Transforming Practice through Innovation and Training: Value-Based Payment and QI Consulting

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VICE PRESIDENT FOR EDUCATION, TPF
Purpose

» Share initial TPF Consulting Activities

» Gather feedback and input from you as TPF Stakeholders
TPF Offerings

- Chronic Care Management and Remote Monitoring Academy
- QI Consulting
- CPC+ Comprehensive Medication Management
## CCM/RM Medicare Billing Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 99490*</td>
<td>Chronic Care Management Services: Non face to face clinical staff time</td>
<td>$42.60</td>
</tr>
<tr>
<td>CPT 99091*</td>
<td>Telehealth: Collection and interpretation of physiological findings</td>
<td>$59.92</td>
</tr>
<tr>
<td>CPT 99487*</td>
<td>Complex Chronic Care Management Services</td>
<td>$94.00</td>
</tr>
<tr>
<td>CPT 99489*</td>
<td>Complex Chronic Care Management: Additional clinical time</td>
<td>$47.00</td>
</tr>
</tbody>
</table>
Established 2015

- Time directed by physician or another qualified health care professional for the specific purpose of coordinating care for patients with two or more serious chronic conditions that are expected to last at least 12 months.

Established 2017

- At least 60-minutes of time provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate-to-high-complexity medical decision making.
“Telehealth: Collection and interpretation of physiological findings”

- **New** charge, established January 2018
- Referred to as remote monitoring (to distinguish from other telehealth codes that patient has to be at qualified site, in rural area)
- May be billed concurrently with CCM codes
- 30 minutes of time spent in accessing, reviewing and/or interpreting data, adjusting care plan, communicating with patient/caregiver and associated documentation
  - Data = digitally stored and/or transmitted by patient/caregiver to the physician or other qualified health care professional
  - Examples: BP, weight, glucose, activity
Return on Investment for CCM

*Based on 2015 code before complex CCM and RM codes were established!

Assume ½ eligible pts enroll = 12 hours nursing time/week and $75K net revenue per FTE physician in “typical” practice

~130 pts to recoup costs of hiring full-time RN to provide CCM

Anticipate revenue loss for some practices if MDs deliver all CCM
Early CCM Findings (2015-2016)

- Delivered to >680K beneficiaries by 16K providers
- Decreased rate of growth in est. expenditures at 12-18 mos, saved Medicare ~$36 million
  - ↓ in inpatient, SNF, hosp outpatient
  - ↑ for home health, amb procedures, PCP visits
- Uptake greater in small independent practices with “self-motivated clinicians” and frontline staff with “greater flexibility and autonomy”
- Provider perceptions: + patient satisfaction, adherence and access, clinician efficiency
- Beneficiary/caregiver perceptions: satisfied, see value for complex patients but not sure they fit criteria

## Return on Investment: Potential Practice Income*

<table>
<thead>
<tr>
<th>TPF Practice</th>
<th>Pts &gt; 65 years with HTN</th>
<th>¼ eligible pts 1 RM/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN</td>
<td>648</td>
<td>$9,700</td>
</tr>
<tr>
<td>WA</td>
<td>1193</td>
<td>$17,800</td>
</tr>
</tbody>
</table>

*Conservative projections.
**Return on Investment: Potential Practice Income**

<table>
<thead>
<tr>
<th>TPF Practice</th>
<th>Pts &gt; 65 years with HTN</th>
<th>¼ eligible pts 3 RM/year</th>
<th>¼ eligible pts 3 RM + 3 cCCM/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN</td>
<td>648</td>
<td>$29,000</td>
<td>$74,000</td>
</tr>
<tr>
<td>WA</td>
<td>1193</td>
<td>$53,000</td>
<td>$137,000</td>
</tr>
</tbody>
</table>

*Conservative projections.*
GOAL: Deliver enhanced, customized training for TPF members to support implementation of CCM and remote monitoring
Chronic Care Management and Remote Monitoring Academy

