# Fee-For-Service Population Health Management Services:
## Getting Paid Now to Prepare for the Future

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To succeed under alternative payment models, healthcare providers will need to develop population health management (PHM) skills and infrastructure. But with fee-for-service (FFS) reimbursement still dominating most markets, many providers are hesitant to make necessary investments.

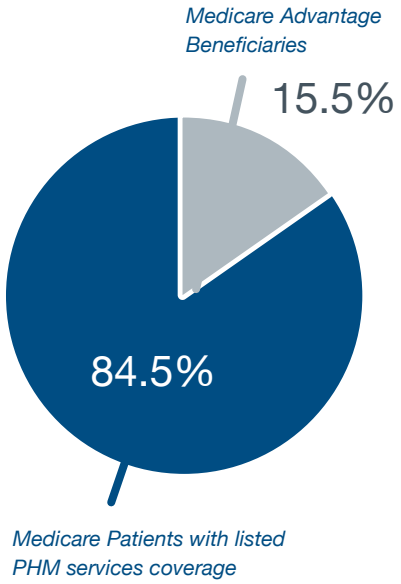
Providers, however, can realize a substantial short-term return on these investments through FFS payments for PHM services. Specifically, the Medicare Physician Fee Schedule now includes payment for the following five PHM services:

1. Annual Wellness Visits
2. Transitional Care Management
3. Chronic Care Management (including Complex Chronic Care Management)
4. Care Plan Development
5. Advance Care Planning

To illustrate this opportunity, PYA has prepared a financial analysis for a hypothetical 10-physician primary care practice. Our analysis shows the FFS payments for these PHM services are more than sufficient to fund the staffing and infrastructure needed to build the bridge to new payment and delivery models.

## Underlying Assumptions

To ensure accuracy, we have based our calculations on the following conservative assumptions. (Yes, this is the boring - but important - technical stuff.)




1) Based on the most recent MGMA *Cost Survey* for Primary Care Providers, we assume the 10-physician practice's patient panel includes 5,485 unique Medicare beneficiaries. We assume 4,635 of these beneficiaries have coverage for the listed PHM services.

   How do we get to that number? According to the Centers for Medicare and Medicaid Services (CMS), 31% of Medicare beneficiaries are enrolled in a Medicare Advantage plan.[1] Non-capitated Medicare Advantage plans are required to make available all Part B covered services, including those listed previously. However, some plans have resisted paying for PHM services, claiming the plans provide these services directly. To account for those beneficiaries enrolled in capitated plans and plans that do not make FFS payments to providers for PHM services, we include only one-half of Medicare Advantage beneficiaries in our calculations (31% x 0.5 = 15.5%). Stated another way, we assume only 84.5% of the practice's Medicare patients – 4,635 individuals – have coverage for the listed PHM services.

[1] CMS Medicare Enrollment Dashboard (December 2016).

2) With the exception of Annual Wellness Visits, PHM services are subject to co-insurance. We assume the practice will collect the full amount of co-insurance from the 83% of Medicare beneficiaries with supplemental insurance, but only one-half of the amount owing from the 17% of Medicare beneficiaries without supplemental insurance.[2] To account for this, we deduct 2% from the total gross revenue from PHM services.

3) We used the 2017 Medicare Physician Fee Schedule National Payment Rates in making our calculations. The actual payment rate for a provider will vary based on geographic location and applicable payment adjustments (*e.g.*, Physician Quality Reporting System [PQRS], Meaningful Use, Merit-Based Incentive Payment System [MIPS]).

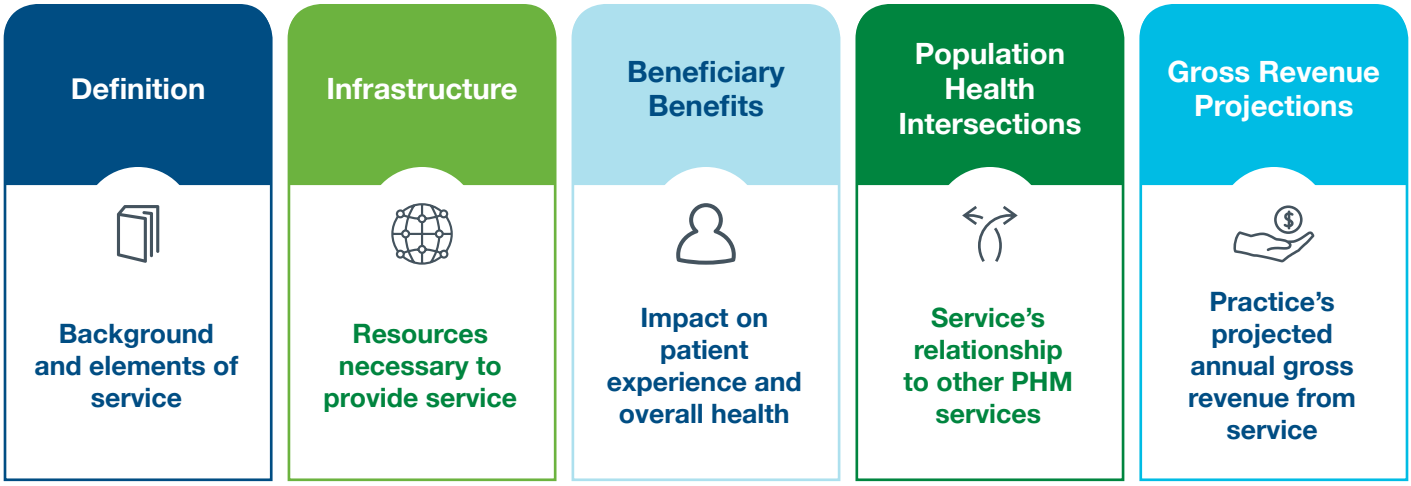
4) We assume the practice is adequately staffed and maintains appropriate infrastructure (*e.g.*, practice management system and electronic health records [EHRs]) to provide, bill, and collect for the full range of primary care services for its patients. However, we assume the practice does not presently employ individuals who can serve as care managers or health coaches, or has not deployed a technology solution for PHM services.

