Benefits of Preventive Services in Chronic Disease Management

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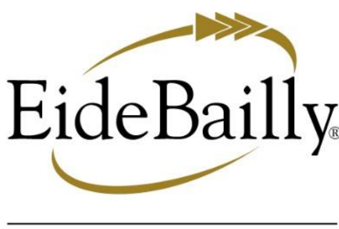


Objectives

- Examine preventative service processes related to billing regulations and organizational implementation
- Understand the impact of chronic disease management to patients' quality of life
- Determine potential resource allocations to support organizational goals related to population health management
- Identify potential revenue sources through accurate billing of preventive services

Medicare: Changing the Landscape

From

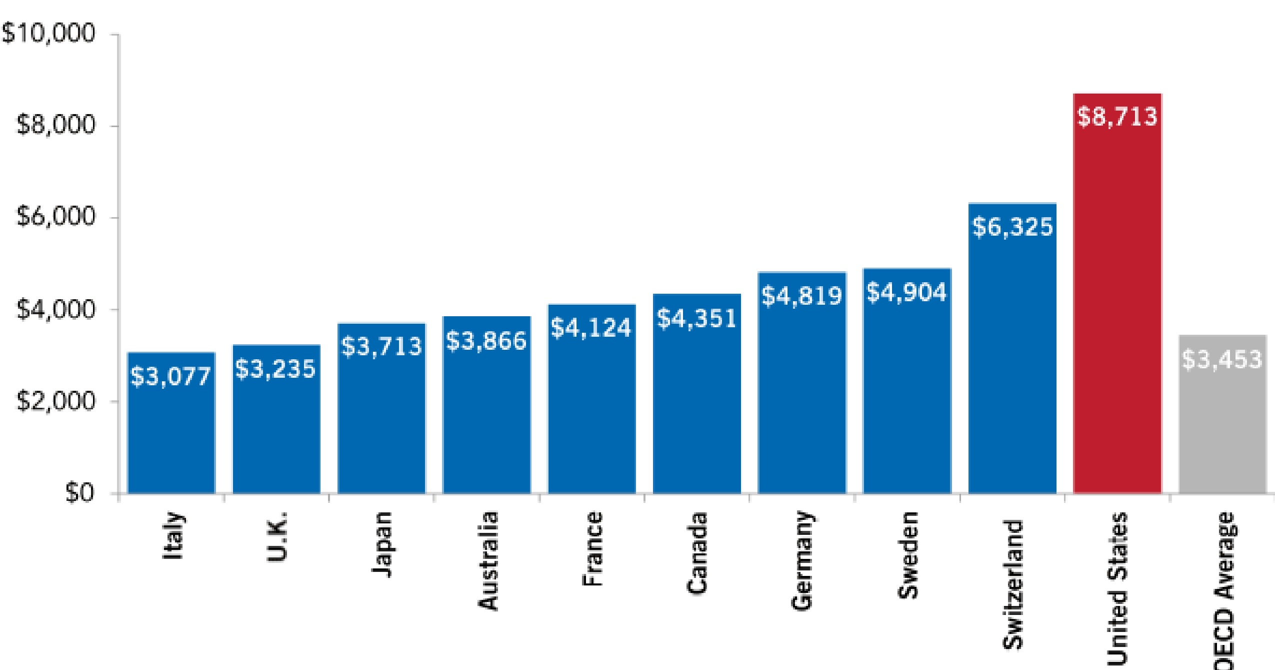
- Nine individuals under 65 contributed to each person over the age of 65.
- 19,000,000 enrolled in Medicare in 1967

To

- Five individuals under 65 who contribute to each person over the age of 65.
- Nearly 58 million enrolled in Medicare as of February of 2017

Source: CMS

Per Capita Costs Comparison



SOURCE: Organization for Economic Cooperation and Development, *OECD Health Statistics 2015*, November 2015. Compiled by PGPF.
NOTE: Data are for 2013 or latest available. Chart uses purchasing power parities to convert data into U.S. dollars.