- Baseline assessment of current approach with key stakeholders
- Evidence-based training and support curriculum
  - “How to” deliver (or improve delivery) of CCM and RM services
    - HTN: protocols for rx adjustment and monitoring, home BP monitoring support and guidance
    - Diabetes: measurable, actionable care plans, adherence tips/tricks
    - COPD: stepwise therapy, incorporating symptom scores into care plans
    - Other common diagnoses (CHF, CKD, depression, others)
- Forum to share complex patient scenarios, CCM “wins” and best practices
- Individual coaching and support
## Chronic Care Management and Remote Monitoring Academy

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who’s Involved</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline assessment (prn)</td>
<td>CCM staff Clinicians</td>
<td>2 hours</td>
</tr>
<tr>
<td>• Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-month CCM/RM curriculum</td>
<td>Academy Participants</td>
<td>2 hours/month</td>
</tr>
<tr>
<td>• Web meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Add-on in person training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forum</td>
<td>Academy Participants</td>
<td>2 hours/month</td>
</tr>
<tr>
<td>Individual coaching and support</td>
<td>Academy Participant Lead Clinician (beginning, wrap-up and prn)</td>
<td>2 hours/month</td>
</tr>
</tbody>
</table>
Chronic Care Management and Remote Monitoring Academy

Why TPF?

- Trusted, experienced faculty with focus on quality
- Innovative network of “do”ers
- Need for supplemental training and support to allow team members to practice at the top of their licenses and deliver high quality, high value CCM and RM
Sample Practice Proposal

TPF members currently delivering CCM to ~100 patients (of 500 enrolled) per month

Their goals

- Increase reach
- Prepare/train new staff member for CCM and general care manager role
- Enhance current CCM approach

TPF solution

- Customized assessment and recommendations
- Enroll two staff members in CCM and RM Academy
Sample Practice Proposal

- Potential ROI (from increased CCM, complex CCM, remote monitoring) = $100K+ annual revenue

- Academy fees for 2 participants: $2,000 per month or $10,000 if paid in advance

- Option for Baseline Assessment and Recommendations (limited offer): $1,000
Discussion
Quality Improvement Consulting
QI Consulting

GOALS:

- Maximize MIPS payment adjustments
- Enhance incentives from other value-based payment models
  - ACOs
  - CPC+
  - Million Hearts
  - Others
- Improve quality and joy of practice by engaging staff and physicians
- Meet ABFM Certification Self-Directed Performance Improvement Projects criteria
- Position practice for success as value-based payment models evolve
Return on Investment: MIPS Impact on Medicare Payments

$500 million EXTRA per year for exceptional performance up to +10%

Potential to scale up to 3 times positive adjustment for exceptional performance*

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Return on Investment: MIPS Impact on Medicare Payments

TPF Members
High Scores (per physician average)

<table>
<thead>
<tr>
<th>Year</th>
<th>±4%</th>
<th>±5%</th>
<th>±7%</th>
<th>±9%</th>
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<tbody>
<tr>
<td>2017</td>
<td>$4800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>±4%</td>
<td>±5%</td>
<td>±7%</td>
<td>±9%</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
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<tr>
<td>2021</td>
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<tr>
<td>2022</td>
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</table>

“Exceptional performance” bonus

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$9600</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Exceptional performance” bonus</td>
<td>$9600+</td>
<td>$9600+</td>
<td>$9600+</td>
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<td></td>
<td></td>
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</table>

Potential “exceptional performance” bonus

<table>
<thead>
<tr>
<th>Year</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$14,000</td>
<td>$20,000</td>
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</table>

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Return on Investment: ACO Examples
Total Net Change in Medicare Spending

Physician-Group ACOs (n=203, 1.83 M patients): -$256 M

Hospital-Integrated ACOs (n=132, 2.6 M patients): 111 Million

Figure 1. Differential Changes in Total Medicare Spending for Patients in Accountable Care Organizations (ACOs), According to the Type of ACO, Year of Entry, and Number of Years of Participation.
ACO Investment Model in the First Performance Year

