Understanding Chronic Care Management

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Agenda

- Overview
- Billing requirements and eligibility
- CCM implementation
- Proposed regulatory changes

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Poll Question

Have you ever billed for the Chronic Care Management service before?

a) Yes, but we didn't get too many patients enroll

b) Yes, and we were fairly successful

c) No, but we're looking into it

d) No, and we're not interested in the near future

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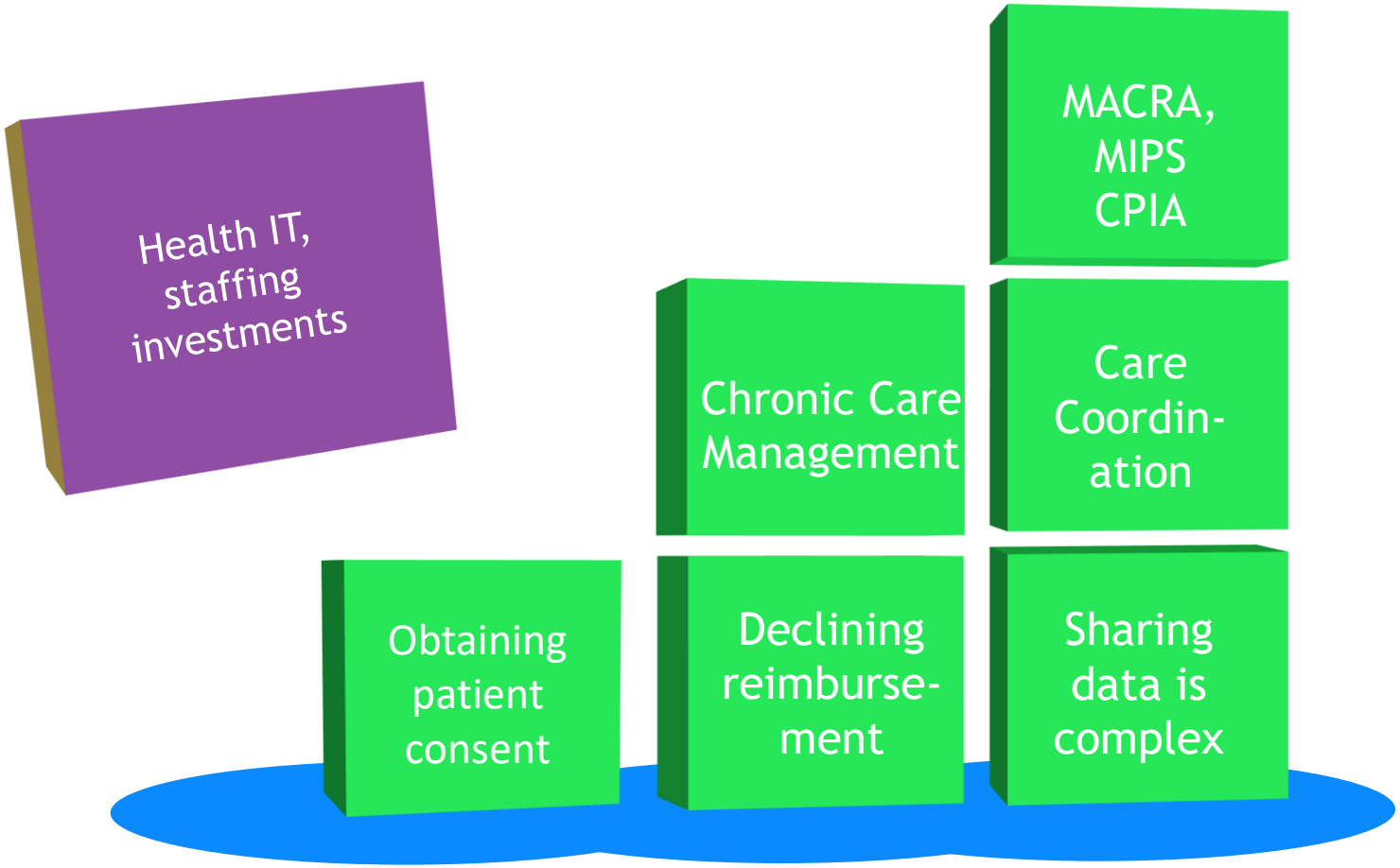
Overview