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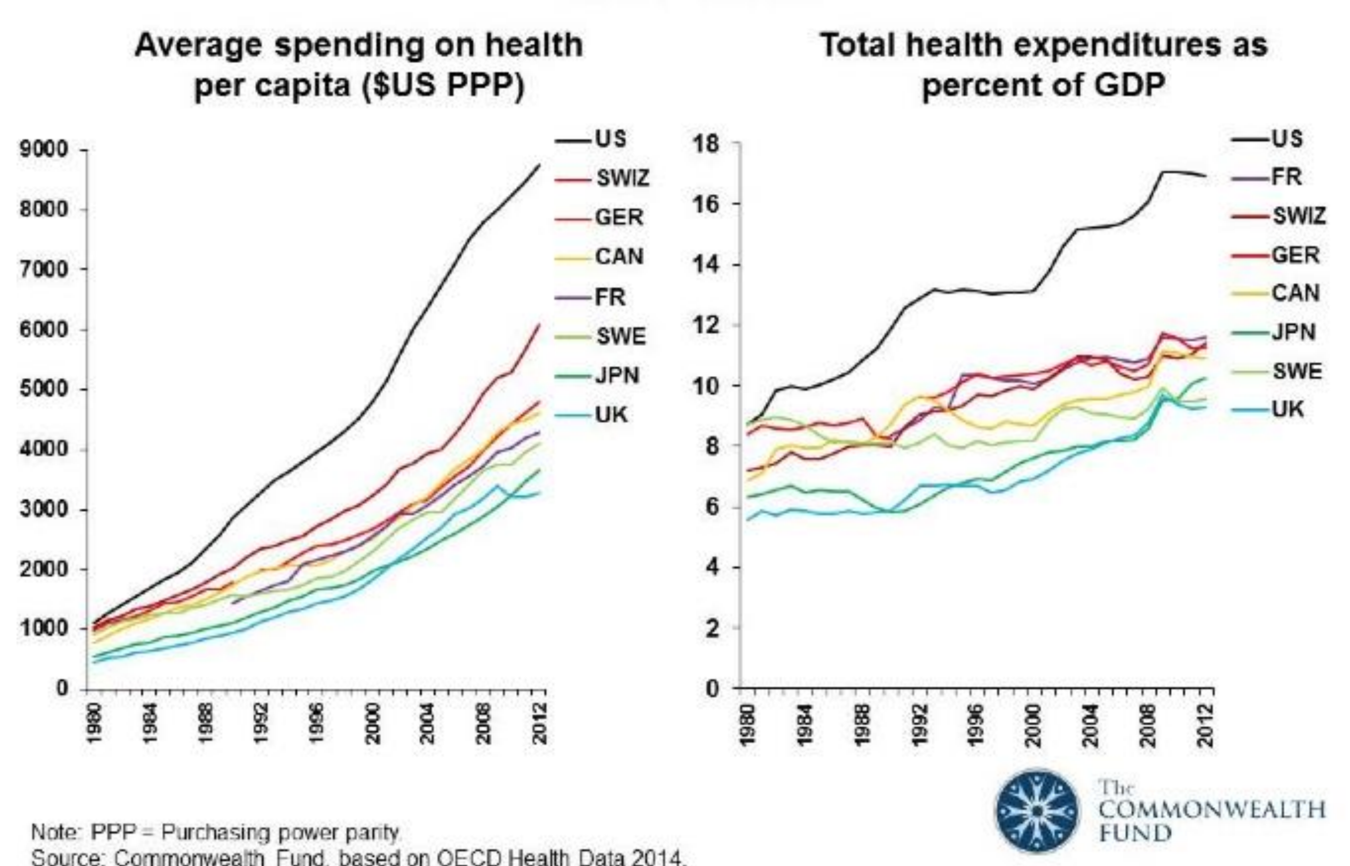
Spending



Quality Comparisons Worldwide

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

Growth of Health Care Costs

Year	Health Insurance Premiums	Workers' Contribution to Premiums	Workers' Earnings	Overall Inflation
2006	98%	93%	24%	21%
2011	160%	168%	50%	38%

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).

Obesity and Diabetes Epidemic

- Correlation between Obesity and Diabetes
- Epidemic Trend over the last 30+ Years

Obesity Trends* Among U.S. Adults BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)

1990

2000

2010

No Data | <10% | 10%–14% | 15%–19% | 20%–24% | 25%–29% | ≥30%

Obesity Trends* Among U.S. Adults BRFSS, 1990, 2000, 2010

- In 1990, **10** states had a prevalence of obesity less than 10% and no state had prevalence equal to or greater than 15%.
- By 2000, no state had a prevalence of obesity less than 10%, **23** states had a prevalence between 20–24%, and no state had prevalence equal to or greater than 25%.
- In 2010, no state had a prevalence of obesity less than 20%. **36** states had a prevalence equal to or greater than 25%; **12** of these states had a prevalence equal to or greater than 30%.

Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among U.S. Adults Aged 18 Years or older

Obesity (BMI ≥30 kg/m²)

1994

2000

2010

No Data | <14.0% | 14.0-17.9% | 18.0-21.9% | 22.0-25.9% | ≥26.0%

Diabetes

1994

2000

2010

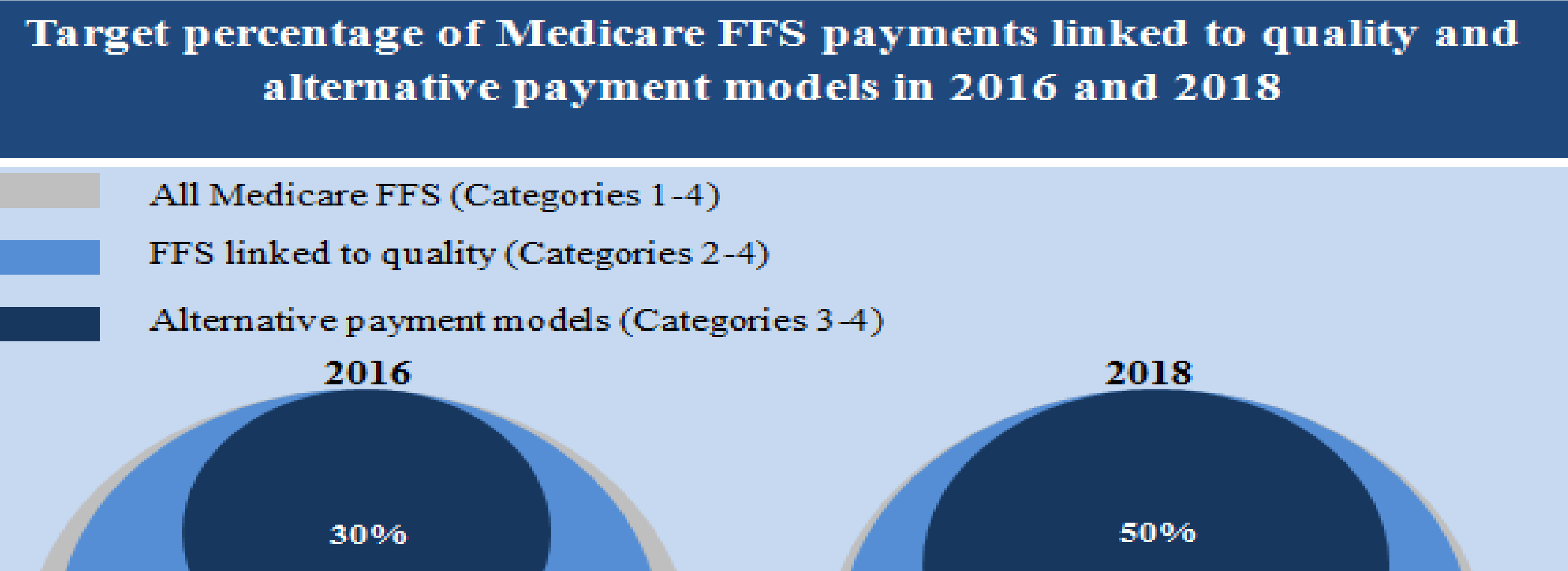
No Data | <4.5% | 4.5-5.9% | 6.0-7.4% | 7.5-8.9% | ≥9.0%

CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at http://www.cdc.gov/diabetes/statistics

International Health Institute - Triple Aim

- 94% of Medicare spending is on seniors with 2 or more chronic conditions
- 52% of Medicare spending is on seniors with 6 or more chronic conditions, which is 14% of the people
- 6% of Medicare spending is on seniors with less than 2 chronic conditions which is 32% of the people
- 19% of total Medicare spending is on people less than 65, which are 18% of the total people on Medicare

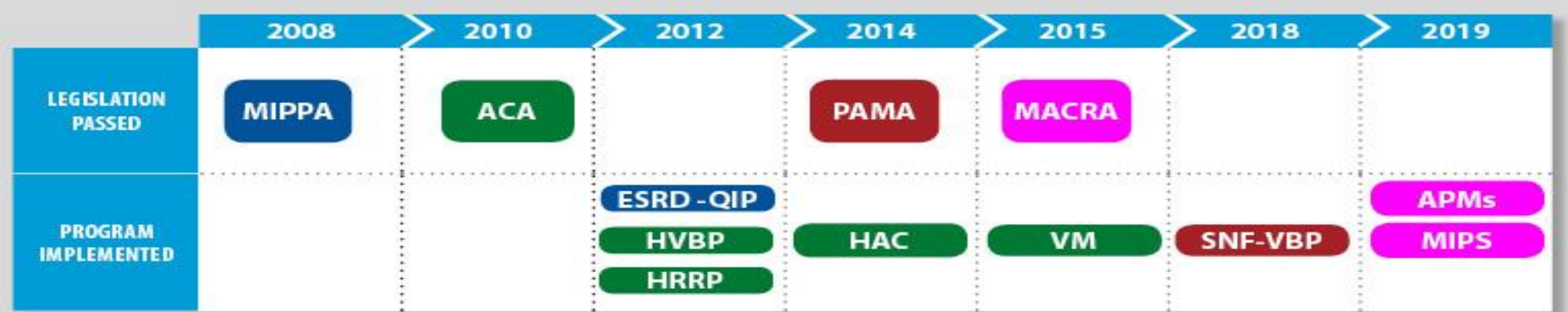
Movement to Value-Based Care



Source: CMS

Value-Based Programs

VALUE-BASED PROGRAMS



LEGISLATION

ACA: Affordable Care Act
MACRA: the Medicare Access & CHIP Reauthorization Act of 2015
MIPPA: Medicare Improvements for Patients & Providers Act
PAMA: Protecting Access to Medicare Act

