Nevada

Although there are no formal public patient-centered medical home (PCMH) programs in the state, the Nevada Division of Health Care Financing and Policy (DHCFP) has identified the most pervasive high cost and chronic conditions for persons served through the fee-for-service (FFS) system. Because the care enrollees received in Nevada's FFS program have historically been unmanaged, the DHCFP estimates that costs for providing care to persons with chronic illness will only escalate. To curtail the costs and provide appropriate care navigation assistance to persons with chronic illness, the state has identified a distinct need for a comprehensive care management program, namely, the Nevada Comprehensive Care Waiver (NCCW) program. The DHCFP as well as its sister agencies and counties are partnering with the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Administration (SAMHSA) to develop both the NCCW program and a model for Health Homes and Care Management and Coordination.

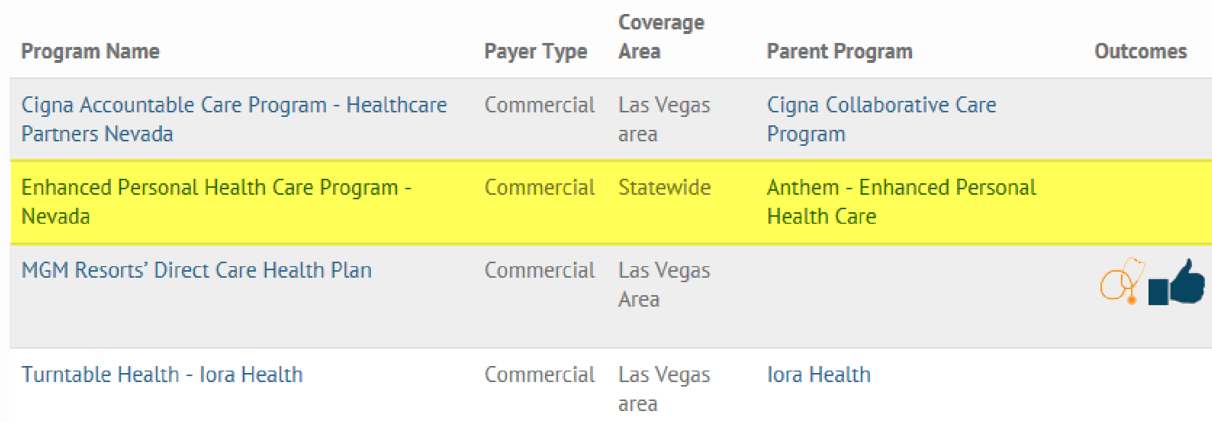
State PCMH Activity

CHIPRA	MAPCP	Dual Eligible	2703 SPA	CPC	SIM Award	PCMH QHP	PCMH Legislation	Private Payer
✗	✗	✗	✗	✗	✓	✗	✗	✓

Public Payer Programs

Program Name	Payer Type	Coverage Area	Parent Program	Outcomes
CMS State Innovation Model (SIM) Design Award - Nevada	Grant	Statewide	CMS State Innovation Model (SIM)	

Private Payer Programs



Program Name	Payer Type	Coverage Area	Parent Program	Outcomes
Cigna Accountable Care Program - Healthcare Partners Nevada	Commercial	Las Vegas area	Cigna Collaborative Care Program	
Enhanced Personal Health Care Program - Nevada	Commercial	Statewide	Anthem - Enhanced Personal Health Care	
MGM Resorts' Direct Care Health Plan	Commercial	Las Vegas Area		
Turntable Health - Iora Health	Commercial	Las Vegas area	Iora Health	

Who's in the Quality Payment Program?

You're a part of the Quality Payment Program in 2017 if you are in an Advanced APM or if you bill Medicare more than $30,000 in Part B allowed charges a year and provide care for more than 100 Medicare patients a year.

You must both meet the minimum billing and the number of patients to be in the program. If you are below either, you are not in the program.

For MIPS, you must also be a:

- Physician
- Physician Assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

The MIPS Final Score Will be Between 0 and 100 points. How is the Payment Adjustment Based on the MIPS Final Score Calculated?

