An Unintended Medicare DPC Pilot

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Proactive MD Clinical Innovation Summit

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Outline

- Review historic DPC & Concierge approaches
  - Fee For Noncovered Service concepts
  - Civil Monetary Penalties law concepts
- Review Chronic Care Management (CCM)
- Review Remote Physiologic Monitoring (RPM)
- Review New Specialty Consult Techniques
  - Principal Care Management
  - Interprofessional Consultation Codes
- Review COVID-19 Changes
  - Telemedicine & Opt In ability (without timelines)
  - State licensure (for Medicare patients)

What is the ONLY reason to opt out of Medicare?

- You must want to do **ALL** three things:

1) See Medicare patients
2) Under a private contract
3) For “covered services”

Which of the following physicians should opt out of Medicare?

- Pediatrician
- Correctional Medicine Physician (Prison or Jail)
- Occ Medicine Physician (only Worker's Comp)
- Concierge Physician (Fee for noncovered serv)
- New DPC Physician with panel under age 65
- Established DPC physician with many older pts

What about those Concierge Drs?

- They are doing 2 out of 3 three things:

1) See Medicare patients
2) Under a private contract
3) For “covered services”

- Their agreements are carefully crafted to only treat patients for “noncovered services” but this box of items is growing smaller

OLD Non-covered Service Loopholes

- Annual wellness visit
- Phone calls & emails
- In home Telemedicine visits
- “Routine” Physicals
- Newsletters
- Functional and Integrative Medicine items

What if you…?

- Argued that all of your monthly membership fee for Medicare patients was for “noncovered services?”
  - Then you would lose once the investigators proved that you did indeed also provide some covered services
- Argued that you simply gave away the regular fee for service items that you were supposed to charge for completing?
  - Then you are admitting to a Civil Monetary Penalties law violoation

Civil Monetary Penalties Law

Section 1128A(a)(5) of the Act, 42 U.S.C. 1320a–7a(a)(5), the "beneficiary inducements CMP," provides for the imposition of civil monetary penalties against **any person who offers** or transfers **remuneration to a Medicare** or State healthcare program (including Medicaid) beneficiary **that the benefactor knows or should know is likely to influence the beneficiary's selection of a particular provider**, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a State healthcare program (including Medicaid).

Civil Monetary Penalties Law

Section 1128A(i)(6) of the Act, 42 U.S.C. 1320a–7a(i)(6), defines "**remuneration**" for purposes of the beneficiary inducements CMP as including "**transfers of items or services for free or for other than fair market value**." Section 1128A(i)(6) of the Act also includes a number of exceptions to the definition of "remuneration."

Civil Monetary Penalties Law

Pursuant to section 1128A(i)(6)(B) of the Act, **any practice permissible under the anti-kickback statute, whether through statutory exception or regulations issued by the Secretary, is also excepted from the definition of "remuneration" for purposes of the beneficiary inducements CMP.** However, no parallel exception exists in the anti-kickback statute. Thus, the exceptions in section 1128A(i)(6) of the Act apply only to the definition of "remuneration" applicable to section 1128A.

Proposed Rule
(Don't Hold Your Breath)

"With respect to a fair market value requirement, **we might remove it entirely**; remove it only for monetary remuneration or only for in-kind remuneration; or remove it where the non-fair market value arrangement primarily benefits the offeror of the remuneration, with such benefit independent of any increase in the volume or value of referrals"

Proposed Rule
(Don’t Hold Your Breath)

“We **might also permit a broader set of free or below fair market value arrangements** for providers coordinating care in rural or underserved areas or providers serving underserved populations.”

Proposed Rule
(Don't Hold Your Breath)

"We are concerned that the provision of potentially reimbursable items and services, for free, could result in steering or unfair competition or could create a seeding arrangement where, for example, a physician could be influenced to prescribe an item or service, which may be free at some point, but would be covered by a third-party payor (including Federal health care programs) in the future."

Telemedicine Scramble

- Medicare now has a set of codes for in home telemedicine visits
- Concierge groups and large telemedicine groups are now pivoting their patient agreements and billing decisions
- A co-pay is permitted for these visits, but Medicare participating physicians are free to waive the co-pay without being accused of a Civil Monetary Penalties law violation

Telemedicine Codes

- 99421 – 5-10 minutes $15
- 99422 – 11-20 minutes $30
- 99423 – 21+ minutes $50

- No limit on the number of times you may use each code
- You may currently waive any co-pays
- Each has minimal documentation

Prior attempts at a Medicare Pilot

- Many failures under many names
- Complicated schemes always proposed

- Now we have an accident in our favor:
- CCM + RPM + Wellness Visit + Tele = DPC Pilot
- When a specialist is needed, try
  - Interprofessional Consultation + PCM

TABLE 22: Chronic Care Management Services Summary

CCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using Certified EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Comprehensive Care Management • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Comprehensive Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of CCM.

