# Webinar Q&A: Leverage CCM to Get a Head Start on MACRA

This document was compiled from questions asked during the November 3, 2016 webinar "*Leverage CCM to Get a Head Start on MACRA.*"

### *Under MIPS, for the minimum 100 Medicare patients, does it matter if those patients are under an HMO or are straight Medicare patients?*

According to the final rule, the low-volume threshold means an individual MIPS eligible clinician or group who, during the low-volume threshold determination period, have Medicare Part B allowed charges less than or equal to $30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries. Beneficiaries enrolled in Medicare Advantage plans that receive their Part B services through their Medicare Advantage plan will not be included in allowed charges billed under Medicare Part B for determining the low-volume threshold.

### *Can providers still participate in MIPS under their HMOs?*

According to the final rule, large proportions of the Medicare and Medicaid programs are already delivered through capitated insurance payments to HMOs, PPOs, and related organizations. The Medicare Advantage Plans and related state programs therefore already have substantial incentives to improve quality and reduce costs. MIPS does not affect provider payments under those programs directly, which have their own reimbursement mechanisms for physicians and other clinicians. In many but not all cases, those insurance carriers do use incentive mechanisms that are similar in purpose and design to the kinds of APMs that CMS expects to arise under the new payment adjustments. CMS does not expect major near-term changes in HMO and PPO payment arrangements, or performance, from any MIPS or APM spillover effects.

### *This is inherently unfair for small practices with really sick patients, because they are sure to be in the bottom 25% and can't afford the administration cost/resources to bring their score up above the larger practices with lots of admin personnel!*

It is true that clinicians in large groups or APMs were expected to fare much better under the proposed rule. As a result, in the final rule, protection for small, independent practices is an important thematic objective. Many small practices will be excluded due to the low volume threshold. By making 2017 a transition year with "pick your pace" of participation options available, CMS now estimates that at least 80 percent of clinicians in small and solo practices with 1-9 clinicians and 90 percent of eligible clinicians overall will receive a positive or neutral MIPS payment adjustment. Also, in keeping with the objectives of providing education about the program and maximizing participation, and as mandated by the MACRA, $100 million in technical assistance will be available to MIPS eligible clinicians in small practices,

rural areas, and practices located in geographic health professional shortage areas (HPSAs), including IHS, tribal, and urban Indian clinics, through contracts with quality improvement organizations, regional health collaboratives, and others to offer guidance and assistance to MIPS eligible clinicians in practices of 15 or fewer MIPS eligible clinicians.

Additionally, small to mid-size independent groups can actually turn their size into a competitive advantage. Small to mid-size groups are far more agile than the bigger players. Technology investments that leverage that agility, such as improving relationships with value-based partners, are of far greater value than getting bogged down in lengthy implementation cycles such as population health management solutions. Clinicians already know who their highest risk patients are. By leveraging data on beneficiaries from Medicare supplemented with information obtained from the CCM program, high risk patients can be identified and managed closely without expensive and lengthy technology implementations.

Finally, many outcomes measures are risk-adjusted to account for beneficiary severity prior to treatment.

## *We are presently enrolled in 2 ACO's, any other recommendations?*

In addition to considering CCM, TCM, AWV, and Advanced Care planning, we would recommend that you do the following:

1. **Fully participate in your APM**

   Controlling cost and quality is a team sport across multiple providers, not just your practice. Coming together in name only won't help your practice. Think about pooling resources to implement improved processes and technology, and participate in co-management agreements that will help to improve care coordination for all attributed patients.

2. **Take control of downstream spend by coordinating referred care with high value referral partners**

   The average primary care physician makes 1,000 referrals every year, thereby influencing ten million dollars in downstream healthcare spend.* On average, up to half of this spending may be on Medicare patients. All of this begs the question – how can you successfully manage quality and cost if you don't know where your patients are?

   An often overlooked opportunity to control both quality and cost is the referral, because it is both the trigger point that money is about to be spent and an early indicator of a decline in health. By placing patients with the highest value provider and maintaining visibility into that patients care across the continuum, providers can more effectively manage both quality and cost.

*I run a Retina practice and I am excited about the change. I do not understand how we can incorporate CCM into our practice. What are your recommendations?*

It is possible for specialists to deliver Medicare's CCM program, as long as they are able to deliver all of the required components of CPT 99490 and manage the patients overall care. In fact we currently have customers that are cardiologists and oncologists. The majority of providers participating in the program however are PCPs. A retina practice may have a hard time providing all aspects of the program to their patients.