The Accountable Care Organization (ACO) Investment Model (AIM) operates under the Shared Savings Program (SSP), providing up-front funding to encourage:

- New ACOs to form in low-ACO penetration or rural areas (Test 1)
- Existing smaller ACOs to continue participation and assume downside financial risk (Test 2)

47 AIM ACOs: 36 States, 420,000 Medicare Beneficiaries, 12,800 health care providers

AIM ACOs are Mostly Rural

<table>
<thead>
<tr>
<th>AIM Test</th>
<th>AIM Funds</th>
<th>Total AIM Funds Spent[^2]</th>
</tr>
</thead>
</table>
| Test 1:  | 41 ACOs  
           $250,000 +  
           $36 per beneficiary +  
           $8 per beneficiary per month | $58,340,797 |
| Test 2:  | 6 ACOs  
           $36 per beneficiary +  
           $6 per beneficiary per month | $162,657,486 |

[^2]: ACOs spent the most on:
- Care management
- Technology
- Administrative functions
## AIM ACOs Reduced Medicare Spending in First Performance Year

### Test 1 AIM ACOs vs. Local Market Beneficiaries (N=41)^[d]^  

<table>
<thead>
<tr>
<th>PBPM Spending</th>
<th>Aggregate Spending ( Millions )</th>
<th>Percent of Base Spending^[e]^</th>
</tr>
</thead>
<tbody>
<tr>
<td>-$22.7</td>
<td>-$105.4</td>
<td>-2.2%</td>
</tr>
</tbody>
</table>

95% Cl: (-$30.3 to -$15.1) (-$140.8 to -$70.0) (-2.9% to -1.5%)

### Test 1 NET SAVINGS TO THE MEDICARE PROGRAM:

- $82.8M (-1.7%)^[f]^  
  95% Cl: (-$118.2M to -$47.5M) (-2.5% to -1.0%)

### Test 1 AIM ACOs:
- ACOs with relatively lower spending had beneficiaries with fewer acute inpatient visits (including 30-day readmissions and ASC admissions), fewer SNF days, and less chance of visiting the ED.^[g]^  
- 24% (10 ACOs) earned shared savings, totaling $22.6M^[h]^  

### Test 2 AIM ACOs vs. Non-AIM SSP ACOs (N=6)^[i]^  

<table>
<thead>
<tr>
<th>PBPM Spending</th>
<th>Aggregate Spending ( Millions )</th>
<th>Percent of Base Spending^[e]^</th>
</tr>
</thead>
<tbody>
<tr>
<td>-$62.3</td>
<td>-$27.0</td>
<td>-4.1%</td>
</tr>
</tbody>
</table>

95% Cl: (-$134.7 to $10.0) (-$58.3 to $4.3) (-8.9% to 0.7%)

### Test 2 AIM ACOs:
- Aggregate estimated reductions in Medicare spending not statistically different from zero at the 5% level  
- 67% (4) earned shared savings ($2.4M/ACO); 39.4% (28) comparable non-AIM SSP ACOs (71) earned shared savings ($1.4M/ACO)^^[h]^  

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PBPM = per-beneficiary-per-month; Aggregate = total reductions over all beneficiaries and months; Tot. Exp. = Total Medicare Expenditures; CI = Confidence Interval

Reported statistics are based on averages across individual ACOs.
QI Consulting

- Individualized practice consulting and improvement coaching to:
  - Identify opportunities to maximize performance
  - Provide “how to” improvement plan for specific quality measures
  - Advise on clinical interventions to improve performance
  - Work with your team to implement and evaluate improvement plan
Why TPF?

