

Greenway Care Coordination Services

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How familiar are you with Medicaid's code 99490?

- Very familiar
- I know of it
- Never heard of it before



CCM Code 99490 Benefits

Clinical:

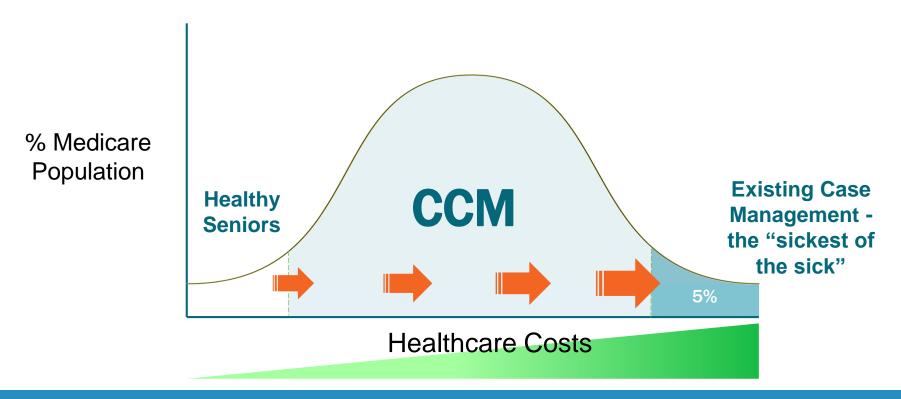
- Increased Access to Care
- Extension of the practice
- Greater patient engagement
- Improved outcomes

Financial

- Represents a reimbursement bridge for providers as they move from fee-for-service towards value-based medicine
 payments (new meaningful use)
- \$42K / provider / year bottom line net income
- First of many population health reimbursement codes



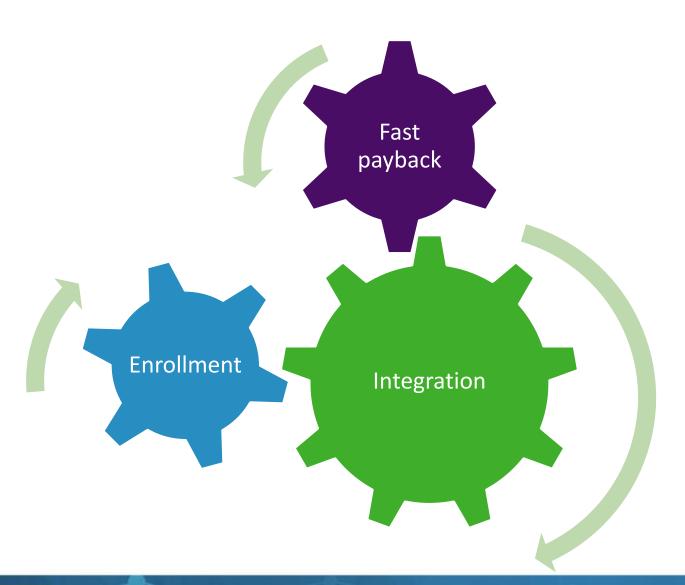
Population Health — Where CCM Fits



Manage disease in ~90% of Medicare patients who are at moderate risk Prevent the progression of chronic disease Avoid unnecessary ED visits/hospital admissions



