Family Choice ACO
2019 ACO and CCM Forum

May 15th, 2019

AGENDA

- Introductions
  - Dr. Toan
  - Dr. Gordon - One Care Connect
- ACO Program Overview
- Chronic Care Management Overview
- Scope of Services ACO will Provide
- Family Choice CCM In-house Billing & Documentation/Addendum
- Member Attribution and CCM Eligibility
- Gaps in Care/Annual Wellness Visit (AWV)

Introductions

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ACO Program Overview

CMS—CENTER FOR MEDICARE SERVICES

MEDICARE MANAGED CARE

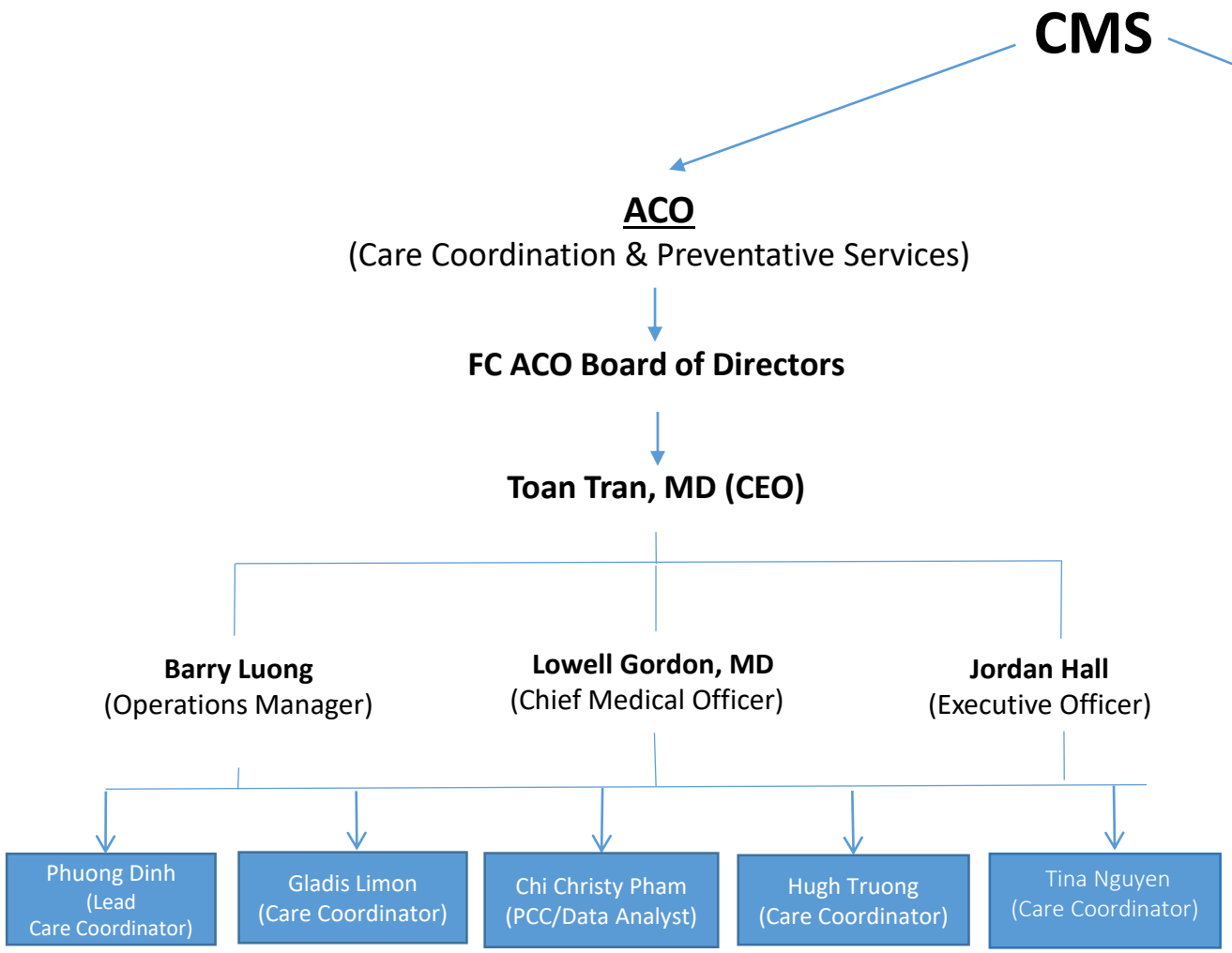
*CAL-OPTIMA (One CareConnect)
*MEDICARE ADVANTAGE
--Brand New Day
--Blue Shield
--Central
--Health Net
--Others