- Quality experts
- Experience preparing practices for value-based payment transformation
- Partners with you in achieving quality goals AND supporting/improving practice quality of life
TPF member will select VBP program goals or general QI goals they want to achieve (with consultation prn)

QI Consulting delivered through:

- Group webinars
- Individual webinars
- Regular follow-up/support for QI liaisons
- On-site visits available as add-on

Cost will depend on practice size, projected incentives and virtual vs on-site meetings
Discussion
CPC+
Comprehensive Medication Management
Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.).

- Advanced Alternative Payment Model under MACRA
- ~3K practices in 18 regions with 61 aligned payers
- "Aims to improve quality, access and efficiency of primary care"
- Payment adjustments:
  1. Care management fee
  2. Performance-based incentive
  3. CPC payments: hybrid Medicare FFS adjustment for Track 2
CPC+ Requirements

Practices expected to make changes in the way they deliver care:

1) Access and Continuity
2) Care Management
3) Comprehensiveness and Coordination
4) Patient and Caregiver Engagement
5) Planned Care and Population Health
CPC+ Requirements

Practices expected to make changes in the way they deliver care:

1) Access and Continuity
2) Care Management
3) Comprehensiveness and Coordination
4) Patient and Caregiver Engagement
5) Planned Care and Population Health

“Develop a plan to provide comprehensive medication management to patients discharged from the hospital and those receiving longitudinal care management”
Comprehensive Medication Management

- Individual assessment of patient’s medication regimen
  - Is it appropriate, effective, safe, able to be taken as intended
  - Goal-oriented care plan
- Greatest benefit for patients:
  - On complex regimens
  - Not at therapy goal(s)
  - Experiencing adverse effects
  - With difficulty following regimen
  - Readmitted to the hospital or ER
Return on Investment: CPC+

1. Care management fee

<table>
<thead>
<tr>
<th>Risk Tier</th>
<th>Attribution Criteria</th>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; quartile HCC</td>
<td>$6</td>
<td>$9</td>
</tr>
<tr>
<td>Tier 2</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; quartile HCC</td>
<td>$8</td>
<td>$11</td>
</tr>
<tr>
<td>Tier 3</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; quartile HCC</td>
<td>$16</td>
<td>$19</td>
</tr>
<tr>
<td>Tier 4</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; quartile HCC for Track 1; 75–89% for Track 2</td>
<td>$30</td>
<td>$33</td>
</tr>
<tr>
<td>Complex (Track 2 only)</td>
<td>Top 10% HCC OR Demenita</td>
<td>N/A</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Average PBPM</strong></td>
<td></td>
<td><strong>$15</strong></td>
<td><strong>$28</strong></td>
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</table>

2. Performance-based incentive
   - Up to $2.50 PBPM (Track 1), $4 PBPM (Track 2) from Medicare
   - Other payers expected to set similar incentives

3. CPC payments
   - Hybrid Medicare FFS adjustment (Track 2) – upfront E&M payment to support flexible care delivery, reduced payment for billed E&M claims
Return on Investment: CPC+

1. Care management fee
2. Performance-based incentive
   - Up to $2.50 PBPM (Track 1), $4 PBPM (Track 2) from Medicare
   - Other payers expected to set similar incentives
3. CPC payments
   - Hybrid Medicare FFS adjustment (Track 2) – upfront E&M payment to support flexible care delivery, reduced payment for billed E&M claims

Sample Annual Return on Investment for TPF Practice in CPC+
Track 1 with 650 Medicare Patients:

- Care Management Fee: $117,000
- Performance-Based Incentive: $19,500
- + MACRA 5% AAPM Incentive: $12,000

Potential revenue: $148,500+
Comprehensive Medication Management

Why TPF?

• “Comprehensive medication management” expert = me!
• Resource for CPC+ practices to meet program requirements
• Test case for other pharmacy services/offerings
Comprehensive Medication Management

Costs will depend on number of patients eligible for CMM and projected hours of my time/month
Discussion
Purpose

▶ Share initial TPF Consulting Activities

▶ Gather feedback and input from you as TPF Stakeholders