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building a fee-for-service bridge to population health

Organizations that have been slow to prepare for value-based care may find that fee-for-service strategies can be helpful in population health management efforts.

Many healthcare organizations have been reluctant to commit to population health strategies due to reasonable fears of financial losses from traditional fee-for-service revenue streams. With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), however, physician organizations that continue to delay making the transition to value-based care risk seeing reductions in Medicare Part B payments. These financial consequences for remaining on the outskirts of an increasingly value-based payment system will make long-term financial sustainability difficult. Nonetheless, the sheer effort of deciding how best to initiate population health management (PHM) activity

can be daunting, and inexperienced organizations tend to overcommit to lofty value-based initiatives without great success.

With MACRA legislation changes to Medicare Part B payments coming soon, health systems and physician groups that can implement some elements of value-based care should do so. However, organizations should not rush the development of advanced value-based payment models without taking time to learn the basics of PHM. Fortunately, organizations that rely heavily on fee for service still can initiate PHM without a major commitment to building program structure, bearing risk, or developing alternative payment models on a large scale. Instead, those organizations should seek out programs that offer a bridge strategy to begin PHM in a fee-for-service context that can cover the cost of building a PHM infrastructure.

Medicare FFS Programs

During the past decade, the Centers for Medicare & Medicaid Services (CMS) promulgated several payment models designed to encourage health-care organizations to invest in evolving their care delivery toward population health, including some initiatives that generate fee-for-service revenue. Three of these revenue-generating PHM

AT A GLANCE

Three programs that generate fee-for-service income can help lay the foundation for population health management.

- > Transitional care management
- > Chronic care management
- > Quality improvement

The major barriers to adopting transitional care and chronic care management programs are largely procedural and can be easily addressed with staffing, technology, and proper work flow planning.

programs in particular—transitional care management (TCM), chronic care management (CCM), and quality improvement—require similar support activities and are well aligned for concurrent implementation for organizations seeking a PHM entry point.

Transitional care management. CMS introduced the TCM codes (99495 and 99496) in 2013 to allow providers to bill for their efforts in helping to transition patients from an inpatient setting to a community setting (e.g., home, assisted living).

A primary care physician looking to bill for TCM activities takes on the role of coordinator in a patient's post-acute care even when that care is delivered outside of the primary care physician's office, ensuring appropriate follow-up and helping to avoid unnecessary readmissions that cannot be reimbursed. To be paid under the TCM code, the physician must communicate (by phone, by email, or in person) with the patient or the patient's caregiver within two business days of inpatient discharge, engage in medical decision making of at least moderate complexity, and conduct a face-to-face visit within seven or 14 days of patient discharge, depending on the clinical complexity of the patient's condition.

In 2013, CMS estimated that two-thirds of discharged patients would be eligible for TCM

services and that these services could generate a 2 to 4 percent increase in total collections for a primary care physician.^a With payment for TCM services set at \$165.42 and \$233.09 for patients of moderate and high complexity, respectively, as compared with \$108.13 for a standard office visit, the TCM program offers a clear opportunity to realize incremental revenues.^b

To illustrate, consider that a primary care physician practice has a panel consisting of 2,500 patients, and that the practice's average payer mix includes 31 percent Medicare patients (i.e., 775 patients). If 25 percent of those patients (i.e., 194) are hospitalized in a year, and 67 percent of those are of moderate complexity and are eligible for TCM (i.e., 130), the practice could obtain an additional annual reimbursement of \$21,450 for these patients ($130 \times \$165 = \$21,450$).

