Care Coordination Services

CHRONIC CARE MANAGEMENT FEE

and Coordinating Care

Greenway Health

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INTRODUCTION

Over the past ten years, the government and private payers have introduced numerous programs aimed at controlling healthcare costs and improving quality. In the United States, far too many patients have multiple chronic conditions, are noncompliant, and/or require continuous reinforcement and coaching to manage their health. At the same time, payers have not stepped up to compensate providers for delivering the coaching and long-term care that's needed to positively impact patient health.

Fortunately, the Center for Medicare and Medicaid Services (CMS) introduced the Chronic Care Management (CCM) fee in 2012. It reimburses providers for patient encounters made outside of the office where they establish, monitor, and update or coach patients on their care plan.

At $42 per patient per month, this represents a substantial revenue opportunity for healthcare organizations. Given the requirements of the program and limited scope, this program looked like a great starting point for practices new to population health management.

Still, adoption has been slow. According to a study by the Journal of the American Medical Association (JAMA), in the first nine months of 2015, Medicare processed CCM claims for a mere 2,000 patients, representing less than one percent of the projected 20 million eligible patients. Reasons for slow adoption include lack of awareness, tough billing requirements, the 20% Medicare copay, and more.

Greenway Health is committed to helping our customers succeed in this ever-shifting reimbursement landscape. In this piece, we'll review what the CCM program entails, as well as identify barriers to implementation and how to overcome them. We'll also show you ways to leverage the CCM fee to take the next step in your organization and fund other initiatives.

Finally, we'll provide insight on how you can use Greenway Care Coordination Services and Greenway Community to help you excel.

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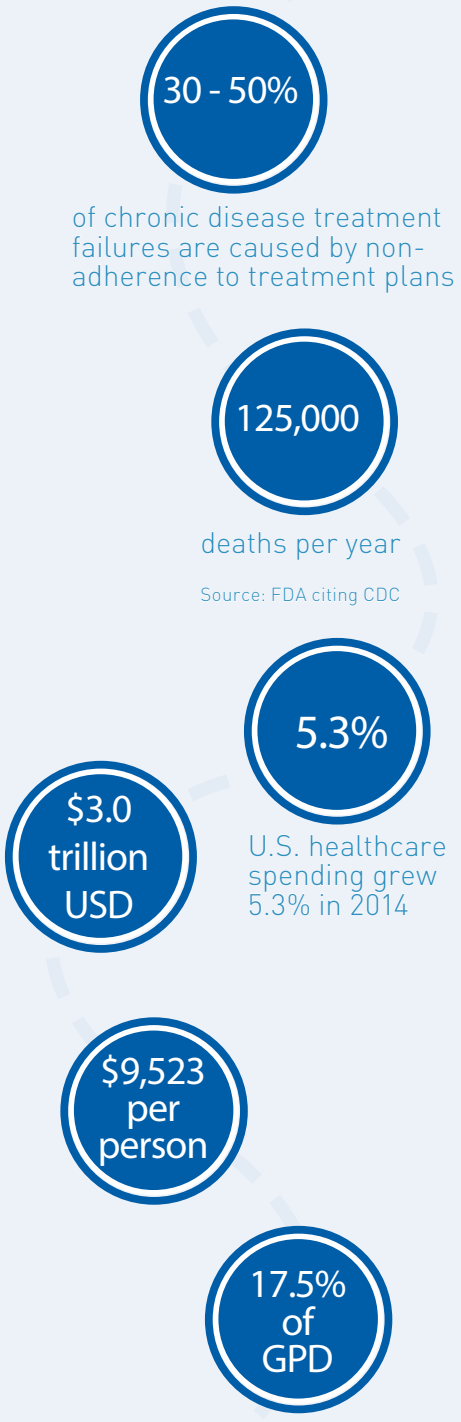
AS PATIENTS FACE INCREASING CHRONIC CONDITIONS, HEALTHCARECOSTSRISE