MEDICARE FEE-FOR-SERVICE (FFS)

TARGET ACO/CCM POPULATION

*****NOT IMPACTED BY ACO*****

Family Choice ACO



Care Coordinator & LVN coordinate with Patients, Providers, Hospitalists, SNFist

CCM Operation Structure mirrors ACO

Chronic Conditions (Sample list):

-Alzheimer's disease
- Arthritis
-Asthma
-Atrial fibrillation
-Autism spectrum disorders
-Cancer
-Cardiovascular disease
-COPD
-Depression
-Diabetes
-Hypertension
-Infectious diseases such as HIV/AIDS

Basic Functions of an ACO

- Coordinate clinical efforts among all participating providers (e.g. primary care, specialists, inpatient facilities).
- Facilitate the delivery of more effective and efficient care through increased care access, population management, care management.
- Reduce cost of care, increase quality performance.

Todays benefits of being in the ACO

- "MACRA" - ACO = Advanced Payment Model (APM) vs. Merit-Based Incentive Payment System (MIPS)
- In 2020/2021, APA ACO Participants will receive **5% bonus payments** made to physicians participating in Advanced APM in PY2018/2019 based on Part B allowed charge (the entire calendar year preceding the payment year.)
- ACO Bonus - Part 1- CMS pays the APM Incentive Payment amount to the TIN associated with the QP's participation in the Advanced APM entity
- Medicare Fee schedule payment updates will be higher (0.75%) for Advanced APM participants than for MIPS participants (0.25%) starting 2026
- Advanced APM participants do not have to participate in MIPS (models include their own EHR use and quality reporting requirements)

What you can expect from CMS…

The Direct Contracting path, together with the Primary Care First payment model options and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to **drive broader delivery system reform to improve health and reduce costs.**

Benefits of staying or joining the ACO!

- FC ACO will be grandfathered until 12/31/2022

Chronic Care Management Overview

Chronic Care Management--CCM

- CMS recognizes the superiority of care coordination in managed care and wants them applied to Fee-for-Service recipients
- **CMS has made care management reimbursable, but it requires a care team to effect**
- CCM activities include:
  - Post hospitalization discharge planning and follow up
  - Medication reconciliation
  - Coordinating care among specialists
  - Sharing of ancillary test results
  - Managing length of stay in both hospital and Skilled Nursing
  - Engaging families and determining care expectations and goals
  - Working with ER physicians and Hospitalists to determine optimal care setting
  - Coordinating with home and community based services
  - Facilitating appointments and accessing care as recommended
  - 24/7 access to address urgent needs/care coordination

Scope of Services ACO will Provide

Family Choice ACO Implementation Beneficiary Services Provided by ACO

- **FCHN will identify potential CCM beneficiaries using the ACO data provided by CMS**
- In order for CCM to be billable by physician the following needs to take place:
  - Performed by Family Choice ACO
    - Identify with **2 qualifying conditions:** Expected to last until patient's death
    - Develop and maintain a comprehensive care plan for the member
    - Track in a common EMR
    - Provide with **24/7 access**
    - Receive monthly outreach
    - Senior must agree verbally or in writing to receive CCM services
    - Ensure patient receives all recommended preventive services (also necessary for ACO)
  - Performed by physician
    - Bill for CCM services— Providers must do monthly to ensure payment!

ACO Participation Agreement Addendum – Chronic Care Management Program

Date of Letter

Re: ACO Participation Agreement Addendum – Chronic Care Management Program

Dear Family Choice Provider:

We are excited to announce that beginning in Quarter 4 (Q4) 2019, Family Choice ACO will begin to prepare, process and submit ACO CCM Program claims to Medicare and government payors through our internal in-house billing revenue cycle team. After listening to provider suggestions, Family Choice ACO will apply its best efforts to obtain reimbursement for billed charges for all CCM services rendered each month through billing of patients and third-party payers for the CCM management of ACO Provider's patients. Over the next several weeks, we will work with Medicare and your practice to secure appropriate PECOS enrollment and delegation which will allow Family Choice ACO to submit charges for your CCM patients. Each provider is required to sign the attached ACO Participation Agreement Addendum – Chronic Care Management Program.