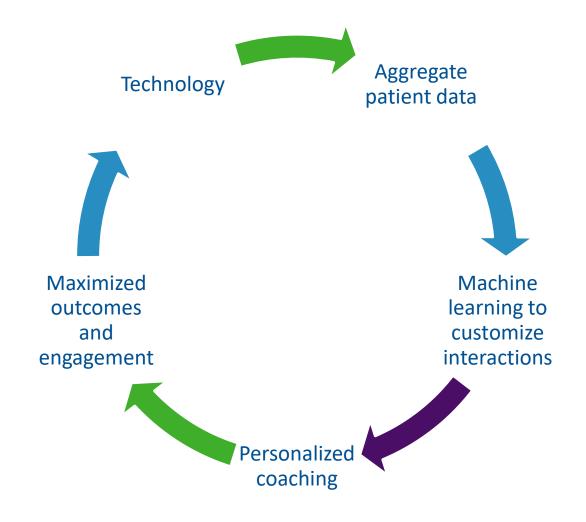
Integration makes getting started easy





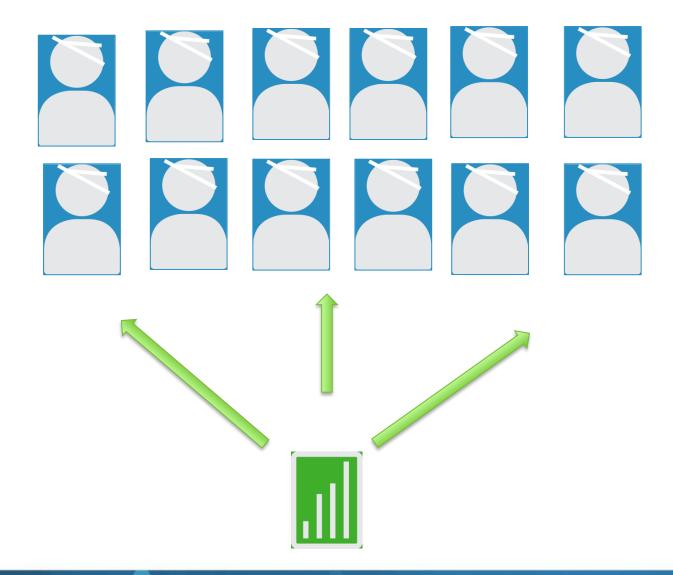


Technology and engagement driving outcomes





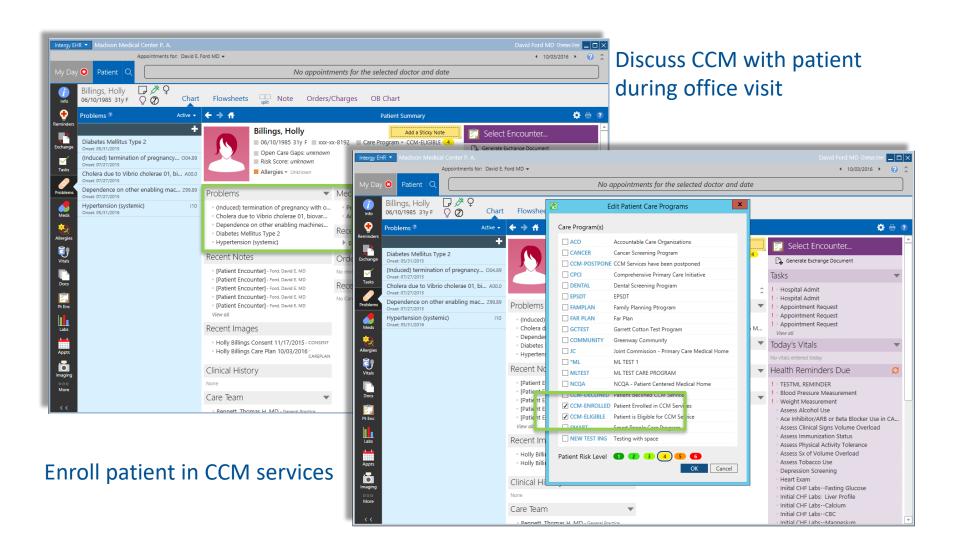
More care in twenty minutes







Identify & Enroll





CCM services model

Practice

Enroll patients:

- 2+ chronic conditions
- Eligible payer
- · Consent form signed
- Assign Care Program of CCM-Enrolled

Patient enrolled

Service

Patient enrollment validated

CCD extracted for diagnoses and goals

CCM Services provided during month

Patient Imaging:

- Care plan
- Evidence of care
- Patient reported vitals

Billing:

Process claims
Collect patient copayment

Documentation sent

Billing information sent

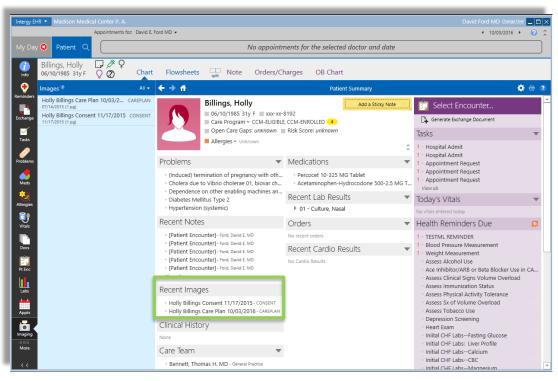
Documents updated

- RevUp care plan
- Evidence of care
- Patient reported vitals

Patient CCM minutes diagnosis codes, CPT codes aggregated

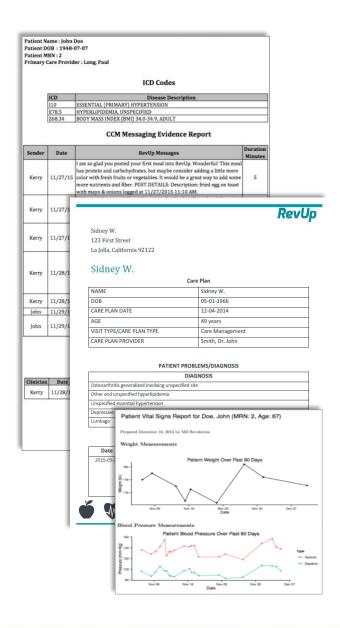


Documentation updates



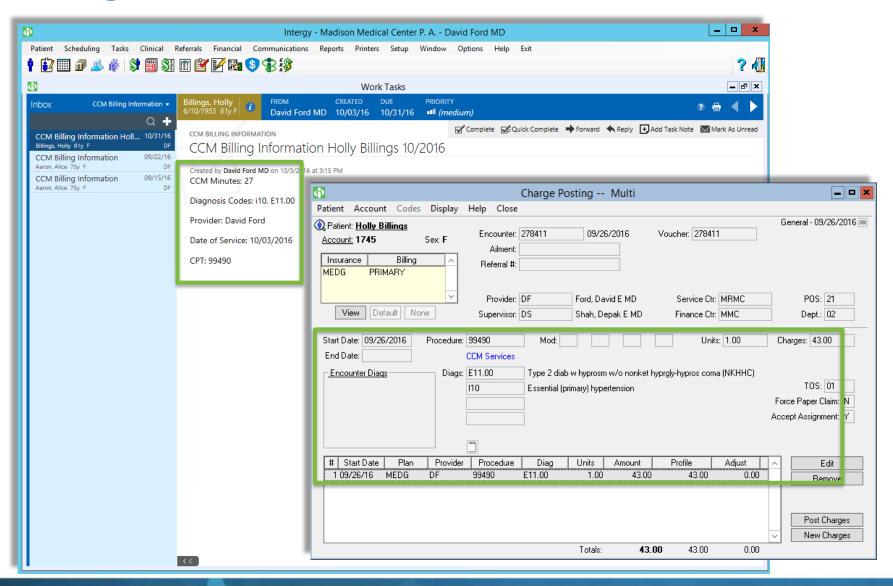
Documents linked to patient chart:

- Evidence of care
- Care plan
- Patient generated vitals



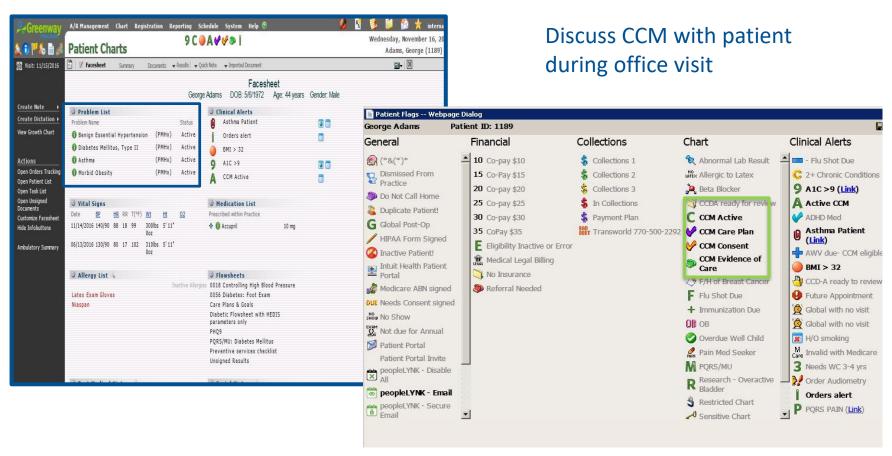


Billing





Identify & Enroll



Enroll patient in CCM services



CCM services model

Practice

Enroll patients:

- 2+ chronic conditions
- Eligible payer
- Consent form signed
- · Flag as CCM-Enrolled

Patient enrolled

Service

Patient enrollment validated

CCD extracted for diagnoses and goals

CCM Services provided during month

Patient Documents:

- Care plan
- Evidence of care
- Patient reported vitals

Billing:

Process claims
Check patient out for visit
Collect patient copayment

Documentation sent

Charges posted

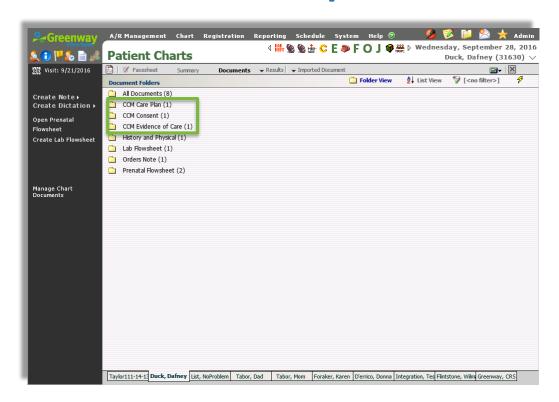
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- Evidence of care
- Patient reported vitals

Patient CCM minutes, diagnosis codes, CPT codes aggregated

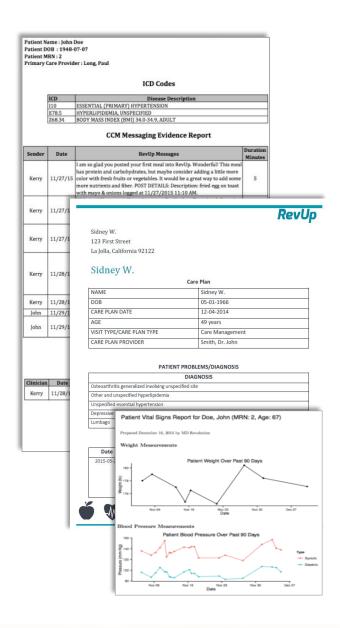


Documentation updates

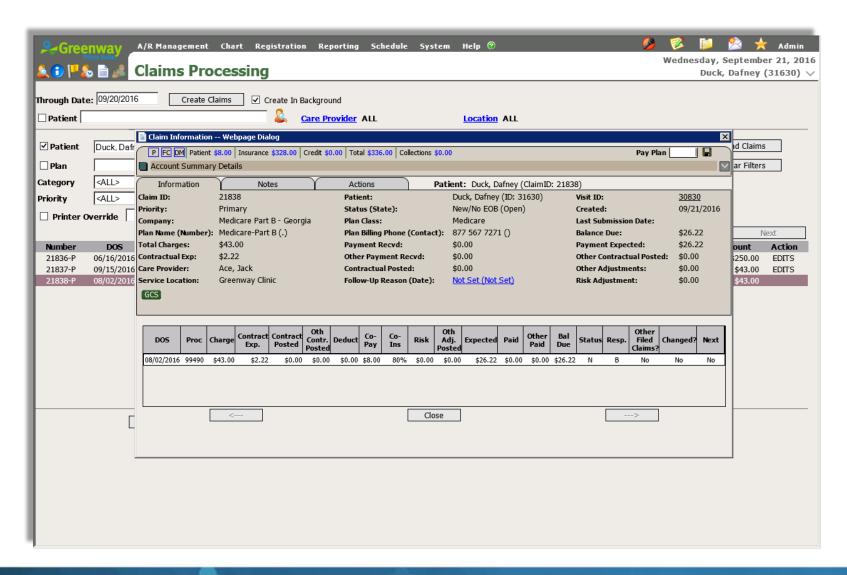


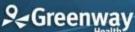
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Billing