Taking the first step is hard



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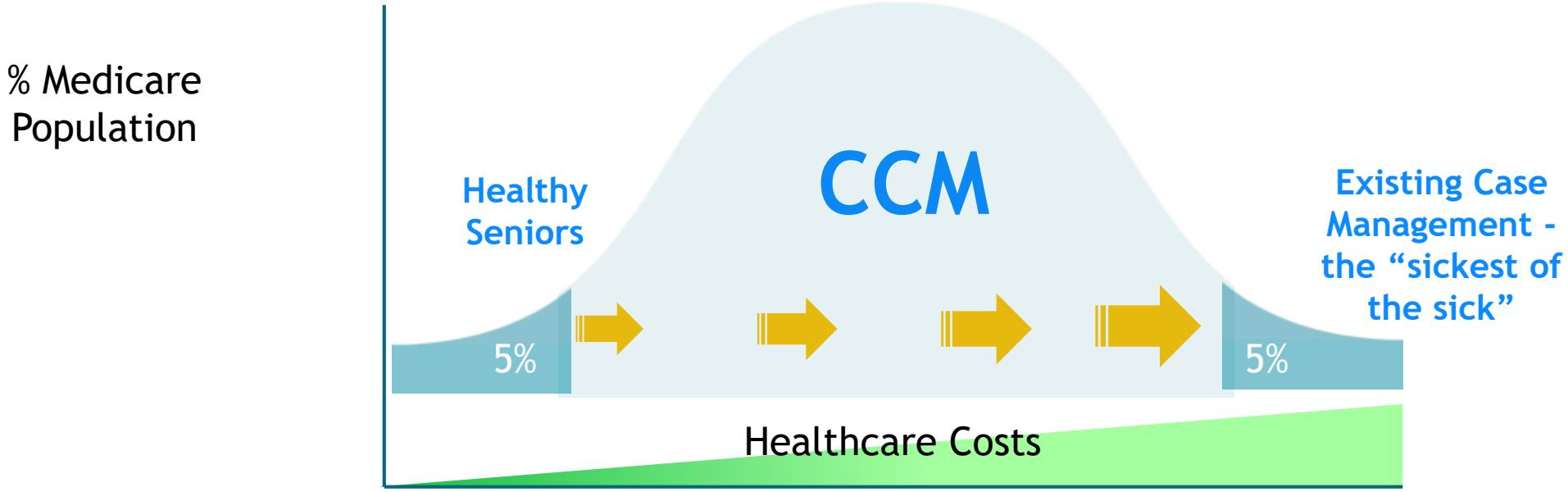
Where CCM fits in population health



Manage disease in ~70% of Medicare patients who are at moderate risk

Prevent the progression of chronic disease

Avoid unnecessary ED visits/hospital admissions

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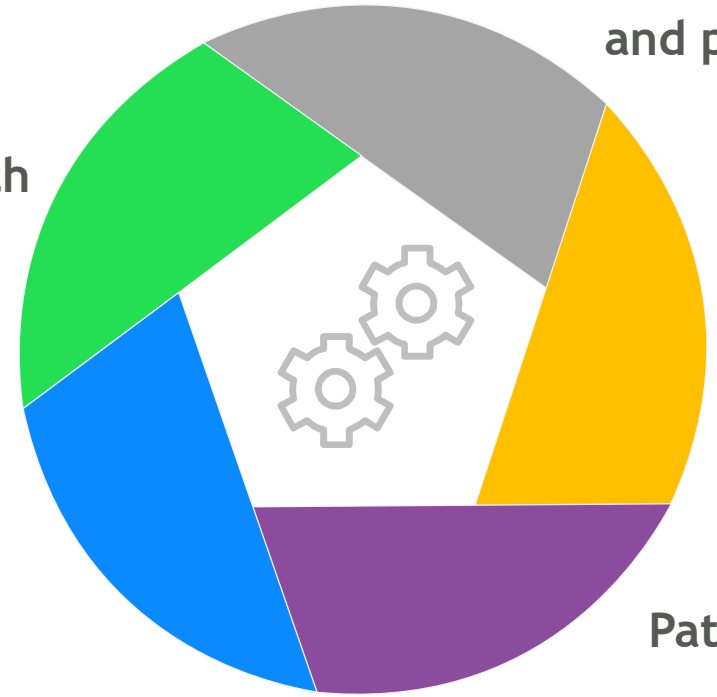
CCM benefits

