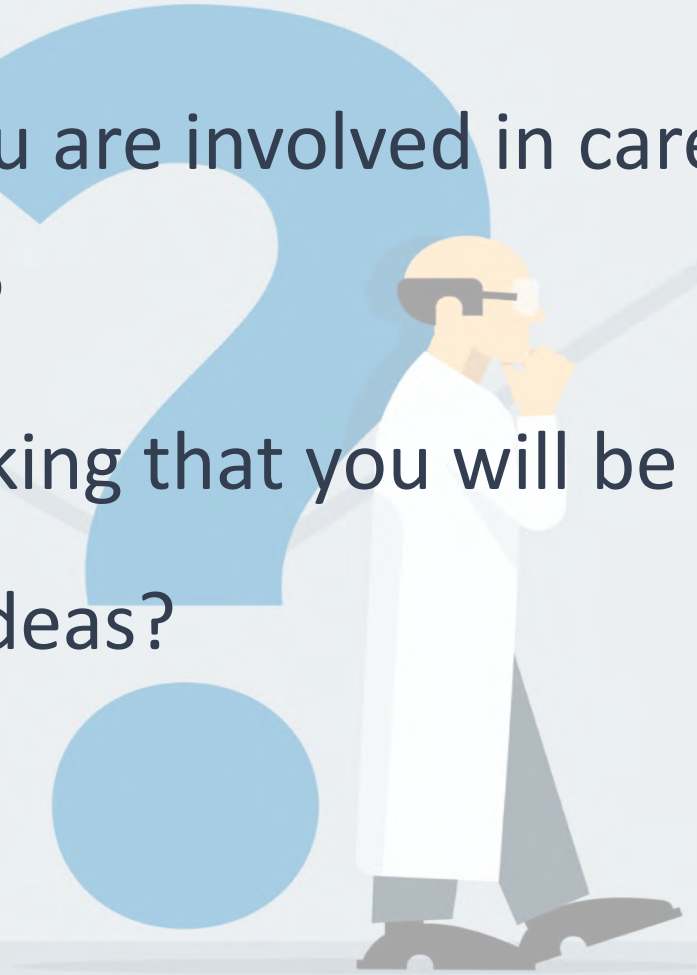
# CALCULATING ROI | TCM

## Other Methods to Calculate ROI

- Use baseline, implement program, measure outcomes
- Select metrics such as inpatient utilization, ER utilization, primary care utilization, specialist utilization, PAC utilization, etc.

# WHAT ARE YOU DOING RIGHT NOW?

- How many of you are involved in care management?
- What's working?
- What is not working that you will be changing?
- Any innovative ideas?



# THANK YOU

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