Chronic Care Management (CCM)

- 99490 Noncomp, 20min staff, 15 min Dr $42
- G2058 20min additional staff time $38
- Totals = 40 min staff, 15 min Dr = $80 PMPM

- G0506 for 1st CCM visit - one time charge $63
- You may include physical office visit time in above math if desired (avoids CMP violation)

CCM – What if you did extra work?

- If you established or substantially revised a care plan
- 99487 Complex, estab 60 min staff $92
- 99489 Complex, addit 30 min staff $45

- Keep things extra simple and rarely use these codes. I suspect that their usage will increase audit risk.

What Qualifies as a Chronic Condition?

CCM is not limited to a specific list of illnesses. The chronic conditions must meet the criteria in the CPT code descriptors, so eligible patients must have **two or more chronic conditions expected to last at least 12 months or until the death of the patient**, **and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline**.

Medicare Chronic Condition Examples

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

CCM “Care Plan” Documentation

- Problem list.
- Expected outcome and prognosis.
- Measurable treatment goals.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.
- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan.

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Clinical Staff Defined

"Clinical Staff" = A person who works under the supervision of a physician or other qualified health care professional, and who is allowed by **law, regulation and facility policy** to perform or assist in the performance of a specific professional service, but does not individually report that professional service.

(Always an RN & LPN, sometimes an MA)

Clinical Staff Details

- A billing practitioner **may arrange for clinical staff activities to be provided by an individual(s) external to the practice** (for example, in a case management company) if all of the applicable "incident to" and other rules for the PFS are met and there is clinical integration among the care team members.
- …services cannot be billed if they are provided to patients or by individuals located outside of the United States

CCM – Civil Monetary Penalties Exception

- Do face-to-face activities count as billable time?
- CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers. Prior to separate payment for CCM, these activities were primarily included in the payment for face-to-face visits (though they usually occurred before or after), and we tend to refer to them as "non-face-to-face" activities because generally, they are such. **If these activities are occasionally provided face-to-face for convenience or other reasons, the time may be counted towards a CCM service code(s).**

CCM – Civil Monetary Penalties Exception

- CCM also includes activities such as patient education or motivational counseling that are frequently provided to patients either in person or non-face-to-face (such as by phone). **If the practitioner believes a given beneficiary would benefit or engage more in person, or for similar reasons recommends a given beneficiary receive certain CCM services in person, they may still count the activity as billable time. In all cases, the time and effort cannot count towards any other code if it is counted towards CCM.**

Remote Physiologic Monitoring (RPM)

- 99454 Device Code $62
- 99457 Remote Mon Initial staff 20 min $51
- 99458 Remote Mon Addit staff 20 min $42
- Totals = 40 min staff time, 0 Dr time $155

- 99453 Remote Mon Initial Set Up $19
- The RPM physician does not have to have ANY other treatment relationship with the patient (may be furnished under “general supervision”)

“General Supervision” Defined

- **Direct Supervision** – means the physician and auxiliary personnel must be in the same building at the same time (albeit not the same room).

- **General Supervision** – does not require the physician and auxiliary personnel to be in the same building at the same time, and the physician could instead use telemedicine to exert general supervision over the auxiliary personnel.

Remote Physiologic Monitoring (RPM)

"Finally, we proposed that RPM services could be **furnished under general supervision**. Because care management services include establishing, implementing, revising, or monitoring treatment plans, as well as providing support services, and because services include establishing, implementing, revising, and monitoring a specific treatment plan for a patient related to one or more chronic conditions that are monitored remotely, we believed that CPT codes 99457 and 99458 should be included as designated care management services. Designated care management services can be furnished under general supervision. Section 410.26(b)(5) of our regulations states that designated care management services can be furnished under the general supervision of the "physician or other qualified health care professional (who is qualified by education, training, licensure/regulation and facility privileging)" (see also 2019 CPT Codebook, page xii)…"

https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

Remote Physiologic Monitoring (RPM)

"…when these services or supplies are provided "incident to" the services of a physician or other qualified healthcare professional. The physician or other qualified healthcare professional supervising the auxiliary personnel need not be the same individual treating the patient more broadly. However, **only the supervising physician or other qualified healthcare professional may bill Medicare for "incident to" services**."

https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

“Incident to” Defined

- To qualify as “incident to,” services must be part of your patient’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. You do not have to be physically present in the patient’s treatment room while these services are provided, but you must provide **direct supervision**, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service. More specifically, these services must be all of the following:
- • An integral part of the patient’s treatment course;
- • Commonly rendered without charge (included in your physician’s bills
- • Of a type commonly furnished in a physician’s office or clinic (not in an institutional setting); and
- • An expense to you.
- Examples of qualifying “incident to” services include cardiac rehabilitation, providing non-self administrable drugs and other biologicals, and supplies usually furnished by the physician in the course of performing his/her services (for example, gauze, ointments, bandages, and oxygen).

