

# Care Management for ACOs

**Presented by: Salient Healthcare**

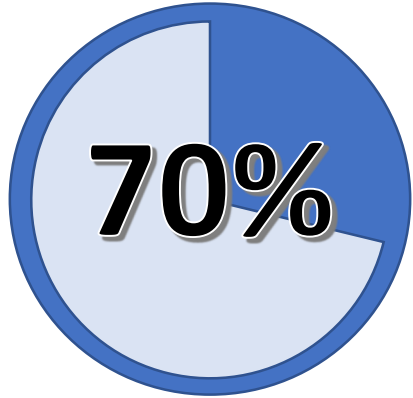
**Speakers: Amy H. Kotch, MHA and Maria Nikol, MJ**

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

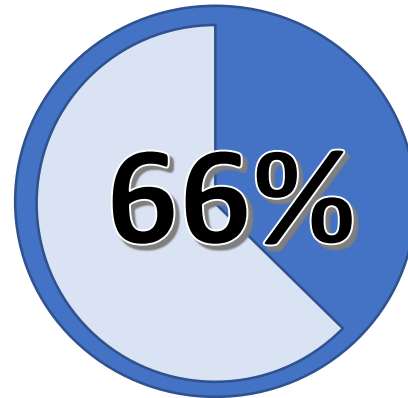
*DISCLAIMER: All PHI has been cleansed as per HIPAA protocols.*



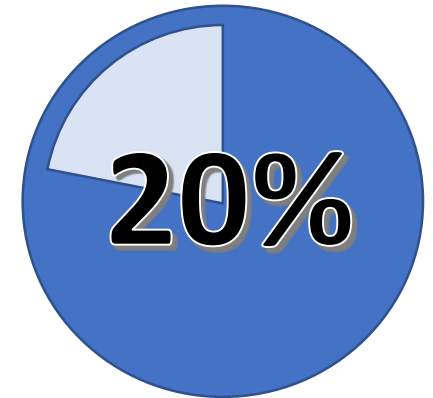
# THE PROBLEM



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

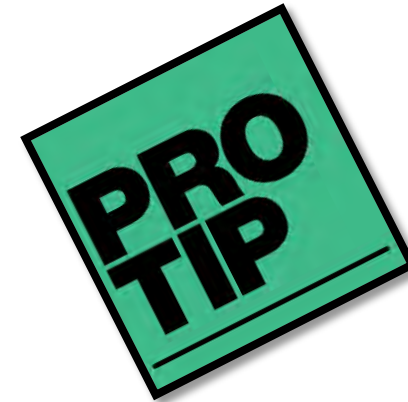
<https://www.hhs.gov/ash/about-ash/multiple-chronic-conditions/about-mcc/index.html>