*Could you speak a little bit to the new 2017 CCM changes?*

Under the final rule, CMS has made it much easier to participate in the CCM program. Here are the key things that are changing in 2017:

**Enrollment**

- Patients no longer must be enrolled in the program during a face to face encounter. Only patients that have not been seen within the last year have to be enrolled via an AWV, IPPE, or E/M visit. Additionally, written patient consent is no longer required. Consent is verbal, and must be documented in the EMR.

**Billing Codes**

There are several new billing codes associated with the CCM program:

- GPPP7 – care plan development
- 99487 – 60 min (one billing per month per patient)
- 99489 – 30 min (only in additional to 99487)

**Technology Requirements**

- The requirement for structured recording of patient information in the EMR no longer requires the creation of a structured clinical summary record.
- The exchange of continuity of care documents in a timely manner with other providers can now be done via fax in any circumstance, and is no longer limited to "extenuating circumstances."
- The electronic exchange of the care plan can also be shared by fax.
- 24/7 access to the care plan for all practitioners is no longer required.

*The co-pay of $8 for CCM was supposed to be waived, as we were told this year. Is that a change in 2017? Will we indeed not be penalized for not pursuing the collection of that co-pay…in 2017?*

At this time, the copay is still in effect. How CMS will react to practices not pursing the collection of the co-pay is not something we are able to speculate on.

### *Ok so your plan is to have those team members with the least clinical background making the "value call" to the most complicated patients in the practice?*

No, that is not what we are saying.

In terms of the "value call" as it relates to decreasing preventable utilization, Smartlink's Value-Based CCM aims to guide the MA's discussion with the patient so they are able to identify potential warning signs that might otherwise go un-noticed and potentially result in a visit to the ER and/or a hospitalization. Triggers in the system alert the MA that the clinician should be notified. The clinician can then make the decision as to what, if any, action is warranted.

In terms of utilizing referral partners that are the highest value providers in the community, high value providers are identified as such in the system, so that the referral coordinator or care manager knows who to refer the patient to. The clinician can also specify a specific referral partner when the referral is requested in the EMR. Thus the "value call" determination in terms of who the patient is referred to is determined by the clinician, not by the person conducting the referral.

### *The key to low utilization is the right care in the right place by the right provider, not sure that is within the scope of practice of an MA.*

Absolutely. The right care at the right time is also important. CCM is a great opportunity to touch *all* poly-chronic patients at least once a month and between office visits, not just the sickest 1-5%. It is also a great opportunity to provide self-management coaching, disease specific education, check symptoms, and identify potential warning signs that could result in an expensive escalation. Unfortunately, MA's do not possess that scope of knowledge. Smartlink's Value-Based CCM has built in condition specific clinical protocols, disease education, and symptom checkers that guide the MA through a meaningful dialog with patients. Patient responses trigger an alert to the MA so they know when to notify the clinician of potential warning signs. The system is based on 17 years of experience managing a population of 1.5 million patients. Without this level of guidance, it would be nearly impossible to impact quality and utilization with MA's via the CCM program.

### *Can you repeat the key updates to CCM in the 2017 rule?*

With the 2017 final rule, participation in CCM is much easier, and also has the potential to be more profitable. Here are the key updates that we covered in the webinar:

**Patient Enrollment**

Previously patient enrollment had to be in person, and the clinician had to obtain written consent. That is changing in 2017, and now only has to be in person for new patients or if the patient hasn't been seen within the last year. Also patient consent in 2017 will be done verbally and documented in the EMR. Written consent will no longer be required.

**Electronic Requirements**

The electronic requirements have also been relaxed.

- For care transitions, you will need to exchange continuity of care document(s) timely with other providers. That can now be done via fax.
- Sharing of the care plan can also be done via fax.
- The requirement for 24/7 access to the care plan for anyone caring for the patient is being eliminated.

**New Billing Codes**

In terms of new revenue opportunities, there are several new billing codes in 2017, including codes for care plan development as well as the ability to provide complex care management, which is 60 minutes instead of 20. There is also an additional code for 30 minute increments to complex care management. The new billing codes are:

GPPP7 – care plan development
99490 – 20 min
99487 – 60 min
99489 – per 30 min (in addition to the 60 min)

And finally, RHC's and FQHC's will no longer be subject to the "incident to" rule.

## References

*Health Reform and Physician-Led Accountable Care: The Paradox of Primary Care Physician Leadership. Farzad Mostashari, MD, MPH; Darshak Sanghavi, MD; Mark McClellan, MD, PhD. JAMA. 2014;311(18):1855-1856. doi:10.1001/jama.2014.4086