Integrated Care Resource Center

TECHNICAL ASSISTANCE BRIEF

NOVEMBER 2015

Medicare Chronic Care Management Services Payment: Implications for States Serving Dually Eligible Individuals

By Julie Stone, Mathematica Policy Research

IN BRIEF: Medicare's new payment to physicians and other practitioners for chronic care management provides states with an opportunity to enhance and better coordinate services for Medicare-Medicaid enrollees (dually eligible individuals). This brief identifies opportunities for states and their contracting plans that serve Medicare-Medicaid enrollees to align Medicare and Medicaid coverage of care management. Such alignment could facilitate a more seamless and coordinated approach to providing the medical, behavioral, and social supports covered under both programs.

High-performing care systems rely heavily on care management for the highest-need, highest-cost individuals. Evidence shows that care management can, under certain circumstances, improve outcomes for individuals with chronic conditions.[1] Effective care management includes improving provider-enrollee and provider-to-provider communication, increasing an individual's adherence to recommended medications and self-care regimens, and increasing the use of evidence-based care. Many of these activities are conducted outside of face-to-face physician office visits, with practitioners often connecting high-need individuals to a range of medical and behavioral health services and social supports, including long-term services and supports (LTSS).

Medicaid pays for care management for Medicare-Medicaid enrollees through a variety of state plan benefits and waivers that focus primarily on LTSS. However, physicians and other primary care practitioners are usually not included in these arrangements since Medicare is the primary payer for their services. Until recently, Medicare's physician fee schedule limited reimbursement of care management primarily to face-to-face visits through the Evaluation and Management payment.[2] Medicare has also paid for non-face-to-face care management services on a limited basis through home health, hospice, discrete initiatives (e.g., Primary Care Incentive Payment Program), and, more recently, care transitions from hospitals to community settings.

This technical assistance brief describes the new Medicare payment for chronic care management (CCM), which became effective in January 2015. It also identifies opportunities for states and their contracting plans that serve Medicare-Medicaid enrollees to use the CCM payment to align Medicare and Medicaid coverage of care management, potentially improving coordination of care.

Medicare Payment for CCM

To provide financial incentives and compensation for care management for Medicare enrollees with the highest needs, the Centers for Medicare & Medicaid Services (CMS) established a new Medicare fee-for-service (FFS) payment policy for CCM services.[3] As of January 2015, qualified physicians can receive monthly payments for CCM services furnished for at least 20 minutes per calendar month to individuals with two or more chronic conditions whose need for care management is expected to last for at least 12 months or until death. CCM services include non-face-to-face management/coordination of services, such as the regular development and revision of a plan of care, communication with other treating health professionals, and medication management (see box on next page for requirements).

Medicare Chronic Care Management (CCM): Required Scope of Services[4]

Practitioners must ensure:

- Systemic assessments of an individual's medical, functional and psychosocial needs;
- Access to CCM 24 hours a day, 7 days a week;
- Continuity of care with a designated practitioner;
- Medication reconciliation;
- Person-centered care plans based on physical, mental, cognitive, psychosocial, functional and environmental assessments;
- Availability of non-face-to-face consultation through telephone, secure messaging, internet or other methods;
- Coordination with home- and community-based services;
- Individual's consent to deliver CCM; and
- Electronic health records (using CCM certified technology) for care management.

Considerations for States and Health Plans

The new Medicare CCM payments raise key considerations for states and contracted health plans:

1. State Medicaid programs will be responsible for the 20 percent CCM co-insurance payment on behalf of Medicare-Medicaid enrollees.

State Medicaid programs responsible for paying these amounts under Medicare Savings Programs and the health plans with whom they contract may see increases in co-insurance charges for certain Medicare-Medicaid enrollees.[5] The availability of CCM payments will lead some providers to deliver new care management services, but other providers, who were already performing care management services prior to CY 2015 but not billing for the separately (thus with no additional co-insurance charge), may begin separately billing for CCM.[6]

2. CCM payments give states the opportunity to encourage coordination among providers serving the same individuals and avoid duplicative Medicare and Medicaid payments.

Having certain providers manage Medicare's medical services, other providers manage Medicaid's LTSS, and still others connect individuals to social services could result in the duplication of care management services for a single dually eligible individual. Multiple providers might attempt to coordinate the same services and/or make the same referrals. In addition, Medicare's new CCM payments could, in some instances, duplicate reimbursements by Medicaid to providers for the care management of medical services.

- **In capitated managed care settings,** states will want to work closely with their Medicare-Medicaid Plans (MMPs) and Dual Eligible Special Needs Plans (D-SNPs) to ensure that providers align care plans and establish complementary person-centered goals. In some instances, the development of a common care plan may even be appropriate. Through collaboration and regular communication, these providers might be able to more seamlessly manage the entire spectrum of an individual's medical and social service needs.
- **In FFS settings,** states may want to consider giving providers engaged in integrated care guidance on billing Medicare first for care management services, then billing Medicaid for just those care management services not covered by Medicare. This issue of Medicare and Medicaid payment overlaps may arise in managed FFS model financial alignment demonstrations, as well as in Medicaid health home and targeted case management programs.

3. States also have the opportunity to coordinate Medicaid health home benefits with Medicare's provider payments for chronic care management.

The Medicaid health home benefit allows states to receive federal reimbursement for comprehensive care coordination for certain Medicaid enrollees with chronic conditions. As of November 2015, 19 states and the District of Columbia have approved health home programs, totaling 27 unique health home models.

