ChronicCareIQ
SUCCEED WITH REMOTE CARE

# THE HEART OF THE MATTER:
## The New Care Management Opportunity for Cardiology

## *OPERATIONALIZE COMPREHENSIVE REMOTE CARE STRATEGIES AND GROW YOUR PRACTICE*

### SUMMARY

The American Heart Association released a position paper on the importance of remote monitoring and the American College of Cardiology took the step of offering several position papers in support of remote care management, notably one here around heart failure patients[1,2,3,4]. This Executive Brief will echo the sentiments of the AHA and the ACC through examination of a strategic approach to care management which will be centered on the new reimbursements outlined by Medicare. The opportunity is this: cardiologists managing chronic diseases are not only eligible for the new reimbursements from Medicare, but are in a better position to fund efforts to reduce utilization and 30-day readmissions.

Announced in the 2021 final rule from CMS were several new code definitions that are applicable to activities cardiologists and their staff are already performing in patient care: phone time with patients or their loved ones, refilling prescriptions, reviewing images, vitals, labs, complex care planning and interactive communication with other providers. Some of these codes involve devices but 12 of the 15 codes are geared towards time thresholds of 20-60 minutes of care time by physicians or qualified healthcare professionals (QHCP). The billing is 'incident to' under general supervision and thus captures the life cycle of care activities in a given month and accounts for all staff involved.

For Cardiologists there is now a payment mechanism in place which recognizes the existing and necessary engagement of chronic patient populations remotely. The new recurring monthly revenue from CMS to support these new care management activities range from $42-$247 per patient per month in range based on 4 core CPT code groups.

1. ACC/HRS/EHRA/APHRS/LAHRS/AHA Release Guidance Document on Telehealth and Arrhythmia Monitoring During COVID-19, June 11, 2020
2. Using Remote Patient Monitoring Technologies for Better Cardiovascular Disease Outcomes Guidance. AHA advocacy department 2019
3. Mathematica Study for CMS also published in Journal of General Internal Medicine vol. 24, no. 2 Nov 2, 2017
4. Heart Failure Collaboratory Statement on Remote Monitoring and Social Distancing in the Landscape of COVID-19 June 30, 2020

## THE OPPORTUNITY

The 2021 Final Rule outlines 4 main 'pillars' of Care Management: Chronic Care Management (CCM), Chronic Remote Physiologic Monitoring (RPM), Principal Care Management (PCM) and Transitional Care Management (TCM). These are the mechanisms CMS has put in place to enable reimbursement for activities their data shows will lead to high quality and low costs. Since the beginning of CCM in 2015 with code 99490, several new codes have been added for CCM and new PCM and RPM codes have come onto the scene as well. The effects of CCM have been documented to be reduced utilization so the proliferation of this code set is easy to understand from the Medicare perspective (see Mathematica report graph here on CCM savings to Medicare[3]). The opportunity has been expanded and potential interference among physicians reduced by Principal Care Management and Remote Patient Monitoring. Until now, there was no reimbursement or cost-effective workflow in place to make 'keeping tabs-on' an at-risk population a worthwhile endeavor. And TCM which has been in place now for nearly a decade, is the type of activity which leads to reimbursement for re-admission reduction efforts.

**Principle Care Management**
G2064 - $92
G2065 - $39

**Chronic Care Management**
G0506 - $64
99491 - $74
99490 - $42
99439 - $37
99487 - $94
99489 - $47

**Remote Psysiologic Monitoring**
99453 - $21
99454 - $69
99457 - $54
99458 - $42

**Transitional Care Management**
99495 - $187
99496 - $247

Cardiology practices have another opportunity though. They can be aided in their transition to value by encasing their cadence for care of complex chronic patients within the framework of CMS's Care Management reimbursements. Situational awareness of their most at-risk population is a direct line of sight to patients who may become more expensive or whom will decompensate without intervention. These 'care management reimbursements' are payable when it can be shown that staff have devoted 20 minutes or more towards non-face-to-face patient care activities. The periods of defined time increments (20 mins per month for example) satisfy the requirement for several of the codes- including add on codes for additional time increment codes. Non-face to face activities on a patient's behalf are covered under CCM, PCM, and RPM. Medicare now recognizes and covers the immense effort your practice puts in for its chronic and fragile patients with a total of 21 codes in several categories collectively known as 'care management.'