Reallocate questions about self management and patient education

Reimbursable opportunity, $42 per qualifying patient per month



Expanded access to clinical services and health record

Improved population health, patient education, and outcomes

Patient satisfaction

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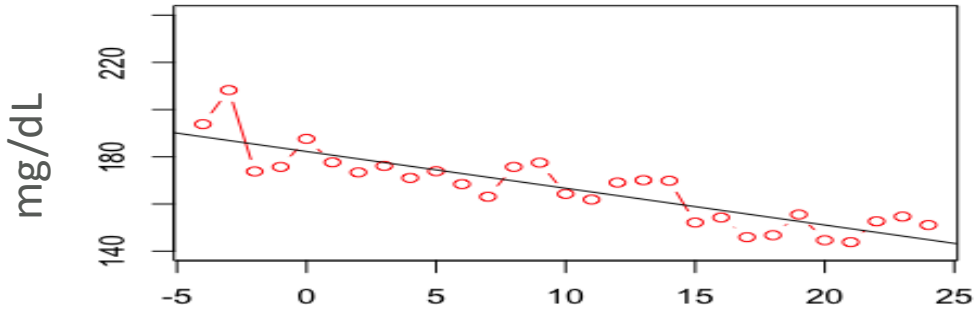
Trends over time

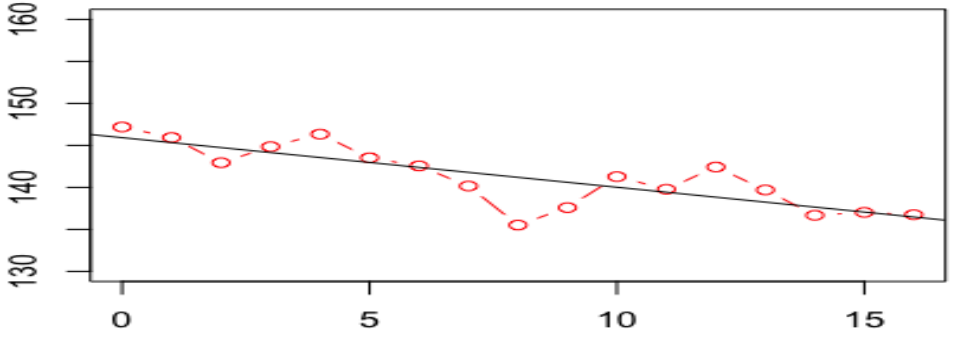
Blood Glucose

Baseline values ≥ 140 mg/dL



Systolic Blood Pressure

Baseline values ≥ 135 mm Hg



Number of weeks after activation

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Medicare unplanned re-admission rates

- Specific Readmission Measures: 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%**

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Billing requirements and patient eligibility

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CCM Requirements to Bill

- Multiple **(two or more)** chronic conditions
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored
  - Document its provision in the medical record.
- A practitioner must inform eligible patients of the availability of and obtain **consent** for the CCM service before furnishing or billing the service.

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CCM Requirements to Bill

- CMS requires the use of **certified EHR technology** to satisfy some of the CCM scope of service elements.
  - use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year
    - referred to as “CCM certified technology”.

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Access to Care

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. Do this through telephone, secure messaging, secure internet, or other non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA)
- Manage care transitions between and among health care providers and settings, including referrals to other providers, including: coordinate care with home and community based clinical service providers.

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Who's eligible?

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

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Who can bill for CCM?