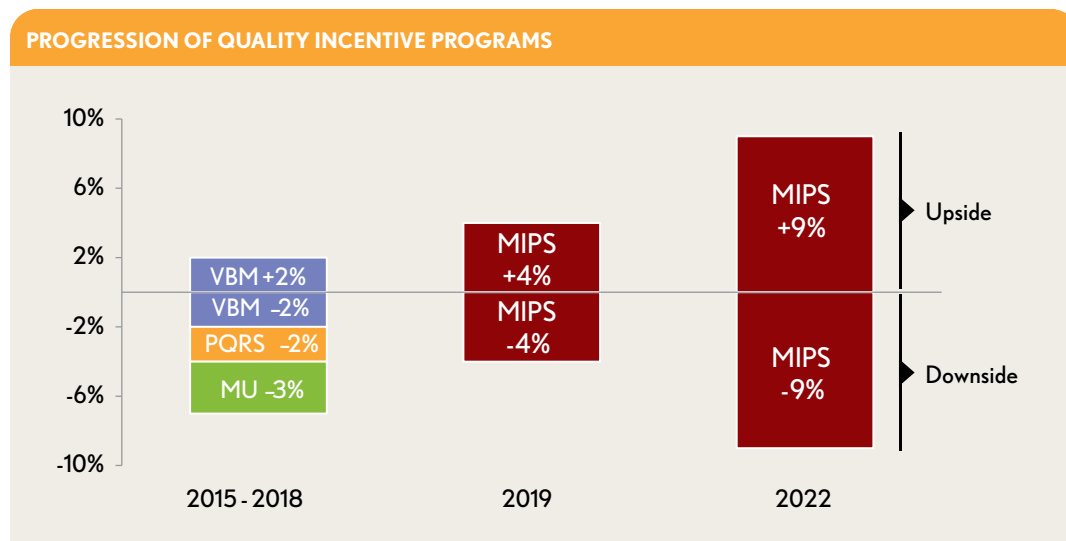
Chronic care management. In January 2015, CMS followed up its TCM initiative with the introduction of a CCM code (99490) that would allow providers to bill for incremental time spent managing patients with chronic diseases. This code allows providers who dedicate more than 20 minutes a month to managing patients with multiple chronic diseases (not including face-to-face encounters) to bill for their efforts. Activities allowed in the required 20 minutes include monitoring patient care plans, reviewing test results, consulting the patient's other providers, and following up with the patient via phone.

CMS has reported that approximately 35 million Medicare beneficiaries (nearly 2/3) are eligible to receive these services.^c At upward of \$41 per

a. Medicare Physician Fee Schedule Final Rule, 2013.

b. These payment figures reflect the national average payment from the 2016 Medicare Physician Fee Schedule. The actual payment will depend on geographic region.

c. "Chronic Care Management Services," Centers for Medicare & Medicaid Services.



Note: The quality component will be 50 percent of the MIPS score.

MIPS: merit-based incentive payment system, PQRS: physician quality reporting system, VBM: value-based modifier, MU: meaningful use

member per month, depending on the market, the financial opportunity afforded by delivering and appropriately billing for CCM services could be substantial.

Consider, for example, our previous scenario of a primary care physician practice with a panel of 2,500 patients and an average payer mix that is 31 percent Medicare (i.e., 775 patients). Let's say that 68 percent (i.e., 527) of these patients have chronic conditions, and that the assumed opt-in rate among these patients is 33 percent (i.e., 174). At \$41 per member per month, or \$492 per member annually, this figure would translate into a potential annual payment of \$85,608 ($174 \times \$492 = \$85,608$).

Quality-focused Medicare programs. In addition to the CCM and TCM fee-for-service billing codes, many organizations identify quality improvement as an initial pillar of activity for starter PHM programs because they are already responsible for monitoring quality delivered to Medicare patients. Current physician quality reporting

system (PQRS) and value-based payment modifier programs require eligible healthcare providers to report quality-related information to CMS to maximize Part B payment. As current PQRS and value-based payment modifier programs are effectively absorbed into MACRA's Quality Payment Program in 2017, the financial impact of demonstrating high levels of quality-related performance will continue to grow, as shown in the exhibit above. Organizations can easily use current quality score monitoring processes to develop a quality improvement or care gap program to improve quality scores.

Under a care gap program, organizations identify areas for improvement by reviewing quality and performance scores and initiating outreach campaigns targeted at patients who require specific types of care. The payment impact of a care gap program is twofold: enhanced Part B payment under a value-based modifier and MACRA's merit-based incentive payment system (MIPS) is achieved when quality scores go up, and

additional services delivered to fill care gaps drive revenue from increased volume.

For Medicare patients, outreach can focus on the Medicare annual wellness visit, during which many care gaps can be filled. The annual wellness visit is a reimbursable visit with no cost to the patient. According to CMS reports, only 12 percent of eligible beneficiaries make use of this option. Without considering additional payment

for services provided during the visit, such as hemoglobin A1C tests for diabetic patients, the potential revenue generated from completing an annual wellness visit for even a small set of patients every month is substantial. For example, based on a payment of \$173 per well visit, 10 additional annual well visits per month can result in an additional \$20,760 in annual revenue ($\$173 \times 10 \times 12 = 20,760$).