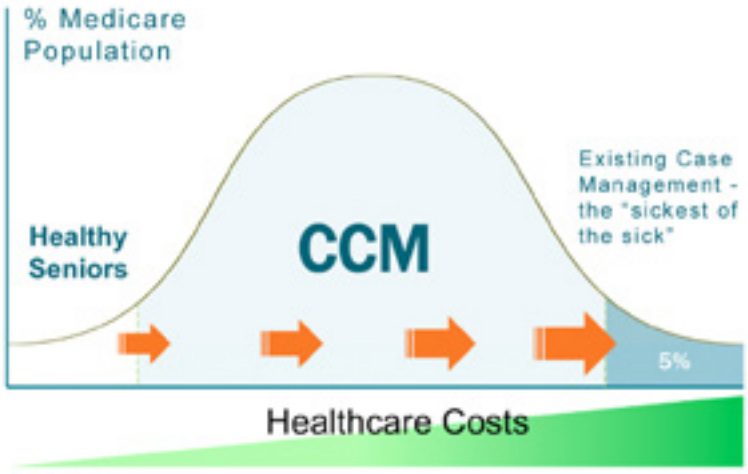


THE CHRONIC CARE MANAGEMENT FEE

Where CCM fits in

Improving population health is a global concern that requires a comprehensive and collaborative approach that extends well beyond the healthcare system alone.

Still, chronic disease in the U.S. represents a significant portion of the cost of healthcare, and many patients have two or more chronic conditions that need to be managed. To that end, implementing chronic care management processes represents a way for practices to begin the move from volume-based services to value-based services in preparation for greater reform efforts to come, including the full transition to value-based care.



Overview

Traditionally, payers have regarded out-of-office tasks that help a patient manage his or her chronic condition as bundled into the fee-for-service model. Payers expected providers to perform these tasks regardless of incentives.

With the Chronic Care Management fee (CCM), CMS now enables practices to charge for care that is not conducted face-to-face, but plays a significant role in helping a patient manage their care. To be able to bill for the CCM fee, a practice needs to meet certain proactive care management prerequisites.

GETTING PAID

Qualified providers, including certain mid-level providers, can bill up to 20 minutes of qualifying care per patient per month for the CCM fee. In return, the practice receives more than $40 per patient receiving such care per month.

Permitted care includes medication reconciliation, overseeing a patient's self-management of medication, ensuring the beneficiary receives recommended preventive services, and actively monitoring the patient's condition. These procedures are meant to encourage patients and providers to actively manage chronic health conditions.

Other value-based organizations, such as ACOs and PCMHs, are eligible to qualify for this payment. This eligibility enables them to use their overlapping and distinctive capabilities in care management to capture additional revenue per patient per month.

THE FIVE CORE COMPETENCIES

To charge for the CCM fee, a practice must have five core competencies in place, including:

01 Use of certified electronic healthcare records for specified purposes, such as symptom management, social resources, and medication management

02 Maintaining an electronic care plan accessible to all relevant care members, particularly the patient, and shared as appropriate under clinical conditions and HIPAA

03 Ensuring a beneficiary access to 24/7 care through successive routine appointments with a care team member and opportunities to communicate beyond the office

04 Facilitating transitions of care by managing referrals, providing post-discharge transitional care management, and sharing a patient's information electronically with other relevant clinicians

05 Coordinating care

CHRONIC CARE MANAGEMENT BENEFITS PATIENTS AND PROVIDERS ALIKE

CMS implemented CCM to give both patients and providers more flexibility in managing chronic conditions. It recognizes that managing chronic conditions out of the office can help improve health and lower spending.

Nuts & bolts – CCM at work

To implement a CCM program, you need to enroll patients, bill for the service, and understand who is eligible to bill for the service.

WHO'S ELIGIBLE AND HOW DO YOU ENROLL THEM?

Patients with two or more chronic conditions that put the patient at significant risk of death, acute exacerbation, or functional decline are eligible to receive the service.

EXAMPLES OF QUALIFYING CONDITIONS	
Alzheimer's disease and related dementia	Depression
Arthritis	Diabetes
Asthma	Heart failure
Atrial fibrillation	Hypertension
Cancer	Ischemic heart disease
Chronic Obstructive Pulmonary Disease	Osteoporosis

How to enroll patients

- The billing practitioner discusses the program during a comprehensive evaluation and management (E/M) visit (e.g., annual wellness visits or initial preventive physical exams).
- The provider informs the patient that the CCM service is available and gets written consent from the patient that his/her medical record can be communicated electronically.
- The provider also explains how a patient can revoke consent and that only one practitioner may bill for the service, and documents the conversation in the patient record.
- The patient signs an enrollment agreement that explains cost sharing, the service itself, and other elements.