PROGRAM

APMs: Alternative Payment Models
ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
HACRP: Hospital-Acquired Condition Reduction Program
HRRP: Hospital Readmissions Reduction Program
HVBP: Hospital Value-Based Purchasing Program
MIPS: Merit-Based Incentive Payment System
VM: Value Modifier or Physician Value-Based Modifier (PVBM)
SNFVBP: Skilled Nursing Facility Value-Based Purchasing Program

Source: CMS

Focus Area: Preventative Services

Welcome to Medicare

Initial Preventive Physical Exam

Introductory visit to the Medicare Part B program ("Welcome to Medicare")

Not a "routine physical checkup"

Source: CMS

Initial Preventive Physical Exam

Frequency

- Once in the first 12 months of enrolling in Medicare

Eligibility

Source: CMS

Initial Preventative Physical Exam – Why is it Important?

- Provides the Clinician and Patient the opportunity to establish a plan of care to support their health
- Increases Patient and Caregiver engagement in their health plan and overall well being
- Opportune time to provide preventative and screening services to proactively manage care

Annual Wellness Visit

Annual Wellness Visit

Used to develop/update personalized prevention plan

A preventive visit – not routine yearly exam

Source: CMS

Annual Wellness Visit

Frequency

- Covered once every 12 months
  - Medicare will look to verify that at least 11 full calendar months have passed since last AWV

Eligibility

- Patients with Part B coverage for more than 12 months
- Have not received an IPPE or AWV service within last 12 months
- IPPE and the AWV cannot be combined into a single visit

Source: CMS

Annual Wellness Visit – Why is it Important?

- Improves Patient satisfaction and the ability to care for themselves
- Helps Patient take responsibility for their own care
- Provides Clinician and Patient the opportunity to establish a plan of care for the Patient's chronic illnesses and health care needs

Annual Wellness Visit

- Marketing and Education of AWV
  - Providers
  - Patients
  - Staff
- Develop workflow and assess additional resources needed
  - Wellness Nurse
- How to get patients in?
  - Dual visits
  - Cold calling
  - Birthday cards
  - Mail letters

Chronic Care Management

Chronic Care Management

Care coordination and care management for a beneficiary with multiple chronic conditions

Requires the use of a certified EHR or other electronic technology

Source: CMS

Chronic Care Management

Frequency

- At least 20 minutes of clinical staff time

Eligibility

- Patient must have two or more chronic conditions expected to last at least 12 months, or until death

Source: CMS

Chronic Care Management – Why is it Important?

- Supports active management of Patient's care plan on a regular basis
- Provides coordinated care across multiple health care resources
- Provides an avenue for active communication and coordinated care

Chronic Care Management

- Comprehensive care management and coordination
- MDH Certified Health Care Home
- Create a comprehensive care plan
- 24/7 access to address urgent needs
- Communication between visits – monthly check-in
- Community Care Team – link them to community resources

Transitional Care Management

Transitional Care Management

Coordination and Management of care for the first 30 days following an inpatient stay to support transition back into the community setting

Source: CMS

Transitional Care Management – Why is it Important?

- Provides opportunity for Clinician support following discharge from a care episode in an inpatient hospital setting

- Reduces potential for re-admission or complications from acute care episodes

- Supports transition of Patient into community setting

Transitional Care Management

- Already doing but not formalized and was not billing appropriately
- Opportunity to assess patients who may benefit from CCM
- Community Care Team – link them to community resources
- Track and monitor patients – avoid preventable readmissions

Additional Services

Additional Preventative Health Services

- Annual Depression Screening
- Annual Alcohol Misuse Screening
- Annual face-to-face Interventional Behavior Therapy for Cardiovascular Disease
- Diabetes Outpatient Self-Management Training
- Medical Nutrition Therapy
- Smoking and Tobacco Use Cessation Counseling
- Advance Care Planning

Source: CMS

Opportunities

- Improve patient care delivery and quality of care
- Improve health outcomes
- Improve financial performance

Challenges

- Change
  - Staff, Providers and Patients
  - Documentation and Billing
  - Learning Curve
- Resources
  - Staff, Time, EHR and Data Analytics

Questions?

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Thank You!

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