TACTICS FOR OVERCOMING PROGRAM BARRIERS

Program	Challenge	Tactics
Chronic Care Management (CCM)	Obtain patient consent and collect an \$8 monthly copayment.	Use patients' supplemental coverage to cover the copayment. (90 percent of Medicare patients have such coverage). Stress the value of additional care for CCM to patients with multiple chronic diseases.
	Identify eligible patients.	Use analytic systems to create a cohort of eligible patients based on disease criteria and prioritize those patients by risk.
	Establish an efficient work flow.	Hire a care coordinator, build a CCM-specific work flow to help guide activities, and create efficient sign-off processes for supervising providers who bill the service.
	Document non-face time appropriately to meet billing requirements.	Work with IT staff and the billing office to ensure documentation standards are built into the care coordinator's work flow.
	Coordinate with other providers and activities as appropriate.	Establish organizational policies around program implementation to determine which providers will be billing CCM. Open communication channels with the billing office to ensure coordination between providers and other programs, such as CCM and annual well visits.
Transitional Care Management (TCM)	Notify primary care physician when eligible patients are discharged from inpatient facilities.	Use IT-enabled alerts and communications to automatically notify primary care physicians when their patients have an inpatient admission and at discharge.
	Establish an efficient work flow.	Hire a care coordinator and build a TCM-specific work flow to guide activities.
	Document TCM activities appropriately to meet billing requirements.	Work with the billing office to ensure documentation standards are built into the care coordinator's work flow.
Quality Improvement	Identify cohorts of patients needing specific services.	Use analytic systems to identify patients with specific care gaps or eligible for an annual well visit.
	Automate outreach to cohorts of patients.	Enable patient portals or other automated communications to conduct outreach campaigns to groups of patients needing specific care.
	Establish an efficient work flow.	Hire a care coordinator and build specific quality improvement work flows to help guide activities that encourage patients to receive needed services and ensure providers are aware of needed services.
	Ongoing monitoring of quality scores	Use technology that allows for frequent updates to quality measures so that providers can track their performance over time. Establish organizational structure and processes for review of quality measurements among provider peer groups.

Laying the Foundation for PHM

Even though these three programs offer significant financial opportunity, they've been adopted nationally only to a limited extent because of operational barriers to their successful implementation. In fact, 2014 Medicare records indicate that only 20 percent of acute hospitalizations were tied to TCM claims and only a few hundred thousand claims have been submitted for CCM, even though 35 million beneficiaries qualify.

The major barriers to adopting TCM and CCM programs are largely procedural and can be easily addressed with staffing, technology, and proper work flow planning. The exhibit on page 4 offers specific tactics to address individual program challenges.

The various program challenges can be addressed most fundamentally by investing in care coordinators and establishing team-based care. Studies have shown that a physician with a panel of 2,500 patients would spend 21.7 hours per day providing all recommended acute, chronic, and preventive care and conducting effective care management and outreach.^d A care coordinator can help alleviate that burden. To implement a successful and cost-effective PHM model, physician involvement in the tasks required for CCM, TCM, and much of the coordination for closing care gaps should be kept to a minimum and organized into a single work flow for a care coordinator. Although care coordinator and care manager salaries vary widely based on licensure, the tasks required to support these programs typically do not require a high level of licensure nor do services involve care management of high-acuity conditions.

d. Yarnall, K.S.H., Østbye, T., Krause, K.M., et al., "Family Physicians as Team Leaders: 'Time' to Share the Care," *Preventing Chronic Disease*, April 16, 2009; Yarnall, K.S.H., Pollak, K.I., Østbye, T., et al., "Primary Care: Is There Enough Time for Prevention?" *American Journal of Public Health*, April 2003.

Filling gaps in care, implementing TCM processes, and providing CCM services are well-aligned fee-for-service strategies that can generate enough revenue to easily cover the cost of a care coordinator's salary, while preparing organizations to enter more mature value-based care arrangements.

For organizations seeking more conservative approaches to building their PHM programs, investing in care coordinators is a reasonable and effective strategy for launching a variety of programs. A care coordinator will schedule and confirm follow-up visits, preventive services, and Medicare annual well visits; prepare lab orders and refills; and discuss care plans with patients. Potential revenue from these items far exceeds the median care coordinator salary. Most organizations find that these starter PHM programs can be supported by existing technology systems, like basic quality reporting applications, secure messaging, and event notifications. Although additional technology investments may enhance program efficacy, larger technology investments in PHM can be delayed until organizations have gained significant program experience.