Various providers can offer the service. All providers must be licensed in the state that the patient receives care. These providers include:

- Physicians
- Certified nurse midwives
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants

WHAT SERVICES COUNT TOWARDS THE CCM SERVICE

CMS has defined the scope of services that are eligible for the CCM service, and has clarified that it expects the full scope to be routinely furnished unless one of the services isn't needed to treat the patient's condition.

Most qualifying activities are related to creating and updating the patient's care plan and record, as well as care delivering tasks like managing a patient recently discharged from the hospital.

Care management has a broad definition, and includes assessing the patient's needs, creating a systematic way to encourage patients to come in for preventative visits, ensuring that medications are reconciled, and more. This aligns with CMS's approach to increasing support for care that occurs out of the office.

> *"We are committed to supporting primary care and we have increasingly recognized care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditures"*
>
> *-Final Rule 2015 Physician Fee Schedule with Comments*

There's solid evidence that efficient delivery of these services fulfill a significant clinical need. In fact, in one study following 150 patients admitted to Toronto General Hospital, 41.3% had a medication discrepancy at discharge. And 29.5% of those represented risks to the patients' health or comfort. Other studies have reported percentages as high as 90%.

A case-controlled study of patients enrolled in our service at Memorial Hospital System's clinics

reviewed the clinical impact of these services on multiple clinical indicators. The results? The 3,529 enrolled patients showed significant improvements compared to the broader Medicare population, and the number of hospital admissions and percentage of readmissions were both cut in half.

MEMORIAL HOSPITAL AT GULFPORT		
	CCM Patients	All Medicare
# of Patients	3529	approx. 12,000
# of Admissions	444	3080
%	**12.60%**	**25.70%**
# Re-Admissions	34	468
%	**7.66%**	**15.19%**

The scope of care management services captures the level of importance CMS places on these visits. They include:

- Assessing the patient's health, mental, and psychosocial needs
- Ensuring all patients receive recommended preventative services systematically
- Medication reconciliation
- Overseeing a patient's self-management of medications
- Managing a patient's transitions of care between providers and healthcare settings, such as a follow-up with a patient after a hospital discharge
- Creating and sharing a care plan based on a patient's comprehensive needs

Billing requirements

There are several restrictions to note on billing for CCM services. These restrictions primarily focus on:

- how many providers may bill for the service
- duplicative billing with other Medicare programs
- provisions relating to Skilled Nursing Facility (SNF) inpatients.

Only one practitioner can bill for any given patient once per patient per month for CCM services. There are also specialty restrictions; chiropractors, for example, may not bill for the service. At the same time, specialists who act as patients' primary care providers, such as cardiologists or pulmonologists, are uniquely positioned to take advantage of the service.

Next, providers can't bill for CCM services that overlap with other programs. For example, if a practice bills for CCM services, it's ineligible to bill for Transitional Care Management services (TCM) in the same period. CMS also does not allow practices participating in certain innovation models to bill for the service, including Comprehensive Primary Care Plus and the Multi-payer Advanced Primary Care Practice programs. To find out whether a model is excluded, practices should consult their model's CMS resources.

Finally, providers can't bill for services provided to SNF inpatients or hospital inpatients in Medicare Part A because the facility is being paid for extensive care planning and care coordination services. However, time the patient spends as an outpatient still counts. Ultimately, CPT 99490 can only be billed for patients who are not hospital or SNF inpatients, and who do not reside in the facility that receives payment from Medicare for that beneficiary.

Recent changes to CCM and commercial payers

In the Physician Fee Schedule for 2017, commenters noted that the billing requirements for CCM were burdensome, the amount reimbursed doesn't justify the cost of delivery, and many of the regulations around CCM were duplicative.

Further, based on its 2015 claims data, CMS discovered that CCM services may be underutilized. Only 275,000 patients were billed for the code. Additionally, many FQHCs and RHCs noted that they would like to hire third parties to deliver this service, but the direct supervision requirement unique to FQHCs and RHCs prevented them.

To address these concerns, CMS has proposed the following changes:

- The introduction of two new codes with additional revenue opportunity for more complex patients
- Requiring that CCM services be delivered through general supervision, rather than direct
- Simplifying the patient consent porocess

Two new codes to manage complex conditions

CMS is introducing two new codes and attaching work relative value to them. The new codes are meant to account for differences in the amount of time provided for managing different conditions, the complexity of medical decision-making under E/M guidelines, and the nature of the care planning that was performed.