Final score	Payment adjustment
Additional performance threshold >70 points	• Positive adjustment • Eligible for additional adjustment for exceptional performance bonus
4-69 points	• Positive adjustment • Not eligible for additional adjustment for exceptional performance bonus
Performance threshold = 3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

MIPS

What we used to do	Quality Payment Program
• PQRS	• Quality
• *New Category*	• Improvement Activities
• Medicare EHR Incentive Program (Meaningful Use)	• Advancing Care Information
• Value Based Modifier	• Cost **

** Cost has no reporting requirements for 2017**

MIPS Scoring Breakdown

• Quality	• 60%
• Improvement Activities	• 15%
• Advancing Care Information	• 25%
• Cost	• 0% for 2017

Reporting Options for MIPS for 2017

- Do Nothing:
  - This will result in a 4% negative payment adjustment for 2019
- Test-Submit Something:
  - Just do one thing and avoid a negative adjustment for 2019
- Partial Year:
  - Submit 90 days of data and possibly earn a positive adjustment for 2019
- Full Year:
  - Submit for the full year and earn a positive adjustment for 2019

Improvement Activities

- This new category is to reward clinicians who focus on care coordination, patient engagement, and safety.
- This category accounts for 15% of the total MIPS reporting categories
- Providers in a certified patient-centered medical home or specialty practice receive automatic full credit in the performance area

Improvement Activities

- Providers recognized as a Patient Centered Medical Home or Patient Centered Specialty Practice will receive full credit in this category
  - The 92 activities that would make up this reporting to CMS include all of the concepts found in PCMH/ PCSP
    - Team Based Care
    - Knowing and Managing your patients
    - Access & Continuity
    - Care Management and Support
    - Care Coordination and Care Transitions

What's Next??

- The 2018 proposed rule for MACRA give even more reasons to become a Patient-Centered recognized practice:
  - Patient Centered Connected Care will also give full credit for the Improvement Activity category. A great option for those non-traditional practices such as urgent care, retail and work clinics, and any other practices that focus on episodic care
  - To receive full credit for the Improvement Activities category, 50% of practice sites in a given TIN will need to be recognized, not just one

Medicare Chronic Care Management

Chronic Care Management (CCM)

Medicare Payment for Non-face-to-face Care Coordination by ***clinical staff***

Fast Facts

- Eligible if ***two+ chronic conditions with significant risk***
  - of death, exacerbation, decompensation or functional decline
- Covered by Medicare Fee-for Service
  - some Medicare Advantage plans cover
- 20% patient cost share
- Time-based codes per calendar month
  - Non-Complex CCM 99490
  - Complex CCM 60 mins 99487
    plus each additional 30 mins 99489
- FQHC and RHC use a *NEW* code!
  General Care Management Code G0511

Key Requirements

- Certified EHR
- 24/7 access to team for urgent advice
- **Verbal** Consent
- Continuity visits
- **General supervision** by billing practitioner
- Comprehensive assessment
- Medication reconciliation
- Comprehensive Care Coordination
- Written shared CARE PLAN

CCM "Time" Includes:

- "Contact initiated" –communication with the patient is included in the effort
- Care planning
- Chart review
- Coordination with community or home-care services
- Coordination with clinical care team
- Med reconciliation

CCM Billing Requirements Simplified in 2017

- No CCM-initiating visit required if visit in last year
- No written consent required
- More flexibility for sharing Care Plan
- Optional Add-on code for physician care plan
  - G0506 Comprehensive Assessment of and care planning by physician
    One time only, WRVU = 0.87, can bill with other E/M services and CCM

CCM services are not billable delivered simultaneously with billed services that include care coordination:

- CCM by any another provider in same calendar month
- Inpatient care or SNF inpatient covered under Medicare Part A
  - CCM time before or after hospital stay in the calendar month is billable
- Home Health Plan Supervision
  - Practice can choose to bill CCM instead of this code
- Hospice or certain ESRD services w/ care coordination
- Transitional Care Management
  - If TCM codes are billed, service period is 30 days after hospital discharge date
  - CCM time before or after the service period can be billed with CCM code
  - Practice may choose to bill CCM instead of TCM codes

Bottom Line:
No Double Dipping!