“General Supervision” vs “Incident to”

- First they state that RPM should be considered a “designated care management service”
- Then they state that a designated care management service can take place via “general supervision” “when these services are provided ‘incident to’”
- The trouble is that “Incident to” is tied to “direct supervision” which requires the physician to be physically present
- Likely an oversight / error in guidance

RPM can be combined with CCM or PCM

- However, we are convinced by stakeholders who stated that **RPM services are distinct from PCM and could be billed concurrently by the same practitioner for the same beneficiary provided that the time is not counted twice**

RPM Details? We'll get back to you

- Several commenters expressed concerns about the ambiguity of the code descriptors for the RPM codes. Commenters requested that CMS define what is meant by "physiologic parameters", "digitally transmitted data" (as opposed to patient-reported data), "medical device," and "interactive communication". Several commenters asked if we could expand the list of practitioners allowed to furnish RPM services, while others requested that we clarify who can furnish and bill for the RPM services. One commenter stated that the prefatory language for the codes should state explicitly that an established patient-practitioner relationship must exist prior to billing for RPM services. Another commenter recommended that we provide guidance related to billing and documentation for RPM. **Some commenters questioned whether the codes could be used for patients that without chronic conditions**.
- **"…we plan to consider these and other questions related to RPM in future rulemaking**."

If you remain “opted out” of Medicare:

- Can another group start offering remote RPM to your patients? (Yes)
- Could they provide data to you? (Yes)
- Would this other physician now share malpractice risk with you? (Yes)
- Could they pay you for suggesting that your patients use their system? (Unlikely)
  - Due to stark and AKS rules applying to their physician
  - Due to state AKS rules that would still apply to you

Routine Annual Wellness Visit

- G0439 Wellness Visit $116
- G0442 Alcohol 15 min screening $18
- G0444 Depression screening $18
- 99497 Advanced Care Planning (30 min) $87
- 99498 Advanced Care Planning (30 more) $76
- **Subtotal (no-copay, yearly visit) $315**
- G0506 CCM Start (if applicable, cp) $63
- 99453 Remote Mon Initial Set Up (if app, cp) $19
- **Total (mostly no-copay, yearly visit) $397**

“Welcome to Medicare” Initial Visit

- G0402 Initial Preventive Exam $168
- G0403 EKG with initial preventive exam $17
- G0438 Initial Visit $172

- These codes are done instead of G0439 and can only be used in the first year of Medicare coverage for the first Medicare visit

“Welcome to Medicare” Initial Visit

- G0402 Initial Preventive Exam $168
- G0403 EKG with initial preventive exam $17
- G0438 Initial Visit $172
- ~~G0439 Wellness Visit $116~~
- G0442 Alcohol 15 min screening $18
- G0444 Depression screening $18
- 99497 Advanced Care Planning (30 min) $87
- 99498 Advanced Care Planning (30 more) $76
- **Subtotal (no-copay, first Medicare visit) $556**
- G0506 CCM Start (if applicable, cp) $63
- 99453 Remote Mon Initial Set Up (if app, cp) $19
- **Total (mostly no-copay, first Medicare visit) $638**

What about specialty consults?

- Start with **interprofessional consultation codes**
- You email or call the specialist and now the specialist is paid for this “curbside consult” based on their time and their verbal or written response to you
- 99446 –5-10mins discussion/review $18.25
- 99447 –11-20mins discussion/review $36.87
- 99448 –21-30mins discussion/review $55.12
- 99449 –31+ mins discussion/review $73.43

Principal Care Management (For Specialty Consultants)

- **One** complex chronic condition
  - 1) lasting at least 3 months,
  - 2) at risk of hospitalization,
  - 3) requiring a disease-specific care plan,
  - 4) requiring frequent medication adjustments (often due to comorbidities)
- G2064 – 30 or more minutes single high risk disease – physician or QHCP time per month
- G2065 – 30 or more minutes single high risk disease – clinical staff time per month

Principal Care Management (For Specialty Consultants)

- Expect specialists to use this when co-managing a patient with an exacerbated chronic condition placing them at high risk for hospitalization or death, typically between 3 to 12 months and not on a chronic basis. Multiple specialists can bill for multiple PCM conditions on the same patient, presumably at the same time their PCP is billing CCM, but if a specialist is using PCM then cannot use the Interprofessional Consultation codes at the same time for the same condition.