5) For each individual PHM service, we have made a "low" and "high" assumption with regard to the percentage of the practice's Medicare beneficiaries to whom the practice will provide the specific service. These estimates are based on our experience with practices now providing PHM services.

6) We recognize a physician practice will experience a ramp-up period as it hires and trains staff, deploys supportive technology, and recruits beneficiaries. Given the number of variables involved, we have not attempted to calculate gross revenue during the ramp-up period. Instead, our assumptions and revenue projections are based on an established service line.

## Service-By-Service Analysis

To assist providers in evaluating the opportunity presented by FFS PHM services, we include the following information for each such service now reimbursable under the Medicare Physician Fee Schedule:




[2] America's Health Insurance Plans, *Report on Beneficiaries with Medigap Coverage* (April 2015).

## 1. Annual Wellness Visits

### *Definition*

Since January 1, 2011, Medicare has covered a one-time "Welcome to Medicare" visit and ongoing Annual Wellness Visits (AWVs) for all Medicare beneficiaries. To bill for these services, a physician practice must (1) administer a health risk assessment, record the patient's medical history, and review current medications and other care providers; (2) measure the beneficiary's vital signs and assess cognitive function; and (3) furnish personalized health advice, including a written prevention plan of service.

### *Infrastructure*

Practices with successful AWV programs have implemented effective processes to schedule patients for the service including, for example, mail and telephone reminders. Also, many practices use a team approach to AWVs, with licensed clinical staff providing services under the direct supervision of a physician.

The AWV office visit also presents an opportunity to provide the beneficiary with regular preventive services. Medicare now provides first-dollar coverage for the following services, which may be separately reimbursable when furnished in conjunction with an AWV visit:

- Alcohol Misuse Screening and Counseling
- Bone Mass Measurements
- Cardiovascular Disease Screening Tests
- Colorectal Cancer Screening
- Tobacco Use Cessation Counseling
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Hepatitis B Vaccine and Administration
- Hepatitis C Screening
- HIV Screening
- Influenza Vaccine and Administration
- BT for Cardiovascular Disease/IBT for Obesity
- Lung Cancer Screening
- Medical Nutrition Therapy
- Pneumococcal Vaccine and Administration
- Prostate Cancer Screening
- Screening for Cervical Cancer and HPV
- Screening for STDs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Exams
- Ultrasound Screening for Abdominal Aortic Aneurysm

### *Beneficiary Benefits*

Unlike an office visit, which is focused on the beneficiary's presenting problem, an AWV is an opportunity to address the beneficiary's overall health. Armed with an updated personalized prevention plan, a beneficiary can take greater responsibility for maintaining his or her health and managing chronic conditions. Such a level of patient engagement translates into a better overall experience of care and more appropriate use of healthcare resources.

### *Population Health Intersections*

Through AWVs, physicians can identify "rising risk" patients, who require additional interventions to avoid worsening health conditions. These interventions include the other FFS PHM services discussed herein. The ability to risk-stratify a patient population in such a manner is critical to success under alternative payment models, which require providers to control overall costs of care.

More immediately, practices that regularly provide AWVs for most of their patients will fare better under MIPS. Many of the MIPS quality measures relate to preventive services (*e.g.,* influenza immunization, diabetes screening, smoking cessation counseling, depression screening, pneumococcal vaccination), all of which can be furnished to a beneficiary in conjunction with his or her AWV.

### *Gross Revenue Projections*

The following projections include both "Welcome to Medicare" visits, CPT® G0438, as well as subsequent AWVs, CPT® G0439. The reimbursement for CPT® G0438 is greater, but only a small percentage of a practice's beneficiaries will be eligible for this one-time service in any given year.

These projections **do not** include the FFS revenue a practice may generate by furnishing preventive services in the course of performing AWVs (*e.g.*, vaccines, screening tests), as there are too many variables to provide reliable estimates.

| **Annual Wellness Visits** | **Low** | **High** | **Formula** |
|---|---|---|---|
| *# of Medicare Beneficiaries w/ AWV Coverage (84.5% of Beneficiaries)* | *4,635* | *4,635* | A |
| *% of Covered Beneficiaries Who Qualify for AWV* | *100%* | *100%* | B |
| *# of AWV-Eligible Patients* | *4,635* | *4,635* | C = A*B |
| | | | |
| % of Eligible Beneficiaries Receiving CPT® G0438 (estimated) | 5% | 6% | D |
| # of CPT® G0438 Services Performed Annually | 232 | 278 | E = C*D |
| National Payment Rate for CPT® G0438 | $173.70 | $173.70 | F |
| | | | |
| % of Eligible Beneficiaries Receiving CPT® G0439 (estimated) | 65% | 81% | G |
| # of CPT® G0439 Services Performed Annually | 3,013 | 3,754 | H = C*G |
| National Payment for CPT® G0439 | $117.71 | $117.71 | I |
| | | | |
| **Potential Annual AWV Revenue, Rounded** | **$394,959** | **$490,172** | **J = (E*F) + (H*I)** |