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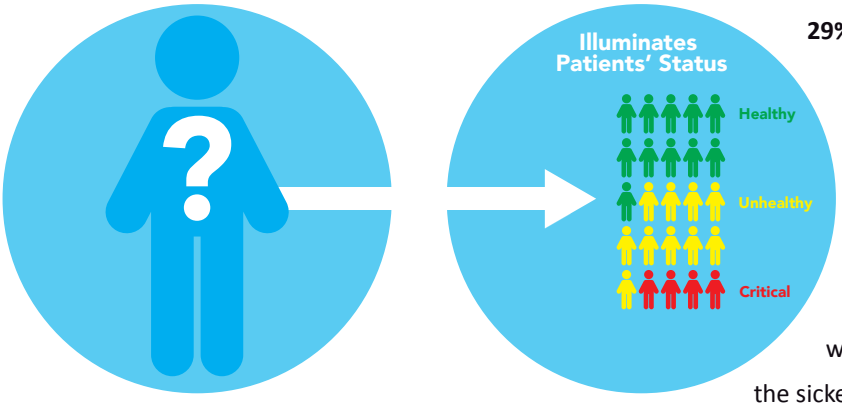
## CARE MANAGEMENT: 4 PILLARS

The four core reimbursement categories discussed in this brief are more than just 'codes' they are 'pillars' because they not only support the transition to value from the Fee for Service payment models but also support daily happenings in a busy cardiology practice. Excelling in these daily workflows is important to success in value-based care. As the goal of Medicare continues to be to move clinicians into Advanced Alternative Payment Models, practices will need to be innovative in how they approach diseases and populations which relate to quality measures and cost measures. These pillars promote patient engagement as a core strategy. **ChronicCareIQ is capturing reimbursement opportunities to fund care management.**

## CONTROLLING COST




Cardiology is ground zero for chronic disease. As the US health system attempts to control the rising costs, there is significant new opportunity here to innovate around services for chronic patients. The future fulcrum of the opportunity can be seen in our heart failure population alone. It increases exponentially when adding in arrythmia, vascular disease and hypertension.

**ChronicCareIQ alerts physicians early of a disease progression and decompensation.**

Here is an excerpt from the AHA journal of Medicine: "HF prevalence in the US population is projected to increase by 46% between 2012 and 2030. Total direct medical costs of HF were estimated at $30.7 billion in 2012 and are projected to increase by 127% to $69.7 billion by 2030." Meeting the demand to reduce hospitalizations and readmissions as a fundamental centerpiece to value-based care will require innovation in patient engagement and early warning systems focused on the timing of a patient's potential decompensation. Essentially, physicians already know what to do, the missing piece is knowing when. That's where technology like ChronicCareIQ helps. Emory University points out in its' Heart and Vascular forum that: Approximately 550,000 new cases of CHF are diagnosed in the U.S. each year. Heart failure is responsible for 11 million physician visits each year, and more hospitalizations than all forms of cancer combined. CHF is the first-listed diagnosis in 875,000 hospitalizations, and the most common diagnosis in hospital patients age 65 years and older. So, it is no understatement to suggest that the digital evolution of patients and providers connecting is a critically important one. Given the current pandemic with COVID-19 this evolution is seemingly on a fast track. And independent research shows that surveilled patients require less hospitalization.

**Independent Study by Karna LLC: 29% reduction in all cause cardiac hospitalizations and 30-day readmissions.** The patients that were offered additional surveillance via CCIQ ("Intervention Cohort"), were by definition, part of the sickest 15% of cardiac patients that make up 85% of system costs for cardiac care (hospital, specialists, pharmacy). The end result was up to a 29% reduction in all-types hospital admissions from one year to the next after the initiation of CCM. Several likely implications of the analysis of this CCM strategy in cardiac patients:

Myocardial Infarction (AMI) is $21,500 over 5.3 days of average admission and $14,631 over 7 days of admission for Congestive Heart Failure (CHF). The cost for hospital readmission of greater than one day for AMI is $9,424 over 5.7 days of average readmission, and $9,051 over 6.4 days of readmission for CHF. A conservative estimate of cost-avoidance in this sickest cohort for AMI was at least $9,424 per patient per year, and for CHF was $9,051 per patient per year. At an annual monitoring cost of $403/patient for CCM, it is possible to estimate the Return on Investment (ROI) of $23.4 per $1 invested per patient-year. ($9,424 / $403) for AMI and $9,051/$403 or $22.5 per $1 invested per patient-year for CHF.