# 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

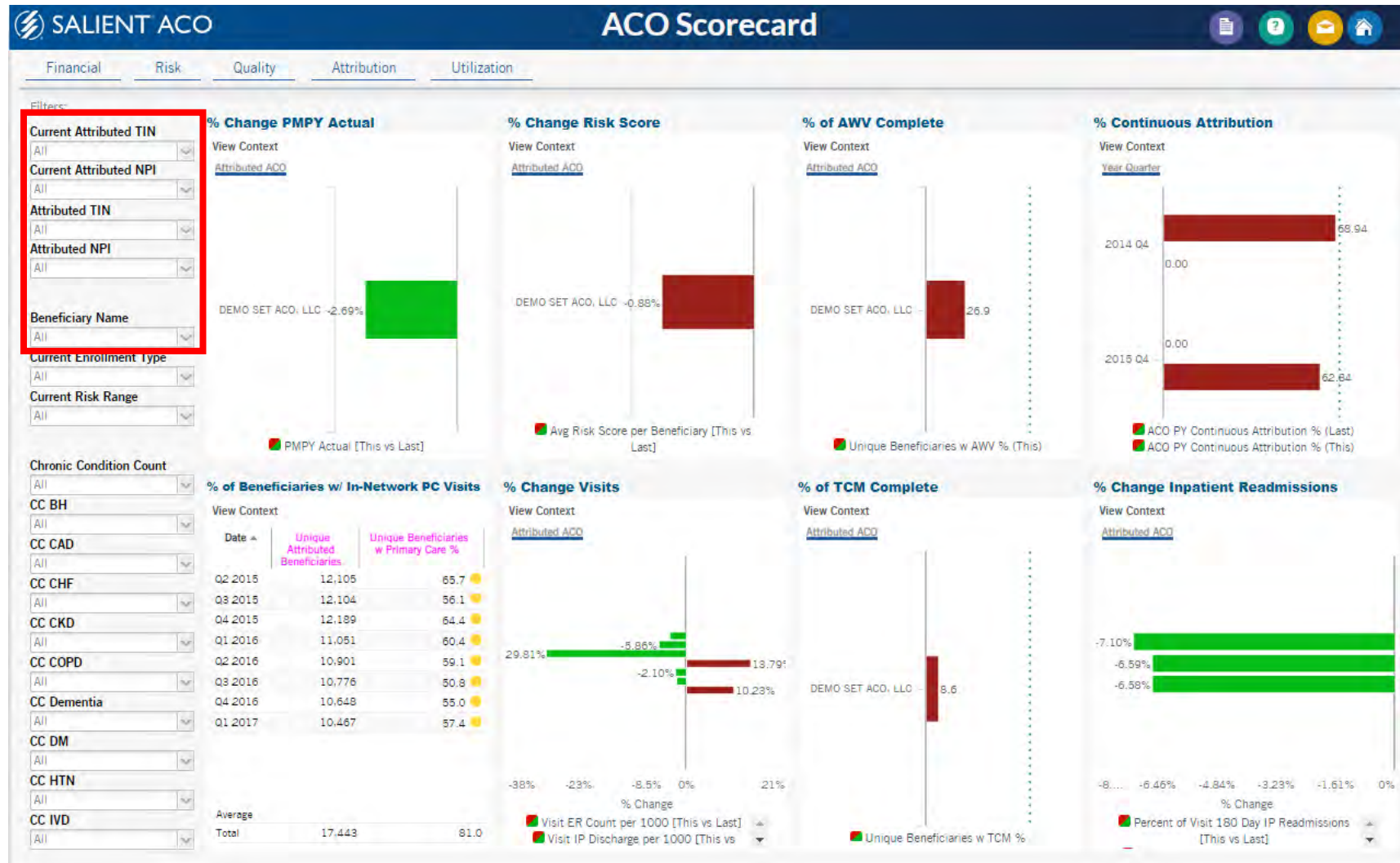
## Performance Management Software

- 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<sup>2</sup>, and Exercise
  - Online Food Journals

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



# Dashboard Sample





# 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>



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# 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

## HIE Opportunities

Financial
Risk
Quality
Attribution
Utilization

Filters:

Current Attributed TIN: All

Current Attributed NPI: All

Attributed TIN: All

Attributed NPI: All

Beneficiary Name: All

Current Enrollment Type: All

Current Risk Range: All

Chronic Condition Count: All

CC BH: All

CC CAD: All

CC CHF: All

CC CKD: All

CC COPD: All

CC Dementia: All

CC DM: All

CC HTN: All

CC IVD: All

Beneficiaries Discharged Within 14 Days

View Context

Beneficiary List

Beneficiary	Beneficiary Name	Date of Birth	Current Age	Gender	Beneficiary State	Beneficiary Zip	Days Since Discharge	Admission Source	Admitting Diagnosis	Pay to Provider NPI	Discharge Patient Status	Discharged To Location	
<input type="checkbox"/>	000191885A	BOHLINDON, SCARLETT	1949-07-23	69	Female	Illinois	60047	1	Emergency	Headache	Smith, Leon	No Status	No Location
<input type="checkbox"/>	000491692H	SUURS, JOSH	1942-12-16	75	Male	Maryland	20815	2	Emergency	Delivery	Jones, John	No Status	No Location
<input type="checkbox"/>	000955105F	AVALOSON, TESSA	1950-07-03	68	Female	Arizona	85284	2	Emergency	Toothache	Pippa, Liz	Home/Self-Care	Delaware
<input type="checkbox"/>	001434160H	AHLERING, ELIE	1948-02-02	70	Male	Pennsylvania	19056	3	Inpatient	Ear Pain	Klein, Smith	HHA	HH Organization
<input type="checkbox"/>	001448294F	BISCHOFF, ELIANA	1946-10-30	71	Female	Maryland	21286	2	Emergency	Migraine	Penny, John	SNF	Nusing Brothers
<input type="checkbox"/>	001486223F	GALLOWAY, JENNIFER	1944-04-26	74	Female	Pennsylvania	19312	3	Emergency	Lyme Disease	Barth, Sarah	Home/Self-Care	California
<input type="checkbox"/>	001489273G	ASHLEY, HAMID	1948-02-07	70	Male	Maryland	21136	2	Emergency	Pregnant	Canva, Jenny	Home/Self-Care	Pennsylvania
<input type="checkbox"/>	001685849A	BLANCHARD, SEB	1947-10-11	70	Male	Illinois	60426	1	Emergency	Cough	Tomosini, Tony	Home/Self-Care	Pennsylvania
<input type="checkbox"/>	001752053C	BONILLA, GENEVIEVE	1943-02-13	75	Female	Wisconsin	53717	1	Inpatient	Pain in Armpit	Ely, Joy	IP Rehab	Vassar Hospital
<input type="checkbox"/>	002060170C	GONZALESON, MAKENNA	1947-02-06	71	Female	New York	11791	1	Emergency	Suture Removal	McKenna, Mike	Home/Self-Care	New York
<input type="checkbox"/>	002489179K1	ABBOTT, ARDEN	1949-01-17	69	Male	New York	11375	1	Emergency	ESRD	McPhee, Doris	HHA	HH Organization
<input type="checkbox"/>	002823716F	CHOW, MCKENNA	1947-01-07	71	Female	Ohio	44024	1	Emergency	Fever	Cam, Phil	Home/Self-Care	New York
<input type="checkbox"/>	002922921F	HEBERT, AMELIA	1942-12-09	75	Female	New York	11223	1	Emergency	Splinter	McClarth, Kevin	Home/Self-Care	Michigan
<input type="checkbox"/>	003186465F	GEE, BLAKE	1946-08-16	72	Male	Michigan	49423	1	Emergency	Broken Foot	Ferrell, Kylee	SNF	Hudson Rehab
<input type="checkbox"/>	003217748A	KHAN, JAN	1947-06-04	71	Male	Maryland	21737	2	Emergency	Eye Injury	Benjamin, Jo	SNF	Ty Nursing Home
<input type="checkbox"/>	003875495D	LIANG, DANNY	1946-12-08	71	Male	Michigan	49444	3	Emergency	Pregnant	Ordonski, Archie	IP Rehab	St. Peter's Centers
<input type="checkbox"/>	004209045G	HARMON, ALEXANDER	1948-07-08	70	Male	Kentucky	40202	2	Emergency	Broken Toe	Lambert, Helen	Hospice	Mary's Home Care
<input type="checkbox"/>	004926078E	HANSEN, GIA	1955-11-01	62	Female	Illinois	60123	2	Emergency	Cough	Gold, Ammie	Home/Self-Care	Illinois
<input type="checkbox"/>	005171221D	LEWIS, LEILANI	1944-05-22	74	Female	Arkansas	7173C	3	Inpatient	Toenail Removal	Franks, Michael	Hospice	Community Hospice
<input type="checkbox"/>	005174866I	ZIMPRICH, KIRA	1945-02-13	73	Female	Michigan	49525	2	Inpatient	Suture Removal	Magellen, Jo	Home/Self-Care	New York
<input type="checkbox"/>	005188351I	MAGENHEIMER, LUKE	1943-02-16	75	Male	Illinois	60123	1	Emergency	Suture Removal	Ivers, Sara	No Status	No Location
<input type="checkbox"/>	005208424G	LOS, CAL	1946-07-26	72	Male	Illinois	60062	1	Emergency	Pain in Ear	Jennings, Vinny	No Status	No Location
<input type="checkbox"/>	005896339F	RUSSO, GENEVIEVE	1952-05-21	66	Female	Arkansas	72601	1	Emergency	Earache	Silms, Jose	No Status	No Location
<input type="checkbox"/>	005943447Q	CAMPEN, ARABELLA	1944-06-08	74	Female	New York	11747	1	Emergency	Adnoids	Issacs, James	Home/Self-Care	Georgia
<input type="checkbox"/>	006006174C	AYERSON, JENS	1959-05-13	59	Male	Pennsylvania	15146	1	Emergency	Fever	Camp, Henry	No Status	No Location

Total (109)

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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

Amy H. Kotch, MHA

Salient Healthcare

E-Mail: [akotch@salient.com](mailto:akotch@salient.com)

Maria Nikol, MJ

Salient Healthcare

*Thank  
you*