The two new codes are 99487 and 99489. Code 99487 is for particularly complex patients, and has requirements similar to the standard CCM services. It allows practitioners to deliver 60 minutes of clinical staff time establishing or substantively revising a comprehensive care plan. The billing requirements are below:

1. Qualifying patients must have two or more chronic conditions that will last for at least 12 months or until death
2. The conditions place the patient at significant risk of death, acute exacerbation/de-compensation, or functional decline
3. Establishes or substantially revises a comprehensive care plan
4. Constitutes moderate or high complexity medical decision-making
5. Contains 60 minutes of clinical staff time directed by a physician or other qualified HCP

Code 99489 supplements 99487. It allows practices to bill for incremental time doing the same thing as they would for 99489. So, if a clinician thinks that more than sixty minutes is required, they are permitted to bill for additional time in thirty minute increments.

Reduced billing and regulatory requirements

CMS has also reduced the billing and regulatory requirements for billing and enrollment.

Now, physicians only need an initiating visit for patients they haven't seen in over a year, versus all patients receiving CCM services. CMS wants to give physicians with patients they've seen recently the ability to initiate CCM services without furnishing a potentially unnecessary E/M visit.

CMS has also removed the requirement that the care plan be available remotely because after-hours care is best implemented as part of a larger practice initiative. Practices now only need a way for patients to contact healthcare providers in the practice to address urgent needs, regardless of the day or time.

Next, one of the pre-existing requirements was that practices always electronically share care plan information within and outside the practice. That is still required, but not necessarily 24/7. CMS now allows transmission of care plan by fax, as well.

Additionally, practices don't need to use specific electronic technology to manage care transitions as a precondition of CCM. Instead, they only need to reply in a timely manner.

Another change simplifies patient consent. Practitioners must still receive consent, but now only need to document in the medical record that consent was given; uploading a consent form is no longer required.

Finally, significant changes to supervision requirements for RHCs/FQHCs are coming. FQHCs/RHCs have commented that the direct supervision requirement has prevented them from entering into third-party companies to provide CCM services. To give these organizations flexibility, CMS is allowing clinicians to operate under general supervision, rather than direct supervision.

GREENWAY CARE COORDINATION SERVICES: CCM SERVICES POWERED BY MD REVOLUTION

Healthy patients, healthy bottom lines

Increasingly, payers are reimbursing physicians based on patient outcomes instead of the number of services performed. Still, even when you advocate for your patients to lead healthier lives, how they manage their chronic conditions outside of the office largely remains out of your control.

That's where Greenway Care Coordination Services comes in. Through our Chronic Care Management (CCM) services, powered by MD Revolution, we enable your practice to take advantage of the CCM fee. Doing so can empower your patients to stay healthy while helping your practice transform into a value-based organization.

YOU *CAN'T* DO IT ALL ALONE

Moving toward value-based care is challenging and necessary in this era of reimbursement reform. Greenway Care Coordination Services can help you take that first step without burdening your staff with extra responsibilities. Taking on these activities also keeps your patients out of the hospital's revolving door.

- We coordinate and manage care for you: Clinical staff use a digital platform to interact with and provide care services to your patients.
- Clinical staff digitally counsel patients on nutrition, fitness, medication compliance, and more — all key drivers to improving the health of patients with chronic conditions.
- We provide thorough documentation from all care coordination encounters, so you can easily collect the CCM fee for each patient.
- The service is integrated with your EHR to ensure you can enroll as many patients as possible, eliminate disruption to your workflow, and enable seamless billing.

DRIVING REAL RESULTS

Our service is backed by a clinical rules engine that learns and adapts to patient behavior over time, ensuring that we're interacting with patients in the most effective way possible. This has led to proven clinical results, including lowering blood glucose levels in patients from 180+ down to 140, and lowering blood pressure from 145 down to 135.

FUNDING FUTURE INNOVATION AND TRANSFORMATION

Managing population health and committing to value-based care is a journey that requires time, money and the right people. And by taking this first step, you can earn the revenue you need to invest back into your practice to continue your practice's transformation.

Take that first step toward practice transformation and improved patient outcomes. To learn more about Greenway Care Coordination Services, call 866-242-3805.

Sources

Chronic Care Management Services MLN Summary

2015 Physician Fee Schedule

2016 Physician Fee Schedule

2017 Proposed Physician Fee Schedule

CCM Services FAQ

Jump-starting Chronic Care Management

Medication Reconciliation at Hospital Discharge: Evaluating Discrepancies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