How will Family Choice ACO CCM In-house Billing Work?

- Patient Care Coordinators (PCCs) will continue to enroll eligible patients and create comprehensive care plans as they do today.
- PCCs will conduct check-in regularly between visits and address any issues.
- FC ACO will track time, document work, review progress, and bill every month.
- FC will disburse monthly payments to providers along with a copy of the patient documentation and an EOB/Superbill for your records.
- FC ACO will bill only one of the below CPT codes monthly. Unfortunately, FC ACO only bill for CCM services below currently:
    - 99490
    - 99487
    - 99489

Key Responsibilities of ACO Monthly Beneficiary Outreach

ACO will establish beneficiary outreach and enrollment via phone

Discuss CCM benefit, etc. with patient

Systematic assessment of health needs and receipt of preventive services

- ACO Care Coordinators will:
- – Review of ED, Inpatient and Discharge activity
- – Request test results and hospital discharge plan (when possible)
- – Provide PCP with coordination and notification of health information
- – Telephone communications to both PCP and Patient
- – Initiate Comprehensive Care Plan
- – Schedule periodic review and care plan revision with patient (Monthly)
- – Community/social services referrals
- – Coordination of ACO specialists/services

ACO will conduct at least 20 minutes per month of non-F2F care management services

ACO will provide 24/7 access to a health care professional/care management

Family Choice CCM In-house Billing & Documentation

CCM Billing Codes and Revenue Potential

PCPs have access to additional billing codes (G0506, CPT 99487, CPT 99489)

PCPs can receive $43 per senior per month for code 99490 (Per Medicare)

Net PCP annualized reimbursement for 100 seniors would be $26 x 12 x 100 = **$31,200 (2,600/mo)**

FC ACO will bill PCP 40% of CCM allowed amount for performing monthly CCM services on behalf of PCP only after PCP has received payment from CMS

Patients may have out of pocket copay/coinsurance /unmet deductible will apply

Key Responsibilities of ACO and PCP
CCM Billing/Documentation

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])

Key Responsibilities of ACO In-house CCM Billing/Documentation

- Starting in Q4 of 2019, Family Choice ACO will now offer in-house billing services to streamline payments and reduce administrative burden on practices.

- When 20 or 60-minute threshold met, ACO will provide that date of service documentation to PCP for medical records documentation.

- FC ACO will bill the charges monthly to CMS on behalf of the ACO provider and make payments to providers monthly.

- 99490 (20 minutes or more)
  – Only one practitioner bills/allowed
  - Time aggregated/documented/collected from different per 30 calendar days

- For providers who opt out of FC ACO in house billing, FC ACO will send quarterly superbill. Superbills will account for each patient who has met the 20-minute time aggregated threshold
  - Provider will bill the charge quarterly to CMS and the ACO will invoice PCP quarterly.

Sample Superbill

Family Choice ACO
7631 Wyoming Street, Ste 201
Westminster, CA 92683
www.familychoice.com/aco

CCM Superbill

Family Choice ACO

Provider's Name
Provider's Address
Provider's Address

Patient Name: **Provider Name:**
HIC Number: **Date of Birth:** **Provider NPI:**

Date of Service	Procedure Code	Mod	Qty	Est. Billed Amount	Conditions:
	99490		1	$46.85	

Notes: *Family Choice ACO - Chronic Care Management - Please bill Medicare within 10 days of delivery of Superbill*
CLAIMS SUBMISSION - All claims submissions go directly to CMS

Patient Name: **Provider Name:**
HIC Number: **Date of Birth:** **Provider NPI:**

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CCM Activity to Date

Multiple CCM trainings

CCM beneficiaries enrolled/contacted: $6,000+

Overlap between beneficiaries enrolled in CCM and those who have been hospitalized in 2018/2019: 100%

CCM Billing/Documentation Reminders!

