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SUCCESS WITH CCM

Chronic Care Management (CCM) from a Physician Practice Administrator's Perspective

ABOUT THE AUTHOR

Dennis Breslin has been a successful C level operations executive in the delivery of healthcare for over 25 years. He served as president and COO of Primedica Hospital Division, the largest turnkey cardiopulmonary department contracting service for hospitals in the country. He provided over 150 hospitals with clinical staffing, equipment and supplies, and managed those departments on a 24/7 basis. He aggressively implemented programs and services in large physician practices that promoted state of the art technology, coordinated patient care, regulatory compliance, and increased profits. As VP of Customer Services of simplifyMD, he helped many medical practices successfully implement an EHR system and successfully attest to Meaningful Use. Breslin holds a BS in Biology from Kings College and an MBA from Georgia State University. He is an active member in the Medical Group Management Association.

SEEK OUT OPPORTUNITY WHEN THE MARKET CHANGES

As a physician practice administrator for many years, I always sought to add services that improved patient care, added new revenue streams and resulted in a competitive edge for the practice. I stayed abreast of changes in the market and in reimbursement. Physician practices need to be nimble enough to react quickly to those changes without creating negative unintentional consequences. It is clear that Medicare cannot sustain the current payment system. So, with the repeal of the Sustained Growth Rate (SGR), now, welcome Value Based Reimbursement. Payment reform is moving quickly to value based reimbursement. Practice administrators should view this as an opportunity to drive new revenue and services. But be aware, the value based adjustments proposed by Medicare are expected to be budget neutral. This means if a provider or group earns a 5% increase adjustment to their Medicare payments then Medicare expects there will be a 5% decrease adjustment to another provider and group. It is imperative for the medical practices to focus on how to maximize compliance to this paradigm shift. One of the more telling and exciting changes to the Medicare Physician Payment System was the funding for Chronic Care Management (CCM) via CPT code 99490.

Medicare now reimburses physicians for non-face to face time that their clinical team provides to patients with 2 or more chronic illnesses. WOW! We will get into the weeds shortly, but I just want to stress that CCM is a big shift in Medicare's approach for paying providers. It shows that Medicare firmly supports the premise that Chronic Care Management (CCM) will reduce the cost of care for patients living with chronic illnesses and is willing to pay for it.

WHY MEDICARE IS PAYING FOR CHRONIC CARE MANAGEMENT

Many studies have shown that monitored patients with chronic disease live longer, have less acute episodic health events and have lower out of pocket expenses. Medicare supports more frequent patient engagement with their care team and expects to lower costs and improve out comes. That is why Medicare approved payment for CPT code 99490 that has a potential of $17 billion in CCM program reimbursement.

The facts are that 80% of all Medicare payments go to treating chronic illness, 67% of all Medicare patients have 2 or more chronic illnesses[1] and the average cost to Medicare for a hospitalization is $12,200[2]. The Medicare National allowable for CPT code 99490 is $40.82 per patient per month. That equates to $515.00 per patient per year. For a provider that services a 1,500 patient panel where 25% of the panel is Medicare, that is a potential of 375 patients that could be eligible for Chronic Care

1 New York Times 'Medicare to start paying doctors who coordinate needs of chronically ill patients' August 16, 2014

2 'Cost for Hospital stay in the United States', Health Care Cost and Utilization Project, AHRQ

Management CCM services. This equates to a potential $192,690 in an additional provider revenue per year. The offset for Medicare would be averting 17 Medicare patient hospitalizations. Realistically not all of the Medicare patients with multiple chronic illnesses will opt to have CCM services, however, some third party payers are already paying for CCM services and it is expected that the others will follow because many patients below the age of 65 can benefit from CCM services.

On its face, this seems to be very attractive for a practice that treats patients with chronic illnesses. It appears to satisfy the triple aim; improvement of patient experience of care, improving health of populations and reducing per capita cost of health care. With this new significant revenue stream for the provider, CCM could actually satisfy the quadruple aim of improved provider satisfaction as well!

So why is there such a low adoption rate for the CMS CCM program?

In 2015, the number of patients receiving CCM services was less than 1% of the total eligible patients! One would think that a new billable code would have much more acceptance. The devil is in the details and there are a lot of details to consider for Chronic Care Management (CCM) but with the right system these details should be easily managed.

BARRIERS TO CHANGE

According to a recent this survey[3], the adoption rates for CCM payments have been surprisingly slow. Only 25% of the 309 respondents included in the final survey analysis said they had launched a CCM program for their Medicare patients and less than half of those (49.2%) said they had successfully submitted a claim and received payment for CCM.

The Survey found three key concerns among most participants:

- Insufficient reimbursement for the time and effort required (47%)
- Lack of awareness regarding the opportunity (43%)
- Compliance concerns (39%)

These other concerns were also cited by survey respondents:

- Patient involvement is difficult and time consuming
- Copayments create patient concerns and dissatisfaction
- Electronic health records may not effectively support CCM requirements
- CCM services may require an investment

The take away is that most administrators do not know how to implement a cost effective CCM program easily into their practice.