Although significant differences exist between Medicaid's health home benefit and Medicare's payment for chronic care management (e.g., enrollee and provider eligibility criteria; requirements concerning the scope of allowable services; and Medicare's and Medicaid's payment of providers[7]) opportunities exist for states to help coordinate services and payments under both programs for Medicare-Medicaid enrollees. States interested in better aligning Medicare and Medicaid policies and finding additional sources of funding for care coordination may want to explore the following options:

- **Coordinating through the use of care management entities.** States with Medicaid health home programs may rely on care management teams or other entities to provide care management services for health home enrollees. Although Medicare's CCM payment limits reimbursement to qualified physicians and certain other clinical providers, Medicare guidance specifies that an eligible physician or other qualified practitioner may, under certain circumstances, subcontract with staff external to the practice, such as a care management entity, to conduct CCM.[8,9] Physicians and clinical staff who serve large numbers of Medicare enrollees and do not have the in-house capacity or expertise to perform care management may want to partner with Medicaid-participating care management entities to deliver CCM. Such organizations could serve as a single coordinating entity for the provision of the full range of medical and non-medical services for Medicare-Medicaid enrollees. The potential for receipt of payment by both programs may enhance the quality of coordinated care and the resources available to deliver this care. In addition, there is evidence that relying on non-physician team members to deliver CCM may be cost effective for physician practices.[10]
- **Coordinating Medicare CCM and Medicaid health home funds under capitated Medicare-Medicaid Plans.** States that operate both capitated financial alignment demonstration programs and offer Medicaid health home benefits may want to explore opportunities to help MMPs coordinate care management services and payments provided by both programs. Although the state would need to both: (1) identify Medicare providers who are delivering, or have interest in delivering, CCM services; and (2) facilitate cooperation and coordination with Medicaid's care management entities, such efforts have the potential to improve the seamless delivery of Medicare and Medicaid services and promote effective utilization of payments under both programs.

4. Not all physicians and qualified non-physician providers who wish to bill Medicare for CCM will be able to do so.

Without additional investments in infrastructure, some providers may not be able to meet the minimum service or electronic health records requirements for CCM payment (see required scope of services on prior page). This may prevent certain safety net and rural providers, who often have fewer resources to start with, from being able to bill Medicare for CCM. States that rely heavily on their safety net and rural providers to serve Medicare-Medicaid enrollees may want to work with their contracted health plans to help providers develop or gain access to this capacity.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**

Endnotes

[1] J. Libersky, M. Au, and A. Hamblin. “Using Lessons from Disease Management and Care Management in Building Integrated Care Programs.” Integrated Care Resource Center, April 2014. Available at: http://www.integratedcareresourcecenter.net/PDFs/ICRC%20Disease%20Management%20and%20CareCoordination%20Brief%204-15-14.pdf.

[2] CPT codes used to bill for E/M office/outpatient visits were designed to reflect an overall orientation toward episodic treatment and not intended to cover comprehensive, coordinated care management for individuals with high levels of care need. See: Federal Register/Vol. 78, No. 237/December 10, 2013, 74415.

[3] Federal Register/Vol. 78, No. 237/Tuesday, December 10, 2013, pp. 74414-74427. Additional information about the valuation of CCM services, payment standards, and scope of services can be found in the CY 2015 Final Rule: Federal Register/Vol. 79, No. 219/Thursday, November 13, 2014, 67715- 67730. CMS Fact Sheet on chronic care management services is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

[4] 2015 PFS final rule (CMS-1612-FC), Federal Register/Vol. 79, No. 219/Thursday, November 13, 2014, 67715- 67730.

[5] State Medicaid programs may have to adjust Medicaid management information systems (MMIS) edits to recognize the CPT code for the newly Medicare-coverable service, if it is not already known. Medicaid programs will then have to edit claims for payment based on the Medicare cost-sharing payment methodologies already selected in their state plans, or submit a State Plan Amendment to adjust those methodologies.

[6] A. O'Malley, A. Tynan, G. Cohen, N. Kemper, M. Davis. “Coordination of Care by Primary Care Practices: Strategies, Lessons, and Implications.” Health System Change Research Brief No. 12, April 2009. Available at: http://www.hschange.com/CONTENT/1058/.

[7] Medicare limits provider eligibility for CCM participation to physicians and non-physician practitioners, such as certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants, who bill the Medicare FFS program. A state’s Medicaid health home benefits, however, also extend provider eligibility to community-based organizations, such as community health centers, home health agencies, and care management entities, among others. Medicare limits CCM payment for care management services to those provided on a face-to-face basis. A states’ Medicaid health home benefits, on the other hand, often allow providers to bill for a combination of care management services provided on a face-to-face and non-face-to-face basis. See: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html; and K. Moses. and B. Ensslin. “Seizing the Opportunity: Early Medicaid Health Home Lessons.” Center for Health Care Strategies, March 2014.

[8] Centers for Medicare & Medicaid Services. “Frequently Asked Questions about Billing Medicare for Chronic Care Management Services.” May 7, 2015. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf.

[9] Centers for Medicare & Medicaid Services. "MLN Matters: Information for Medicare Fee-For-Service Health Care Professionals." Number: SE0441. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf.

[10] S. Basu, R. Phillips, A. Bitton, et al., "Medicare Chronic Care Management Payments and Financial Returns to Primary Care Practices: A Modeling Study." Annals of Internal Medicine. September 22, 2015 doi:10.7326/M14-2677. Available at: http://annals.org/article.aspx?articleid=2443058.