Duplicate payment not allowed for similar services –
– Transitional Care Management (TCM) in the same month 99495 – 99496

Cannot bill CCM same month as

– End Stage Renal Disease (ESRD) 90951 – 90970

– Home Health (G0181) & Hospice Care (G0182)

– Care Plan Oversight (CPO) G0179 - G0180

Member Attribution and CCM Eligibility Reports

Gaps in Care/Annual Wellness Visit (AWV)

Preferred F2F Annual Wellness Visit (AWV)

- The visit type with the highest weight is the Annual Wellness Visit (AWV)
  - Performing the AWV almost guarantees senior will be attributed to you
  - Can only be done once every 12 months
  - **FCHN has the data to know which seniors are eligible for AWV**
- AWV, according to CMS guidelines, includes the following:
  - HRA
  - List current providers and suppliers
  - PMH/FH
  - Vital signs (document weight and blood pressure)
  - Cognitive evaluation
  - Screening that are due based up USPSTF
  - Risk factors and plan
  - Personalized health advice
  - Advanced care planning (at the discretion of the beneficiary)
  - Goal is to develop Personalized Preventive Plan Services (PPPS) for senior
- Use codes G0439 (established with Medicare) or G0438 (initial) +G0506 Initiating Visit Add On Code

2019 Q1- Q2 Gaps in Care Report to be sent out in May

DOB	Age	Gender	Last PCP Appointmen	# of Care Ops	Member ID	Non-Compliant Measure
05/08/1949	69	F	03/18/2017	1	376868810B	Initial Visit
06/07/1943	75	F	03/02/2017	1	603580514M	Initial Visit
06/04/1948	70	F	04/27/2017	0	606789003A	N/A
01/15/1949	69	M	03/02/2017	0	567698969A	N/A
11/25/1918	100	M	04/28/2017	2	586388017M	Initial Visit; Acute Admission Rate (Multiple Chronic)
04/02/1949	69	M	04/22/2017	1	566639109A	Initial Visit
05/25/1935	83	F	02/07/2017	4	586582915A	Opt In; Pneumonia Vaccination (Seniors); Depression Screening; Fall Risk Screening
08/31/1934	84	M	02/24/2017	7	624151677M	Opt In; Pneumonia Vaccination (Seniors); Body Mass Index Assessment; Depression Screening; BP Control; (IVD): Use of Aspirin or Other Antithrombotics; Fall Risk Screening
02/08/1940	78	M	02/03/2017	0	617644041A	N/A
06/19/1959	59	F	01/31/2017	1	612709057A	Initial Visit
02/08/1942	76	F	04/08/2017	5	230930238M	Opt In; Pneumonia Vaccination (Seniors); Body Mass Index Assessment; Depression Screening; Fall Risk Screening
12/12/1949	69	M	03/14/2017	1	557576862A	Acute Admission Rate (Multiple Chronic)
12/31/1934	84	F	01/19/2017	2	620544738M	Initial Visit; Influenza Immunization
02/28/1930	88	M	03/02/2017	1	603580550M	Initial Visit
05/17/1934	84	F	N/A	10	612252385M	Opt In; Influenza Immunization; Pneumonia Vaccination (Seniors); Body Mass Index Assessment; Tobacco Use: Screening and Cessation Intervention; Depression Screening; BP Control; (IVD): Use of Aspirin or Other Antithrombotics; All Condition Readmissions; Fal
03/30/1941	77	M	04/03/2017	1	613404409A	Initial Visit