## 2. Chronic Care Management and Complex CCM

### *Definition*

Since January 1, 2015, Medicare has reimbursed physicians for 20 minutes per calendar month of non-face-to-face care management services furnished by clinical staff supervised by the billing physician for beneficiaries with two or more chronic conditions. To bill for chronic care management (CCM) furnished to a beneficiary, a physician practice must meet several requirements including, but not limited to, the development of a comprehensive care plan, use of an EHR, and coordination with other providers. As explained in the following section, Care Plan Development is a separately billable service, and is not considered part of CCM.

Hoping to expand access to CCM for beneficiaries, CMS eased these requirements significantly effective January 1, 2017. These revised requirements are addressed in detail in our recent white paper, *Providing and Billing Medicare for Chronic Care Management*.

CMS also recognized some beneficiaries require more than 20 minutes non-face-to-face services, and thus began paying for complex CCM in January 2017. The requirements for billing complex CCM are the same as CCM, except 60 minutes of non-face-to-face services must be provided during the calendar month. CMS also included an add-on code for each additional 30 minutes per month.

### *Infrastructure*

Some practices now furnishing CCM do so using existing clinical staff, but most have hired new staff to assume care manager roles. Initially, most practices utilize their existing EHR in providing the service, implementing more specialized technology solutions to identify and track CCM-eligible beneficiaries as their programs mature.

### *Beneficiary Benefit*

CMS estimates that two-thirds of all Medicare beneficiaries suffer from multiple chronic conditions. Left unmanaged, these conditions can lead to expensive acute episodes. Regular communication with clinical staff helps identify and address potential problems.

With the assistance of a care manager, a beneficiary can better navigate the often-confusing healthcare system. Care managers also can address beneficiaries' medication issues and social needs, such as transportation and nutrition services. Research has demonstrated that care management programs are effective in reducing total costs of care while improving health outcomes.

### *Population Health Intersections*

One key to a successful CCM program is the ability to identify and engage those beneficiaries most likely to benefit from CCM services, which can be incorporated into a practice's AWV program. As discussed previously, providers can use information gathered during an AWV to develop a beneficiary's care plan for purposes of providing CCM services.

### *Gross Revenue Projections*

The recent relaxation of the CCM billing rules and new payment for complex CCM have made CCM programs more financially viable. Based on CMS' estimates, we assume two-thirds of the practice's Medicare beneficiaries have two or more chronic conditions, and thus are eligible for CCM. We assume the practice will provide CCM (CPT® 99490) to 50% to 70% of eligible beneficiaries six to eight months per year, given resource constraints and some beneficiaries' reluctance to initiate services.

We further assume the practice will provide complex CCM (CPT® 99487) (60 minutes per month as opposed to 20 minutes each month) for each patient, once each year. Based on our experience, it requires significantly more time to initiate CCM and to review and revise the care plan annually. Also, for 15% to 20% of patients, we assume that more than 90 minutes (using add-on code CPT® 99489) for one month will be required, allowing the practice to bill the add-on code for each additional 30 minutes of complex CCM.

| **Chronic Care Management and Complex CCM** | **Low** | **High** | **Formula** |
|---|---|---|---|
| *# of Medicare Beneficiaries w/ CCM Coverage (84.5% of Beneficiaries)* | *4,635* | *4,635* | *A* |
| *% of Covered Beneficiaries, Qualify for CCM (2+ Chronic Conditions)* | *67%* | *67%* | *B (two-thirds, not rounded)* |
| *# of CCM-Qualified Beneficiaries* | *3,090* | *3,090* | *C = A*B* |
| | | | |
| **Chronic Care Management** | | | |
| CCM Beneficiaries (% of CCM-Eligible Beneficiaries) | 50% | 63% | D |
| CCM Beneficiaries | 1,545 | 1,947 | E = C*D |
| Average # of Months Billed per Beneficiary | 6 | 8 | F |
| National Payment for CPT® 99490 | $42.71 | $42.71 | G |
| | | | |
| **Complex CCM** | | | |
| Complex CCM Beneficiaries (% of CCM-Eligible Beneficiaries) | 50% | 63% | H |
| Complex CCM Beneficiaries | 1,545 | 1,947 | I = C*H |
| Average # of Months Billed per Beneficiary | 1 | 1 | J |
| National Payment for CPT® 99487 | $93.67 | $93.67 | K |
| % of Complex CCM with 30-Minute Add-On Code | 15% | 20% | L |
| Complex CCM with Add-On Code | 232 | 389 | M = I*L |
| National Payment for CPT® 99489 | $47.01 | $47.01 | N |
| | | | |
| **Potential Combined Annual CCM Revenue, Rounded** | **$551,548** | **$865,913** | **O = (E*F*G) + (I*J*K) + (J*M*N)** |

## 3. Care Plan Development

### *Definition*

Effective January 1, 2017, Medicare reimburses physicians for care plan development, CPT® G0506. There is no minimum number of minutes required to bill for this service. However, the time and effort involved in care plan development must exceed the usual time and effort required for an evaluation and management service. A physician may bill for care plan development only once per beneficiary (versus once a year); CPT® G0506 cannot be billed for the work involved in updating a care plan following its initial development.