CMS REQUIREMENTS FOR THE CCM PROGRAM

CMS has very detailed program requirements for the CCM program from the types of patients that are eligible to the services you need to provide and how

3 The National Chronic Care Management Survey 2015 PYA and ENU Health Intelegence2015

you will need to bill. You will find a comprehensive list of all of the CCM payment requirements at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- To bill CMS under the CPT 99490 code, your practice will need to provide the following:
- The monitoring provider must be using a ONC certified EHR
- Patient has 24/7 access to clinical staff to address urgent chronic care needs.
- Continuity of care through access to an established care team for successive routine appointments.
- Ongoing care management for all chronic conditions, including medication reconciliation and regular assessment of the patient's medical, functional and psychosocial needs.
- The patient needs to sign a consent form indicating the monitoring provider
- The patient receives a comprehensive exam and provided an overview on CCM
- Create a Patient Centered Care Plan
- The Care Plan should be available electronically to the patient and to home and community-based clinical service providers.
- Patient and caregiver access allowing all relevant caregivers the opportunity to communicate about the patient's needs and appropriate care.
- Track and document a minimum of 20 minutes of non-face-to face CCM services per month.
- For billing, the DOS must be the day when the 20 minutes of non-face to face time is reached (this is required by certain MACs)

Primary care providers, specialists, advanced practice registered nurses, physician's assistants, clinical nurse specialists, and certified nurse midwives are all eligible to bill Medicare under this new CCM payment model. Non-physicians and limited-license practitioners – clinical psychologists and social workers – are not eligible to bill for CCM. It is important to note that non FQHCs and RHCs can accrue 20 minutes of non-face to face time incident to general physician supervision. The provider that bills for the services must be prepared to have oversight of the CCM program; however, they are not required to be present for the work to be done. This means any clinically licensed staff member, such as a Medical Assistant (MA), can provide the program services as long as they are an employee or an agent of the practice.

ADDRESSING THE CCM REQUIREMENTS

There are certain requirements that should not be problematic for most practices but there are others that may be outside their current capabilities. The first six requirements are easy enough. As long as your practice is using a ONC certified EHR and you can find examples of a patient consent form that is approved by your legal advisor, the other four should be part of your scope of practice. A Patient Centered Care Plan may be unfamiliar if your practice is not certified as a Patient Centered Medical Home but can be templated in your EHR. The Care Plan must include an assessment of the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient. It must contain a record of preventive care services, medication reconciliation, a review of adherence and potential drug interactions, and oversight of patient self-management of medications. In addition, it must list the clinicians and the community resources involved in the patient's care and explain how the care will be coordinated.

The remainder of the requirements are not easily addressed by most practices. To try to build this functionality into a practice would take significant time and resources. Most practices do not have that extra bandwidth. So should you just give up and not participate in CCM? No, I recommend you find the right solution. So, if instead of building consider buying.

Seek out the vendor partner that can provide the things that you cannot.

The problem is that most CCM vendors only offer partial solutions. They aggregate patient records or just track time. What is the added value of tracking non-face to face time for things you are already providing? How does just tracking time improve patient engagement? It does not. Call centers do not know your patients and demand over half of the reimbursement. You, also, have to ensure that the staff at the call center are licensed in your state. You are taking all the risk, outsourcing your core competence and getting little for it.

FOCUS ON IMPROVING PATIENT ENGAGEMENT

There are effective clinical protocols for treating many chronic illnesses. The problem is chronic illness is being treated periodically with visits with the provider. The patient with Congestive Heart Failure and Hypertension may be seen in the doctor's office once every 2 to 3 months. A lot can happen with the patient in that time that can have a negative effect on the patient's health status. Staying aware of the key indicators of the patient health status is fundamental to keeping patients as well as they can be. Many times chronically ill patients slowly decompensate into a critical health status. Patients that trend poorly need intervention before they slide too far and require a trip to the emergency room or hospitalization. Patients with chronic illnesses that are engaged with their provider's practice and compliant with their care plan generally live longer, have less acute events and enjoy a better quality of life than those that do not. So the key to effective chronic care management is patient engagement and being able to identify which patients may be crossing clinical thresholds.

Patient portals have been marketed to enhance patient engagement, however, they have had a very poor track record in that regard. If a patient is going to spend time sending some health status information (weight, blood sugar, blood pressure activity level) to their provider then it has to be very easy. Equally important is for the provider's clinical team be able to easily see what patients, among many, may be trending poorly so they can intervene. The CCM process that would work best is one that improves patient engagement and scales well for large patient panels for the provider's practice. This is effectively getting the right patient to the right doctor at the right time. Now isn't that the essence of treating chronically ill patients effectively.

LOOK FOR THE RIGHT PARTNER FOR CCM

Look carefully for the right vendor partner to ensure your success with CCM. Focus on providing the added value of better patient engagement, knowing when patients need attention and sharing information easily among all members of the patient's care team. Then, you will be achieving the intent of CCM!

The right vendor partner should provide a very cost effective, turnkey implementation that works seamlessly with your current clinical workflow and does not add more work for the provider. The vendor partner should offer online and onsite training, help identify appropriate patients to enroll, provide customizable marketing material, easily facilitate frequent patient engagement, track patient status specific to their diseases with alerts when patients may be trending poorly, provide easy access and input for all members of the patient's care team, provide patient billing and robust audit reports and have 24/7 support. Is there such a vendor?

ChronicCareIQ

SUCCESS WITH CCM

ChronicCareIQ has designed a CCM solution that can ensure your success with the new Medicare billing program. Getting started with the ChronicCareIQ system is simple and easy to implement. We don't ask you to purchase any new technology or disrupt your current practice workflow. ChronicCareIQ can provide you with a true care coordination and patient management system that will meet all of your practice's needs and CMS' program requirements. Get started quickly and efficiently with a system that finally allows you to manage your chronic care patients and begin capturing that additional revenue for your practice.

To request a demo or get more information about ChronicCareIQ's unique program, please visit www.choniccareiq.com or call 855.999.8089