Monthly Gross PMPM Revenue

- 99490 Noncomp, 20min staff, 15 min Dr $42
- G2058 20min additional staff time $38
- 99454 Device Code $62
- 99457 Remote Mon Initial staff 20 min $51
- 99458 Remote Mon Addit staff 20 min $42

- Totals = 80 min staff time, 15 min Dr time $235

Medicare Part B Premiums

If your yearly income in 2018 (for what you pay in 2020) was			You pay each month (in 2020)
File individual tax return	File joint tax return	File married & separate tax return	
$87,000 or less	$174,000 or less	$87,000 or less	**$144.60**
above $87,000 up to $109,000	above $174,000 up to $218,000	Not applicable	$202.40
above $109,000 up to $136,000	above $218,000 up to $272,000	Not applicable	$289.20
above $136,000 up to $163,000	above $272,000 up to $326,000	Not applicable	$376.00
above $163,000 and less than $500,000	above $326,000 and less than $750,000	above $87,000 and less than $413,000	$462.70
$500,000 or above	$750,000 and above	$413,000 and above	$491.60

https://www.medicare.gov/your-medicare-costs/part-b-costs

Costs to the Medicare patient

- Medicare Part B monthly premium $144.60
  - Sunk cost, paid whether the patient does DPC or not
- Medicare Part B deductible $198.00
  - Day 1 $82 toward deductible
  - Day 30 $116 to meet rest of deductible
- Medicare Co-Payment at (20% of 235) $47.00
  - Day 30 (20% of the remaining $119) = $23.80
  - Owed at the end of months 2-12 = $47.00
  - Annual Monthly fee out of pocket total = $540.80
- Total Yearly out of pocket estimate = $738.80
  - Compares to a total average of $61 PMPM

How would you advertise the pilot?

- DPC for Medicare patients
- Chronic care management or only $47/month
  - After deductible met in the first month
  - No co-pay for telemedicine visits or office visits
  - Yearly out of pocket estimate of
- For those without chronic conditions
  - No monthly fee
  - No co-pay for telemedicine visits ($15 - $50 each)
  - No co-pay for yearly wellness visit (likely $315)
  - Our goal is to NEVER charge you out of pocket

Other Concluding Estimates

- If we assume the following
  - 80% of Medicare patients have 2+ chronic conditions
  - Physician hours per CC patient per year = 7.5
  - Staff hours per CC patient per year = 17.25
- Then we assume the following
  - Full panel at around 300 Medicare pts, 240 with CC
  - Gross Revenue per year = $870,000
    - Around 90% of this is paid by Medicare
    - Around 10% of this is subject to risk of patient non-payment
  - Physician to staff ratio of 1:3

What about Medicare Advantage?

- Likely obsolete and irrelevant
- If you do not sign these private insurance agreements you may then treat these patients like any other Medicare patient

How to structure the Medicare Pilot?

- Likely with a different LLC/PC/PLLC
  - If the rules change you need to be able to sunset it quickly without affecting the rest of your practice
  - Transparency contracts with others are less relevant
- Ancillaries are different
  - Labs/Meds/Radiology should NOT be done in house
  - Patients can be referred within the “system” easily
- Maybe in a different physical location
  - Staffing ratios do change a bit (now 3:1 rather than 1:1)

Emergency Rules – Opt Out Change

- You may opt back in at any time (see this CMS "Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19"
  - https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- It states that CMS will "Allow opted-out practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients."
- Each Medicare Administrative Contractor (MAC) has a 1-800 number you may call to opt back in right away
  - https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Emergency Rules – Opt Out Change

- What if you want to see Medicare patients outside of the emergency/urgent care exception without opting back in?
  - You must work with the hospital to apply for your own individual 1135 waiver (theoretically possible)
- What if you want to travel to another state to do this work?
  - Medicare patients now similar to VA or FBOP pts

Pursing Your Individual 1135 Waiver

The March 13th Waiver letter states that "Pursuant to Section 1135(b) of the Social Security Act (the Act) (42 U.S.C. § 1320b-5), I, Alex M. Azar II, Secretary of Health and Human Services, hereby **waive or modify**... to the extent necessary, as determined by the Centers for Medicare & Medicaid Services... **Certain conditions of participation**, certification requirements, program participation or similar requirements for individual health care providers or types of health care providers, including as applicable, a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility..."

Know when to say “No”

- Maybe that is what you keep saying in spite of this indirect pilot opportunity
- Maybe an administrator wants you to code more than what was outlined today
- Maybe Medicare changes a rule
- Maybe the reimbursement falls or the documentation requirements increase

Questions?

- We may have more time for discussion after the shorter (EB)HRA + Telemed HSA discussion later today