### *Infrastructure*

Unlike CCM, which is performed by clinical staff under the billing physician's general supervision, care plan development must be personally performed by the physician, although face-to-face interaction with the beneficiary is not required. A physician, therefore, must allow adequate time to compile and review relevant information and prepare the document. To improve efficiency, clinical staff may assist in preparing documents for the physician's review and approval. Most EHRs include a care plan template, but a physician may prefer to use a customized format. The care plan should be made available to all providers involved in the beneficiary's care.

### *Beneficiary Benefit*

A beneficiary's care plan should include his or her personal health goals and strategies to achieve those goals. Involving beneficiaries in care plan development encourages greater engagement in maintaining and improving their health.

### *Population Health Intersections*

The care plan plays a critical role in identifying and closing gaps in care. It also supports effective transitions of care, as it serves as a communication tool among a beneficiary's providers.

### *Gross Revenue Projections*

We assume the practice will bill for care plan development for 75% to 94% of those beneficiaries receiving CCM services. Again, a physician may bill for CPT® G0506 only once for each beneficiary.

| Care Plan Development (One-Time Opportunity per Beneficiary) | Low | High | Formula |
|---|---|---|---|
| *# of Medicare Beneficiaries w/ CCM Coverage (84.5% of Beneficiaries)* | *4,635* | *4,635* | *A* |
| CPD-Eligible Patients (All CCM Beneficiaries) | 1,545 | 1,947 | B (Previous Table) |
| Annual Volume (% of Billed CCM Beneficiaries) | 75% | 94% | C |
| Annual Volume of CPD | 1,159 | 1,830 | D = B*C |
| National Payment for HCPCS G0506 | $63.88 | $63.88 | E |
| **Potential One-Time CPD Revenue, Rounded** | **$74,037** | **$116,900** | **F = D*E** |

## 4. Transitional Care Management

### *Definition*

A *New England Journal of Medicine* study showed the costs of care during the 90-day post-discharge period exceeded the cost of the initial hospitalization.[3] In an effort to control these costs, Medicare began reimbursing physicians for transitional care management (TCM) back in 2013.

TCM includes the following services furnished to a beneficiary requiring moderate-/high-complexity decision-making following discharge from a Part A stay: (1) initial contact with the beneficiary within 2 business days following discharge; (2) a face-to-face visit within 7 or 14 days (depending on the level of service); (3) medication reconciliation; and (4) non-face-to-face care management services furnished for 30 days, post-discharge (with no specific time requirement). A complete explanation of these requirements is provided in our white paper, *Providing and Billing Medicare for Transitional Care Management*.

### *Infrastructure*

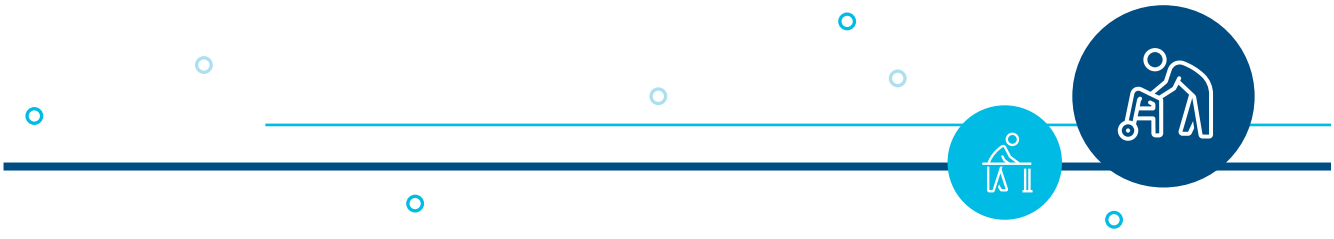
To provide TCM, a physician practice must have a means to identify and timely contact those beneficiaries who have been discharged from a hospital or skilled nursing facility. The practice also must be able to timely schedule beneficiaries for face-to-face visits. Some organizations employ non-physician practitioners (NPPs) to perform these visits, both in the office and at beneficiaries' homes. Finally, clinical staff must be available to provide appropriate non-face-to-face care management services.

### *Beneficiary Benefit*

A significant percentage of hospital readmissions could be avoided if patients and their family members had adequate support following discharge. TCM is intended to provide that support, ensuring that concerns are addressed and problems are avoided. By performing a medication reconciliation, for example, a care manager can identify a beneficiary's non-adherence to prescription orders, one of the most common causes of hospital readmissions.

### *Population Health Intersections*

TCM and CCM are closely related, as both provide payment for non-face-to-face care management services. Note that a physician cannot bill for TCM and CCM for the same beneficiary during the same month.



[3] Robert Mechanic, M.B.A., and Christopher Tompkins, Ph.D., *Lessons Learned in Preparing for Medicare Bundled Payments*, N. ENGL. J. MED. 2012; 367:1873-1875 (Nov. 15, 2012) (available at http://www.nejm.org/doi/full/10.1056/NEJMp1210823).