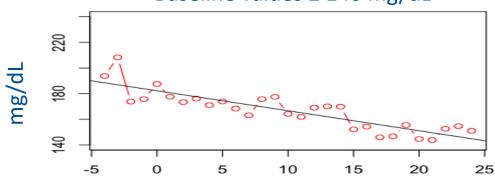


HELPING PATIENTS GET HEALTHIER

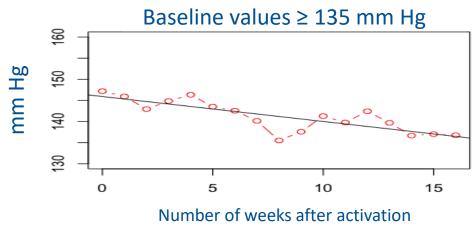
Trends over time support the role of engagement in generating clinical outcomes

Blood Glucose

Baseline values ≥ 140 mg/dL



Systolic Blood Pressure







Medicare unplanned re-admission rate: RevUp CCM patients vs. all Medicare

<u>Specific Readmission Measures:</u> Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease, Heart Failure, Pneumonia, Stroke, Coronary Artery Bypass Graft, Total Hip and/or Total Knee Surgery

Memorial Hospital at Gulfport

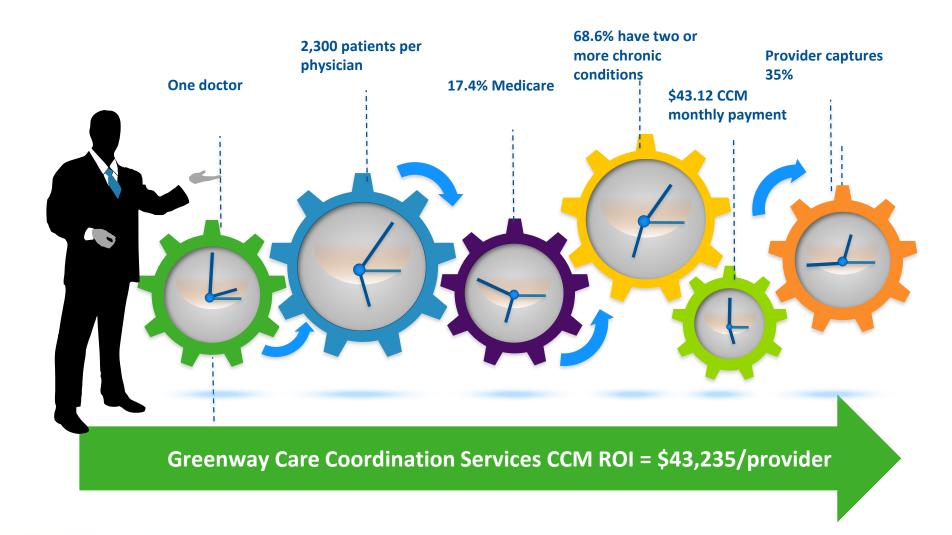
	CCM Patients	All Medicare
# of Patients	3529	~12,000
# of Admissions	444	3080
%	12.60%	25.70%
# Re- Admissions	34	468
%	7.66%	15.19%

Note: All Medicare column as filed with Medicare by Gulfport - 2014





How you earn by partnering with Greenway Care Coordination Services





More Than Just 99490

- Many commercial payers are starting to reimburse for 99490
 - Requirements not as stringent
 - Payments are ~ 15-25% higher than Medicare
- 2017 PFS CMS proposes to add two new CCM codes
 - 99487, 99489
 - additional reimbursement for additional time spent to patients with additional condition



Value Proposition

- EHR integration (less work) save \$5-\$12 pppm
 - Increases patient enrollment
 - Billing automation no manual billing
 - No disruption in office workflow
- Better for your patients
 - Extension of the physician practice
 - Increased patient engagement with personalized messaging
 - Improved outcomes
- Better for the practice
 - Faster enrollment means faster reimbursement
 - Greater patient engagement means the clinical and financial benefit continues over time – instead of tapering off



Implementation Process (4 to 6 Weeks)



Client Details Form

- Sales Rep completes CDF and collects required items regarding:
 - Provider Details
 - Patient List(s)
 - · Software / IT Details
 - Marketing & Communication

Client Project Scoped

 Implementation Manager (IM) and RevUp IT team draft Work Plan.