## PATIENT ENGAGEMENT USING CHRONICCAREIQ – WHY IT WORKS

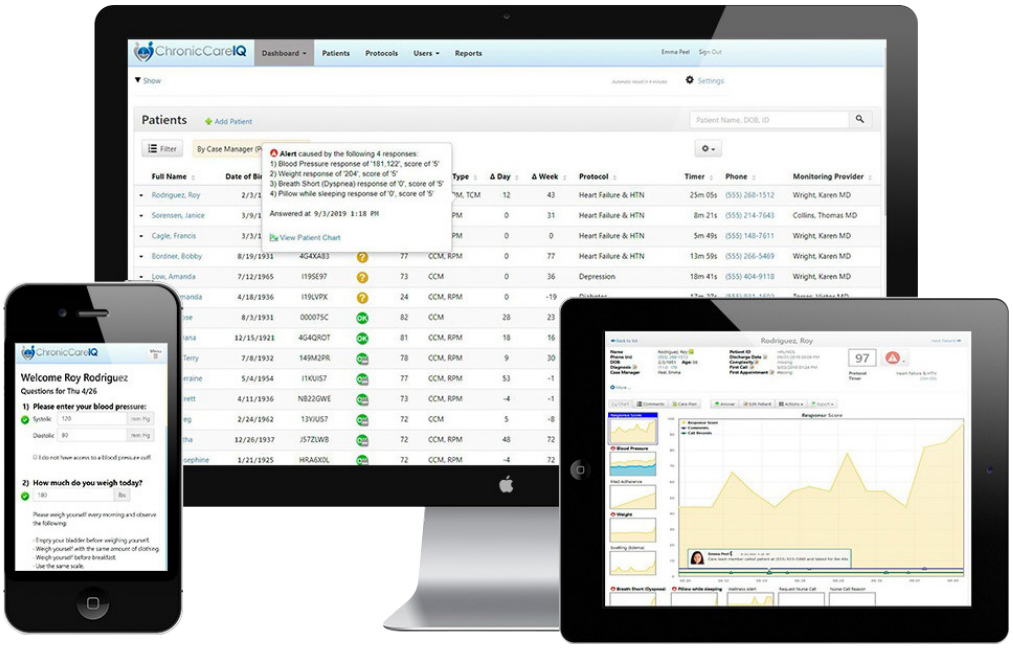
The new CPT codes for Care Management of chronic disease enable practices to be reimbursed for the things which contribute to the wellness and stability of chronic patients. Medicare has seen that patient interaction with physician practices between visits reduces costs of care, improves outcomes and patient satisfaction. ChronicCareIQ engages patients in multiple ways depending upon the comfort level of the patient: text, email, smart phone app, device and even land line. The technology prompts patients for responses to questions guided by the patient's individual risk factors and alerts staff for early intervention when those responses are trending negatively or have excessed clinical thresholds. One of ChronicCareIQ's Approaches Uses Questions Sets and Surveillance Protocols.

A heart failure patient may be prompted for their weight or asked if they have noticed any new swelling or how many pillows they slept with. The highly evolved survey tool dynamically allows updates from patients on key parameters and uses intelligence to prompt for follow-on information. A high blood pressure reported later than usual in the morning may then query the patient if they'd taken their medications yet.

Patient responses are analyzed and collated on a red, yellow and green color coded dashboard for prompt intervention. The dashboard also tracks days from discharge for risk-windows, those with delayed check-ins and even offers a checkered flag for those who have completed a pre-defined monitoring period. The awareness generated by ChronicCareIQs engagement strategy enables an immediate impact on quality by driving focus to the patients most at risk and subsequently reducing hospitalizations, diverting ED visits, and increasing patient satisfaction by not only keeping at-risk patients out of the hospital, but by meeting their communication needs in the most streamlined way possible. Expensive nurses and clinical staff are now directly engaged in pro-active care delivery, which frees up time to provide more pro-active care delivery in a virtuous cycle – especially since the system performs its own compliance tracking and documentation.

## CAPTURING TIME IS IMPORTANT FOR BILLING

ChronicCareIQ's software helps track billable events in care management which make it financially feasible to run high performing care management teams and afford the best people. This revenue becomes significant because most of the activities are captured automatically. To enable this ChronicCareIQ plugs into the two systems every practice already uses. The phone system to gather call-times with patients care-givers, and the EHR to document care management activities like refills, labs, images, care coordination that are already taking place in the daily management of chronic disease populations.



**ChronicCareIQ Deploys a Best Practices Model to Jump-Start Enrollment and Exceed Expectations in Revenue, Clinical Quality and Value.**

Patients are defined in ChronicCareIQ as technology patients, or phone patients. A technology patient uses a device, email, text or downloadable app to answer questions and report vitals at their convenience; they securely communicate electronically with staff and may certainly receive a phone call if the situation indicates. For patients that have no access to technology, the platform will inform a staff member which patient to call and what questions to ask. Children and spouses will often respond for their loved one through their technology. The prevalence of technology has resulted in millions of seniors going online daily. That needs to be leveraged in order for care management strategies to take flight. Guided, pro-active patient engagement, interactive communication, and centralized tracking and documentation are key automations that empower practices to operationalize and monetize care management at scale.