## *Gross Revenue Projections*

According to a recent national survey, 14.3% of Medicare beneficiaries are hospitalized an average of 1.37 times each year.[4] Applying the assumptions discussed previously, our 10-physician practice would have approximately 900 Medicare beneficiary inpatient discharges per year. We assume that two-thirds of these discharges would involve beneficiaries requiring moderate-/high-complexity medical decision-making, and thus would be eligible for TCM. Based on our experience, we estimate that a practice can capture 60% to 75% of eligible TCM beneficiaries.

There are two levels of TCM, CPT®s 99495 and 99496. The higher-level service (CPT® 99496, with higher reimbursement) requires that the beneficiary be seen within 7 days post discharge, while the lower-level service (CPT® 99495) requires that the visit occur within 14 days. We assume that 10% to 13% of TCM services will be the higher-level service.

| **Transitional Care Management** | **Low** | **High** | **Formula** |
|---|---|---|---|
| *# of Medicare Beneficiaries w/ TCM Coverage (84.5% of Beneficiaries)* | *4,635* | *4,635* | *A* |
| *% of Medicare Beneficiaries Hospitalized Each Year* | *14.3%* | *14.3%* | *B* |
| *# of Admissions per Year for Each Hospitalized Beneficiary* | *1.37* | *1.37* | *C* |
| *Moderate-/High-Complexity Decision-Making* | *67%* | *67%* | *D (two-thirds, not rounded)* |
| | | | |
| Annual Volume of Qualifying Discharges | 605 | 605 | *E = A*B*C*D* |
| | | | |
| Estimated % of Eligible Beneficiaries Seen Within 8-14 Days | 50% | 63% | *F* |
| Estimated Annual Volume of CPT® 99495 | 303 | 381 | *G = E*F* |
| National Payment for CPT® 99495 | $165.45 | $165.45 | *H* |
| | | | |
| Estimated % of Eligible Beneficiaries Seen Within 7 Days | 10% | 12% | *I* |
| Estimated Annual Volume for CPT® 99496 | 61 | 73 | *J = E*I* |
| National Payment for CPT® 99496 | $233.99 | $233.99 | *K* |
| | | | |
| **Potential Annual TCM Revenue, Rounded** | **$64,405** | **$80,118** | **L = (G*H) + (J*K)** |

[4] *Summary Health Statistics: National Health Interview Survey*, 2014.

## 5. Advance Care Planning

### *Definition*

As of January 1, 2016, Medicare now pays physicians for advance care planning (ACP). To bill for ACP, a physician must spend at least 30 minutes face-to-face with a beneficiary and/or his or her family members and caregivers discussing ACP, including reviewing and explaining advance directives (*e.g.*, healthcare proxies, durable powers of attorney for healthcare, living wills, medical orders for life-sustaining treatment).

### *Beneficiary Benefit*

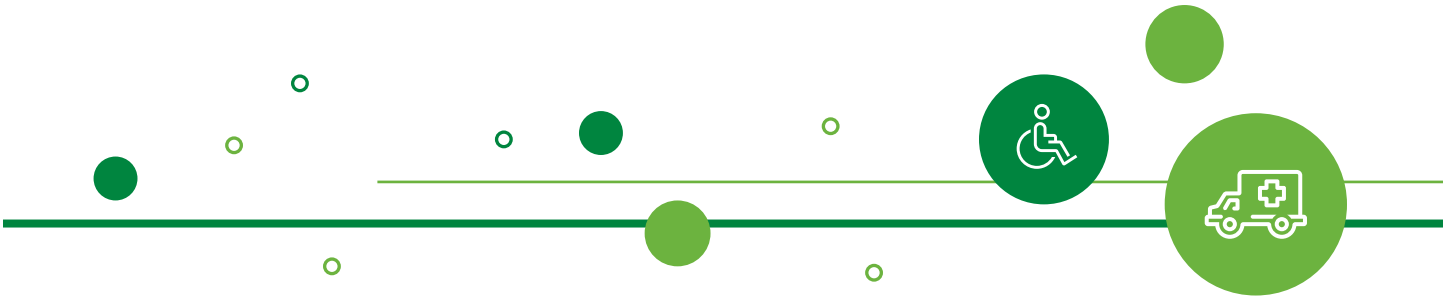
ACP affords a beneficiary the opportunity to consider treatment options with his or her physician and record his or her personal preferences. This process can lead to great comfort for both the beneficiary and family members, in times of critical decision-making.

### *Infrastructure*

ACP services may be provided by physicians or during the course of a team-based approach provided by physicians, NPPs, and other staff under the order and medical management of the beneficiary's treating physician. Due to the nature of the covered services, Medicare expects the billing physician or NPPs to manage, participate, and meaningfully contribute to the services in addition to providing a minimum of direct supervision.

### *Population Health Intersections*

ACP services may be provided in conjunction with other FFS population health services, including AWVs, CCM, and TCM. Research shows a significant percentage of beneficiaries will elect to forgo extraordinary measures through a discussion of ACP. In the absence of advance directives, however, most family members elect to pursue expensive treatments. A recent study showed that Medicare spends roughly four times more per capita for seniors who died during 2014 compared to those who lived the entire year.[5]



[5] J. Cubanski, T. Neuman, S. Griffin, and A. Damico, *Medicare Spending at the End of Life: A Snapshot of Beneficiaries Who Died in 2014 and the Cost of Their Care*, Kaiser Family Foundation (July 2016).