Given the statistics of eligible patients and time commitments, a single FTE may struggle to conduct all of the activities for these three programs, depending on the specifics of an individual provider's practice, panel risk, and

Case Study: Eastern Connecticut Health Network

After the passage of the Affordable Care Act in 2010, Eastern Connecticut Health Network (ECHN), a not-for-profit system serving 19 towns in eastern Connecticut, recognized that the gradual transition of healthcare from a volume- to a value-based industry was inevitable, but the pace of change in the reimbursement landscape was uncertain. ECHN leaders deployed a strategy to carefully plan the pacing of investments in the organization's facility and professional clinical and financial resources, while focusing on engaging physicians and other system-linked care providers, recruiting and developing physician leaders, and establishing a sustainable governance model.

ECHN selected an initial set of clinical programs that would capture incremental fee-for-service revenue to help offset the cost of program infrastructure including transitional care management, chronic care management, care gap closure, per-member per-month care coordination fees, and accurate coding capture of patient complexity. Employers and payers who engaged with ECHN were receptive to supporting programs with care coordination fees. ECHN used these new revenue streams to purchase a population health management (PHM) information system and to hire six community care managers who coordinate with home health staff, home telehealth remote patient monitoring, and primary care physicians who could be deployed in emergency departments as well as in-patient and primary care settings to support the new clinical programs. ECHN's modest but meaningful investments in care management resulted in not only a PHM program that yielded a modest return above the investment but also increased primary care visits, reduced gaps in care, and reduced hospital readmissions for patients with chronic disease. The success of ECHN's initial PHM efforts impressed commercial payers and prompted them to enter upside shared savings agreements with the physician hospital organization (PHO), which would provide further revenues to fund the maturation and expansion of ECHN's PHM program.

The system's thoughtful and sustainable approach to PHM not only resonated with commercial payers but helped it gain credibility with direct providers of clinical care. By showing providers that the PHM program could break even while providing additional resources to help the practice better serve its patients, ECHN positioned the organization to embark on more ambitious PHM initiatives with supportive and engaged providers. Along these lines, ECHN, in collaboration with its new health system, Prospect Medical Holdings, Inc.'s Coordinated Regional Care (CRC) program, is furthering its PHM and risk management capabilities through dual-sided population-based alternate payment models and a Next Generation ACO in 2017.

In an era where most healthcare providers have to carefully navigate their path to value, ECHN has successfully funded the foundation of its PHM program with available incremental fee-for-service revenues in a way that will allow the organization to synch the breadth of this program with the pace of reimbursement reform.

payer mix. Organizations can implement federated care coordinator models, with care coordinators placed in individual practices, or they can use a centralized care coordinator system to balance activities across practices with varying needs. Whichever model is used, care coordinator staffing should be carefully planned with respect to patient volume in selected clinical programs to ensure staffing levels are appropriate.

Building a Fee-For-Service Foundation for PHM

Many foundational PHM programs are available that provide opportunities for additional fee-for-service revenue and allow organizations to enter PHM conservatively. Healthcare organizations employing a phased PHM strategy should keep three key goals in mind as they plan their initial phase:

- > Emphasize activities that apply to multiple programs.

- > Optimize the use of available resources.
- > Add resources in a financially sustainable manner.

Filling gaps in care, implementing TCM processes, and providing CCM services are well-aligned fee-for-service strategies that can generate enough revenue to easily cover the cost of a care coordinator's salary, while preparing organizations to enter more mature value-based care arrangements. These financial opportunities will only increase in the future under MIPS, when providers will be rewarded for being top performers in quality and cost as well as for implementing the structure to support care coordination.

Initiating PHM programs can help organizations prepare for MACRA and capture payment through CMS programs while they still exist. The sample financial projections described here are limited to Medicare, even though commercial payers were expected to follow the trend. In evaluating the specific opportunities an organization can gain by implementing these programs, organizations also should consider commercial payer coverage for TCM and CCM in their markets, evaluate the

current potential to improve on PQRS measures against CMS's published benchmarks, and model the financial prospects under MIPS with these activities in place. Initiating PHM activities today can help organizations avoid falling behind industry trends and incurring penalties under MIPS. ■

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