Family Choice ACO 2019 Quality Measure Checklist

PLACE INTO MEDICAL RECORD AFTER COMPLETION

Gaps in Care Guide—Included as handout

Measure Name	Last DOS	Documented ✔	CPT/ICD-10 Codes
Medication Reconciliation Post-Discharge (30 days) Falls: Screening for Future Fall Risk (2018)		Document date of discharge(s) & provider reconciled current & discharge medications for each discharge Pt screened or assessed for history of 2 or more falls or any fall with injury 0-1 falls	1111F 1101F (0-1 falls) 1100F (2+ falls or any fall with injury)
HbA1c Poor Control >9.0% (2018) (Adults 18-75)		Diabetes diagnosis; and Most recent HbA1c result:	ICD-10 (Diabetes): EII.___ 3046F (most recent HbA1c >9.0%)
Retinal or Dilated Eye Exam in 2018 or negative retinal exam (no retinopathy) in 2017 by an ophthalmologist or optometrist (Adults 18-75)		Diabetes diagnosis; and Report attached; or Negative Retinal/Dilated Eye Exam (no retinopathy) in 2017; or Retinal/Dilated Eye Exam for 2018 results show:	ICD-10 (Diabetes): EII.___ 2022F (dilated retinal eye exam) 2024F (seven standard field stereoscopic photos) 2026F (eye imaging validated to match diagnosis from seven standard field stereoscopic photos) 3072F (Low risk for retinopathy, no evidence of retinopathy in prior year)
Diagnosed with AMI/CABG/PCI in 2017 or active diagnosis of IVD with documentation of use of Aspirin or another antiplatelet medication		Active diagnosis of IVD; or AMI/CABG/PCI diagnosis in 2017; and Active Prescription (Check Category) Aspirin, Aggrenox, Plavix, Prasugrel Eliquis, Heparin, Lovenox, Pradaxa, nnnXarelto, or Warfarin	G8598 (Aspirin or another antiplatelet therapy used)
Controlled BP <140/90 mmHg HTN diagnosis w/in first 6 months of 2018 or prior but does not end before 1/1/18 (Adults 18-85)		HTN diagnosis; and Most recent BP reading:	ICD-10 (HTN): I10 G8752 (Systolic BP < 140mmHg) G8754 (Diastolic BP < 90mmHg)
Major Depression/Dysthymia Remission (PHQ-9 < 5) at 12 mo.		Major Depressive Disorder diagnosis; or Dysthymia Disorder diagnosis; and PHQ-9 >9 (12/1/16-11/30/17); and f/u PHQ-9 <5 at 12 months	ICD-10 (MDD): F33.____ ICD-10 (Dysthymia): F34.1____ G9509 (remission at 12 months)
Breast Cancer Screen (on or between 10/1/16-12/31/18) (Women 50-74)		Normal Abnormal; and Report attached	3014F (results documented & reviewed)
Colorectal Cancer Screen (2018 or indicated timeframe) Fecal occult blood; or Flexible Sigmoidoscopy (4 yrs prior 1/1/18); or Colonoscopy (9 years prior 1/1/18); or CT colonography (4 yrs prior 1/1/18); or Fecal immunochemical DNA test (FIT-DNA) (2 yrs prior 1/1/18) (Adults 50-75)		Report attached; and Normal Abnormal Normal Abnormal Normal Abnormal Normal Abnormal Normal Abnormal	3017F (screening results documented and reviewed)
Vaccinations Pneumococcal (once in a lifetime) Influenza (8/1/17- 3/31/18)		Pneumococcal vaccine received; and PPSV23 or PCV13 (if given between 2015-2018) Influenza vaccine received	4040F (Pneumococcal vaccine administered or previously received) G8482 (Influenza vaccine administered or previously received)
BMI Screening and Follow-Up Plan if abnormal (most recent visit in 2018 or previous 6 months) (Normal BMI= 18.5 kg/m2 - 25 kg/m2)		Most recent BMI result: Follow-up plan given: education/referral/medication/exercise & nutrition counseling/dietary supplements	G8420 (BMI normal, no f/u) G8417 (BMI above normal & f/u required) G8418 (BMI below normal & f/u required)
Tobacco Use: Screened at least once within 24 months and cessation intervention (within 24 months of screened date) if positive tobacco user		Tobacco user Tobacco cessation intervention given Tobacco non-user	4004F (screened for tobacco use & received cessation intervention) 1036F (current tobacco non-user)
Clinical Depression Screening and Follow-Up Plan if positive (2018)		PHQ-9 result: Follow-Up Plan: additional eval given for depression/suicide risk assessment/referral/medication/other intervention	G8431 (positive screening & f/u plan documented) G8510 (negative screening documented, f/u plan not required)
Cardiovascular Disease: (Adults 21+) Previous or current diagnosis of ASCVD/Familial or Pure Hypercholesterolemia; or Fasting or direct LDL-C >= 190 mg/dL; or Diabetes with fasting or direct LDL-C of 70-189 mg/dL (Adults 40-75) who was prescribed Statin Therapy		ASCVD/Familial or Pure Hypercholesterolemia diagnosis; or LDL-C result: or DM diagnosis and LDL-C result: and Statin Therapy Rx	G9664 (current statin therapy users or received a prescription for statin therapy)

2019 Summary Update

- FCHN has extensive data on **12,000+** Medicare Fee-for-Service Seniors
  - Chronic conditions that qualify beneficiary for CCM encoded
  - AWV is encouraged and billable without copay or coinsurance
- For 2019, 70+ new physicians have signed on with Family Choice ACO
- CCM presents an immediate opportunity:
  - 2019 Inhouse billing services
  - Manage chronic conditions more effectively
  - Implement case management techniques for complicated patients
  - Ensure preventive needs are being addressed
- CCM will assist ACO be successful as care coordination through CCM will lower Hospital and Emergency Department costs
- ACO care coordinators will be contacting your office to assist with care coordination