### *Gross Revenue Projections*

We estimate 15% to 20% of beneficiaries eligible for AWVs also will receive ACP services (CPT® 99497) and that 5% to 10% of these patients will require at least 60 minutes of face-to-face discussion (CPT® 99498), which qualifies for additional payment.

| Advance Care Planning | Low | High | Formula |
|---|---|---|---|
| *# of Patients Receiving AWV* | *3,245* | *4,032* | *A* |
| *% of Patients Receiving ACP* | *15%* | *20%* | *B* |
| ACP Volume (CPT® 99497) | 487 | 806 | C = A*B |
| National Payment for CPT® 99497 | $82.90 | $82.90 | D |
| *% of Patients Receiving ACP (Additional 30 Minutes)* | 5% | 10% | E |
| ACP Volume (Additional 30 Minutes) (CPT® 99498) | 24 | 81 | F = C*E |
| National Payment for CPT® 99498 | $72.50 | $72.50 | G |
| **Potential Annual ACP Revenue, Rounded** | **$42,112** | **$72,690** | **H = (C*D) + (F*G)** |

## Future Opportunities – Behavioral Health Integration and the Medicare Diabetes Prevention Program

Effective January 1, 2017, CMS now reimburses practitioners for integrating behavioral health services into their primary care practices. Like CCM and TCM, Medicare will make monthly payments for Behavioral Health Integration (BHI) services.

There are two categories of BHI services: Psychiatric Collaborative Care Services (CoCM) and General BHI. CoCM, which is more resource intensive, takes "typical" primary care services and incorporates care management and regular psychiatric support. General BHI can be billed for core behavioral health services, including systematic assessment and monitoring, care plan revision, and relationship development with a care team member.

Beginning January 1, 2018, practitioners enrolled in the Medicare Diabetes Prevention Program (MDPP) will be reimbursed for furnishing specified services for qualifying Medicare beneficiaries. These services, furnished over a 12-month period, include at least 16 weekly core hour-long sessions, over months 1-6, and at least six monthly core maintenance sessions over months 6-12. Beneficiaries then are eligible for additional services if they achieve and maintain the required minimum weight loss of 5% in the preceding 3 months.

We have not attempted to include revenue from BHI services and MDPP in our analysis. However, the resources required for BHI services and MDPP overlap considerably with other FFS PHM programs, which will make these services logical future expansions of FFS PHM programs for many practices. Both present significant revenue opportunities, and provide effective ways to help some of the most challenging patients in a physician practice.

# Net Revenue Projections

## Combined Gross Revenue Projections

To summarize, we estimate that a 10-physician practice can realize the following gross revenue from FFS PHM services:

| Combined Gross Revenue Projections | Low End | High End | Formula |
|---|---|---|---|
| Annual Wellness Visit | $394,959 | $490,172 | A |
| Chronic Care Management and Complex CCM | $551,548 | $865,913 | B |
| Care Plan Development | $74,037 | $116,900 | C |
| Transitional Care Management | $64,405 | $80,118 | D |
| Advance Care Planning | $42,112 | $72,690 | E |
| **Combined Potential Year One Gross Revenue Projections, Rounded** | **$1,127,061** | **$1,625,793** | **F = sum(A:E)** |
| **Less 2% for Uncollected Beneficiary Co-Payments, Rounded** | **$1,104,520** | **$1,593,277** | **G = F*98%** |

## Infrastructure and Operating Costs Estimates

The required infrastructure and operating costs to deliver FFS PHM services fall into three categories: staffing, expertise, and tools and technology.



### *Staffing*

Today, most primary care practices are staffed to handle the daily volume of office visits and other in-office services. These practices will need to add clinical staff members to provide FFS PHM services. A simple starting point is adding health coaches, who can help manage patient panels by conducting non-face-to-face care management services (for CCM and TCM), assist with quality measurement, and monitor which services each patient has received (such as AWVs and ACP). Based on publicly available staffing benchmarks, we estimate the salary and benefits for each health coach to be just over $50,000 per year. Based on our experience, we assume each health coach can manage a panel of approximately 500 beneficiaries.

In addition, many practices can benefit by adding NPPs to perform AWVs, the face-to-face component of TCM, and ACPs. For purposes of this analysis, we assume the practice will hire three NPPs, each of whom will perform four AWVs per day, along with other FFS PHM services. The salary and benefits estimates for these NPPs are also based on publicly available staffing benchmarks.

Practices should also consider adding a full-time data analyst to the team. An analyst will have an active role with the clinical care team by assisting with patient risk stratification, conducting financial and utilization analyses, tracking cost and quality improvement, and flagging high-risk patients based on various data sources. We estimate the salary and benefits for a qualified full-time data analyst to be just under $100,000 per year, based upon publicly available staffing benchmarks.

### *Expertise*

Accurate diagnosis coding and documentation is another key competency required under a risk-based healthcare system. It is important for physicians and other staff (*e.g.*, coders) to be frequently educated about coding and documentation best practices, but also within the context of defining and understanding risk. Annual training and regular documentation reviews are relatively low cost and should be viewed as necessary investments when establishing a PHM program. Based on our experience, costs range between $10,000 to $30,000 for educational and training resources.