Non-complex and Complex CCM

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

*(Annual Wellness Visit [AWV], Initial Preventive Physical Examination [IPPE], Transitional Care Management [TCM], or Other Qualifying Face-to-Face Evaluation and Management [E/M])

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Proposed payment for FQHC and RHC

NEW

- G0511 New code for General Care Management
- Any patient who meets requirements for any of these codes:
  - 99490 non-complex CCM
  - 99487 complex CCM
  - HCPCS G0507 Behavioral Health Integration
- Payment $61.37 per calendar month

  Based on average of national non-facility payment for 99490, 99487 and HCPCS G0507
- No additional payment for additional time 99489

Who will Perform CCM Work?

Consider Clinical Staff Scope of Practice

Registered Nurse

- Develop Care Plan independently
- Perform assessments
- Clinical decision-making
- Effective triage
- Self-Care Training & Support
- Personalized Patient Education

Other Clinical Staff

- Licensed Practical Nurse
- Pharmacist
- Dietitian/CDE

Medical Assistant

- Cannot develop or modify care plan
- Gather & Relay information
- Provider input needed to triage
- Perform screening but cannot interpret results
- Motivational interviewing
- Relay educational materials by protocol

Medical Assistant or LPN CCM will require *significantly more physician time* than Registered Nurse, especially for initial care planning.

CCM Implementation Models

High Risk CCM

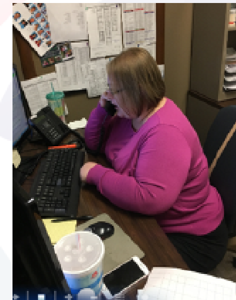
- Highest risk patients targeted for CCM (by registry or referral)
- Consent obtained when enrolled
- Assessments and care plan when enrolled
- Track care coordination time
- Charge when >20 minutes

Outsourced CCM

- Various models
- Usually seek broad enrollment
- Consider how clinical questions will be addressed
- Forgo 50%+ of reimbursement that could build your PCMH team?

"Standby" CCM

- Enroll and Consent all Medicare patients
- All patients undergo assessment and care plan
- All care coordination time documented
- Capture Charge when over 20 minutes and sufficient risk



Analyze the CCM "Business Case"

Consider a primary care practice with 500 Medicare Fee-for-Service patients. Practice is not FQHC or RHC.

Baseline assumptions

1. Ten percent+ are high risk, suitable for CCM (50 patients).
2. Half-time (or 0.5 FTE) RN Salary with benefits is about $37,500
3. Average reimbursement for CCM is $85 per month or $1000 per year

Office RN assigned to enroll 50 patients, 2-3 patients per day.
Plan for gradual ramp up:
Month 1= 10 patients = $850
Month 2 = 20 patients = $1650
Month 3 = 40 patients = $3400
Subsequent months = 50 patients = $4250

1st year Revenue potential $44,100
Each subsequent year Revenue $51,000

Analyze the FQHC/RHC CCM "Business Case"

Consider a Federally Qualified Health Center with 1000 Medicare Fee-for-Service patients.

Baseline assumptions

1. Fifteen percent+ are high risk, suitable for CCM (150 patients).
2. Half-time (or 0.5 FTE) RN Salary with benefits is about $37,500
3. Average reimbursement for CCM is $61 per month or $732 per year

Assign "Case Manager" RN and medical assistant to enroll 50 patients
Interact with about 3 patients per day on average.

Plan for gradual ramp up:
Month 1= 10 patients = $ 610
Month 2 = 20 patients = $1220
Month 3 = 30 patients = $ 1830
Month 4 = 40 patients = $ 2440
Subsequent months = 60 patients = $ 3660

1st year Revenue potential $ 35,380
Each subsequent year Revenue $43,920 +