Kickoff Meeting

 IM reviews drafted Scoping Plan and next steps with Client.

IT Scoping

- Determine secure connectivity options, integration approach, and roles.
- Gain appropriate access to EHR.

Marketing Collateral

 Promotional, educational, and program enrollment materials provided to Client.

CCD Exchange & EHR Data Connectivity

RevUp and EHR integration build.

Practice Training

 Office manager and staff trained on CCM workflows and service.

Enrollment Start

 Begin enrolling them in CCM program.

Patient Engagement

· Begin delivering care.

Reporting & Billing Documentation

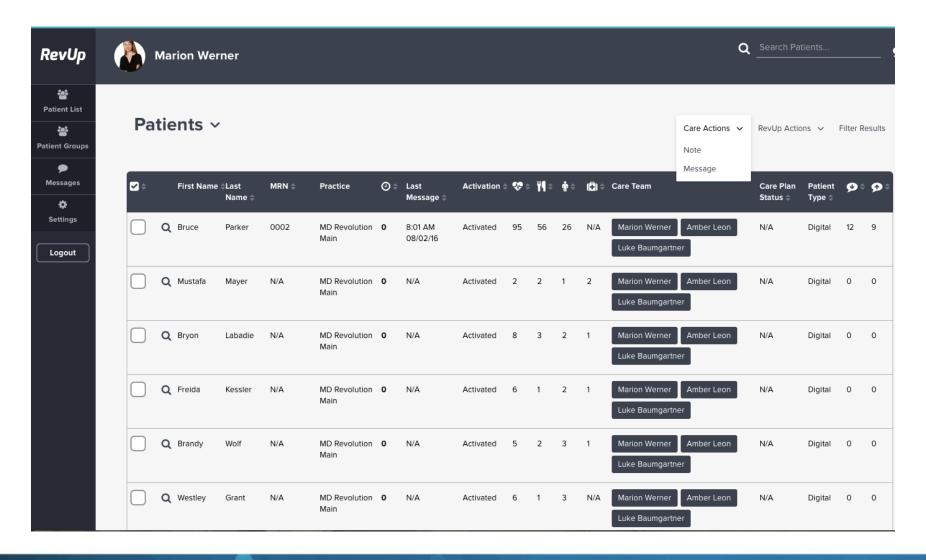
 Documentation provided for billing at end of each month.

Account Manager (AM)

 AM becomes clients main point of contact

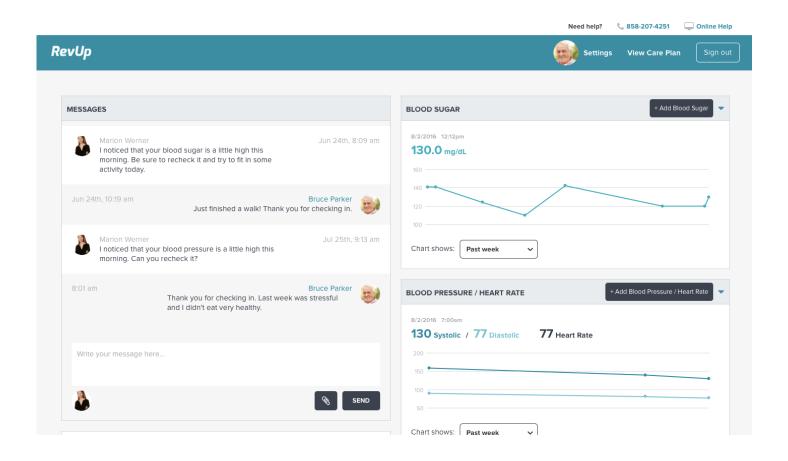


Clinical application





Patient application





Would you like to be contacted by a member of the Greenway Care Coordination Services

- Yes
- No
- Yes, but I may be more interested in hearing about Greenway Community, our other population health management platform