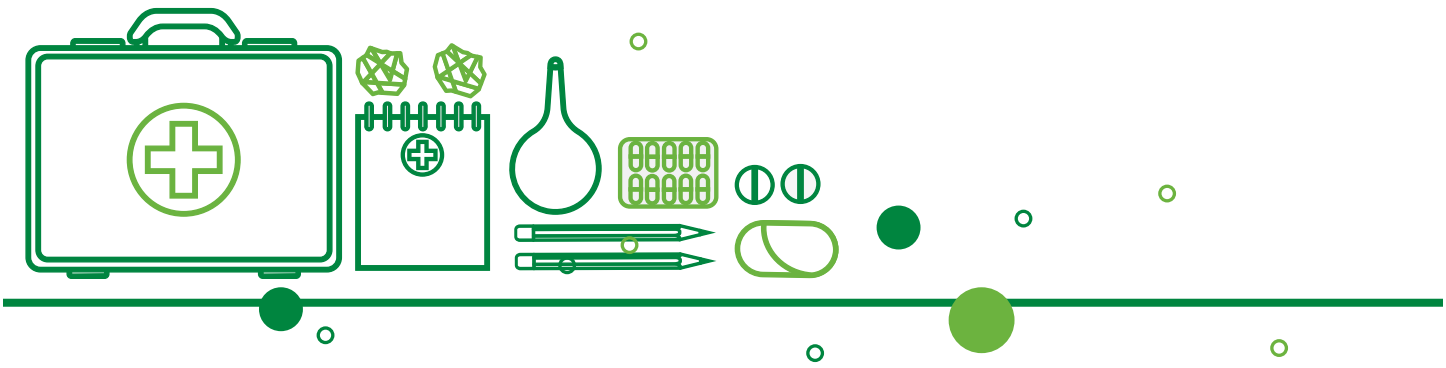
It is also beneficial for organizations to seek assistance from outside organizations to help design and launch these programs. Again, given the resource constraints of existing administrative and clinical staff, plus the expertise of other organizations, the return on investment for an outside resource to assist with program development should be high.

### *Tools and Technology*

In addition to the staff and expertise costs listed, there are certain start-up costs for tools and technology we have not included in this analysis, given the wide range of products available. These expenses include, but are not limited to, the initiation costs for an EHR or population health management software solution (if the practice's current EHR does not have the capacity to produce and manage care plans), ongoing information technology application costs (per-beneficiary-per-month-type fees), staff supplies (*e.g.*, computers, additional phone capacity), and recruiting expenses.

Practices also may consider adding remote patient monitoring technology and capabilities. According to CMS, "[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing CCM, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device." CMS has clarified that "to bill CPT® 99490, such activity cannot be the only work that is done – all other requirements for billing CPT® 99490 must be met to bill the code...." Again, the costs associated with remote patient monitoring solutions vary widely, and as such, we have not included any estimates for this in our analysis.

We recognize that capital investments may limit year-one profitability, but the long-term financial outlook is still strong. The revenue projections are relatively conservative, leaving room for growth and efficiency improvement in the future.