## A WORD ON COVID-19

Practices with remote care technologies in place prior to the pandemic were fortunate. One healthcare system in Maryland ballooned from 10 telehealth visits in a day to over 10,000 in a week. By the time vaccinations began rolling out, they were scaling up their telemedicine facility to provide 'tele-management' for chronic populations through remote monitoring. In the early days of the epidemic, many facilities initiated remote screening to direct patients to appropriate care locations based on symptoms. An additional lasting impact will be that it thrust digital healthcare into the hands of patients and providers alike, and reinforced the viability of care delivery through digital engagement. The time and enhanced care opportunities are now for cardiology to embrace digital and remote care strategies which are aligned to reimbursements.

## CONCLUSION

**Clinically:** ChronicCareIQ is an early warning system that empowers providers with better and more frequent information enabling them to make more timely interventions on behalf of their patients.

**Operationally:** ChronicCareIQ reduces the burden and work required to maintain high-risk patients enabling nurses to be more proactive with greater numbers of patients.

**Financially:** ChronicCareIQ captures the suite of reimbursements now permitted and shows an evolved roadmap to strong recurring revenue and sustainable delivery of a transformed care management model.

This model is one which offers ameliorative strategies for chronic care based on the insights gained from patient engagement and surveillance protocols. ChronicCareIQ enables a model which reduces hospitalization and over utilization to produce improved quality outcomes in the same breath as net new revenue generation. It increases patient satisfaction and delivers an improved and more secure quality of life. The 4 Pillars of care management work together inside ChronicCareIQ to help reduce readmissions, avoid hospitalizations, and engage patients in their disease in a smart and innovative way. This is the opportunity for cardiology. Who's not in on this?

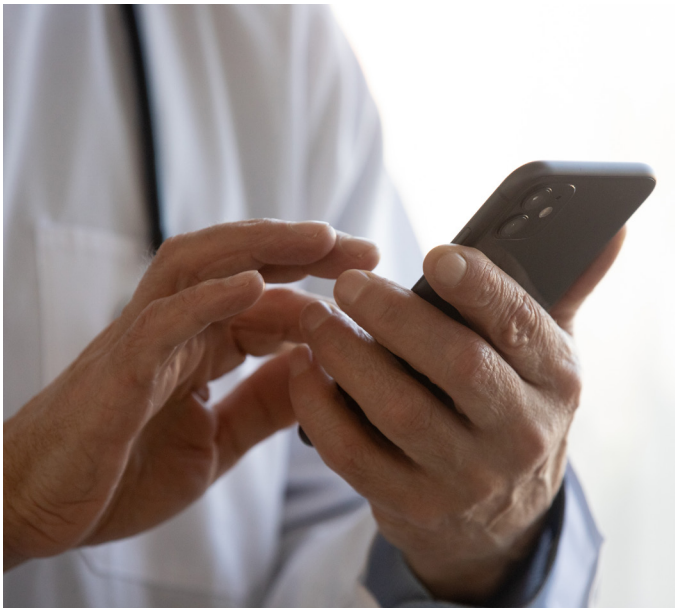
## POST SCRIPT ET AL.

**The work behind running a care management service line has the pleasant effect of also enabling a performance strategy for the Quality Payment Program (QPP) which includes both payment tracks: The Merit-based Incentive Payment system (MIPS now MIPS Value Pathways, MVPs) and Alternative Payment Models (APMs).** The Care Management pillars can significantly improve a practitioner's performance in new Medicare payment models. This is because performance measures do have common metrics which are used to literally score performance. In MIPS for example these are such things as: medication reconciliation, following a comprehensive care plan, 24/7 care access, care coordination, coordination of care in a team setting and reducing hospital admissions and readmissions.

And one such strategy for enhancing MIPS scores is picking Quality measures that have performance benchmarks (not all measures have benchmarks) because by picking measures that do, clinicians can maximize points with their performance. Care Management helps them bet on themselves to engage patients and move a patient from a denominator to the numerator. In cases where a patient attribution is part of an APM or fully risk-based model, it becomes even more important to the business to be able to dote on patient populations through surveillance protocols.

And regarding the QPP don't forget that practices can earn bonus points by reporting on additional outcomes and high priority measures. Many practices stay away from those which are tough to track or those which require them to 'bet on themselves'. Afterall, when you aim to perform on benchmarks or risk, who are you betting on to perform? Is it the doctor doing more work? Is it the CFO working magic in Excel? Or is it the patient engaging in their care strategy?

If you are betting on the patient then ChronicCareIQ is a must have for your cardiology practice.



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ChronicCareIQ is comprehensive, award winning technology that enables doctors, hospitals and health systems to build high-performing care management into their practices or service lines without excessive costs or third parties. With independently documented outcomes of 29% reduction in hospitalizations, 87% patient retention at one-year, and average net-new revenue exceeding $6,800 per provider per month with 91% patient satisfaction, you too can be clinically, financially and operationally successful with chronic care management, principal care management, transitional care management and remote patient monitoring.

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