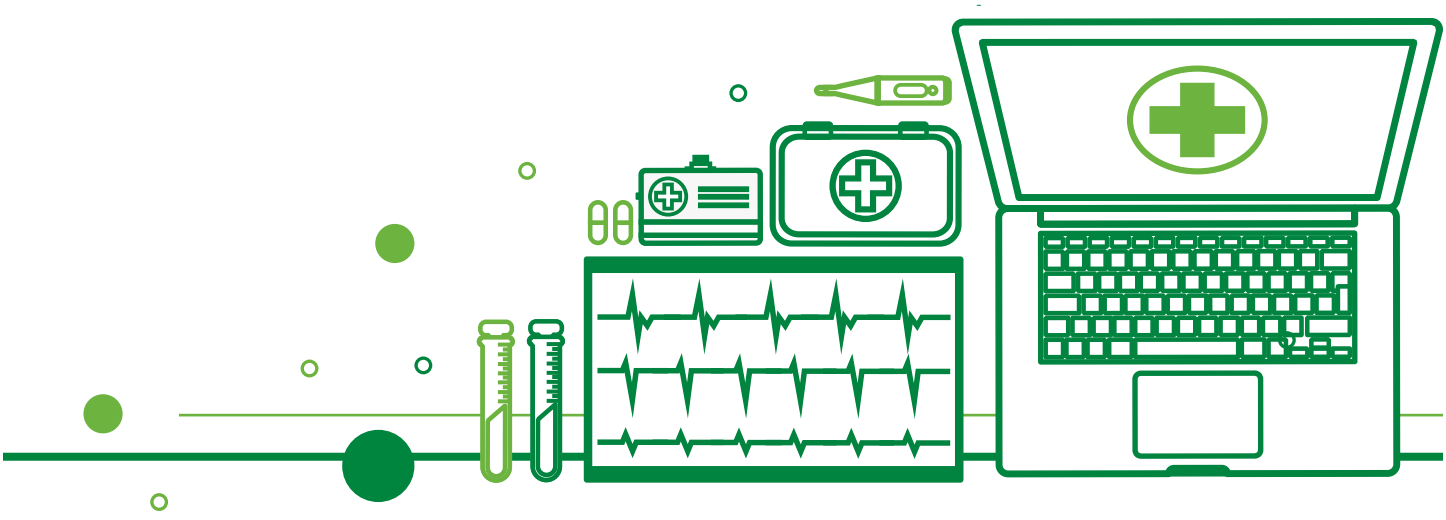


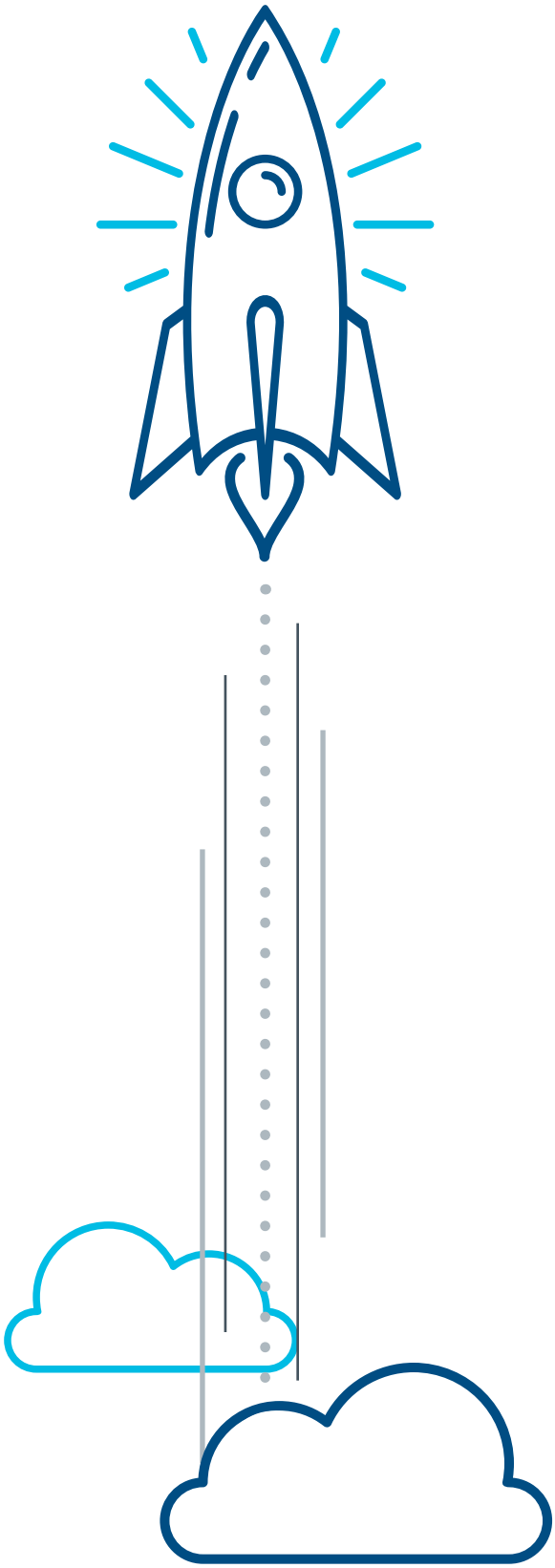
| Net Operating Margin | Low End | High End | Formula |
|---|---|---|---|
| **Operating Expenses** | | | |
| Billing Cost (8% of New Revenue) | $90,165 | $130,063 | A |
| Health Coaches (x3) for Care Management Team* | $161,330 | $161,330 | B |
| Nurse Practitioner (x3) for AWV Program* | $324,601 | $324,601 | C |
| Analyst | $96,000 | $96,000 | D |
| Coding and Documentation Training and Review | $10,000 | $30,000 | E |
| Consulting Fees for Program Design and Development | $35,000 | $75,000 | F |
| **Operating Expense Subtotal (not including start-up costs like tools and technology), Rounded** | **$717,096** | **$816,994** | **G = Sum(A:F)** |
| **Net Operating Margin Projection for PHM Services, Rounded** | **$387,424** | **$776,283** | **H = G – Gross Revenue (Previous Chart "G")** |

*estimates include 20% employee benefits in addition to base salary

Of course, we cannot guarantee an organization will realize this level of success. There are a number of factors that may negatively impact performance including, but not limited to, EHR capabilities, physician buy-in, and staff competencies. In fact, we have heard these objections – and many more – from organizations contemplating CCM programs.

But the decision to launch an FFS PHM program is not like the decision to purchase a new piece of equipment. With respect to the latter, one would not make such an investment unless one was relatively certain the revenue to be generated from the use of the machine will exceed the cost of the machine. The value of an effective FFS PHM program, however, far exceeds any FFS revenue it may generate. The infrastructure required for these programs is the same infrastructure required for success under emerging alternative payment models, including shared savings programs and episodic payments. Thus, the choice is not whether an organization will invest in that infrastructure, but whether the organization will realize FFS revenue to offset those costs.





## Time to Launch

A recent Health Care Payment Learning & Action Network survey of public and private health plans showed that nearly 25% of healthcare payments now flow through alternative payment models, with that percentage expected to increase in the coming years.[6] While an FFS PHM program provides an immediate revenue opportunity for physician practices, the real value in these programs comes from positioning providers for success under emerging alternative payment models. Although harder to quantify at this time, the ability to provide the right care at the right time for the right patient is critical to successfully managing value-based reimbursement.

Developing these new competencies is not an overnight process. But with an immediate revenue stream available to offset necessary infrastructure investments, we believe developing a comprehensive FFS PHM program should be a primary strategy to manage the transition from volume- to value-based reimbursement.

For information about how PYA can help organizations interested in building a population health strategy, please contact David McMillan (dmcmillan@pyapc.com) or Martie Ross (mross@pyapc.com), (800) 270-9629.



[6] Health Care Payment Learning & Action Network, *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs* (2016).