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

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CCM Scope of Service

- Assessing the patient's health, mental, and psychosocial needs
- Ensuring all patients receive recommended preventative services systematically
- Medication reconciliation and overseeing a patient's self-management of medications
- Managing a patient's transitions of care between providers and healthcare settings

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Billing Restrictions

- One patient, one provider
- NO program overlap
- Skilled nursing facilities

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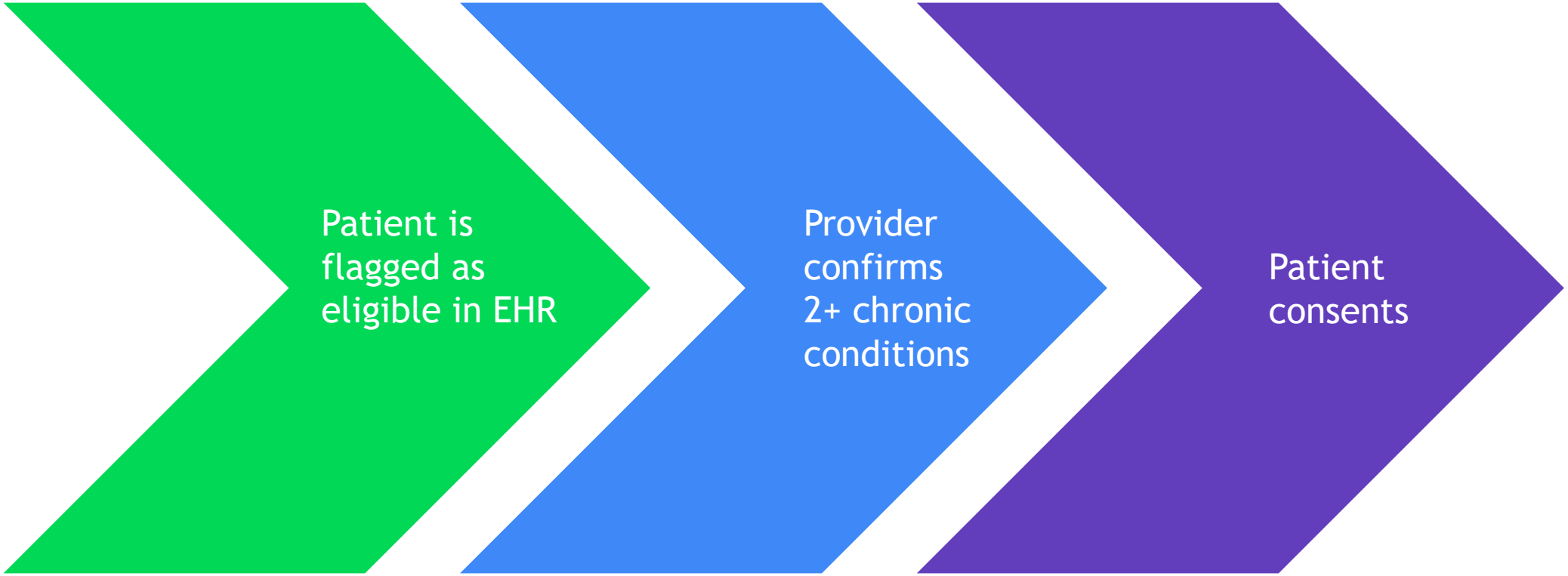
CCM Implementation

Sample enrollment workflow



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Ongoing program implementation

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Regulatory Changes

New codes: 99489 & 99487

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. Establishment or substantial revision of comprehensive care plan; and moderate or high complexity medical decision making
4. 60 minutes of clinical staff time directed by a physician or other qualified HCP

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More flexibility in Physician Schedule

Initiating visit only for patients not seen for over a year

Initiating visits

Care plan no longer required to be available remotely, only need a way for practices to contact HCPs 24/7

Care plan availability

More flexibility in sharing electronic care information outside the practice

Sharing information outside the practice

No need to use specific technology to manage care transitions, only need to respond in a timely manner

Managing transitions

Written consent no longer required

Patient consent

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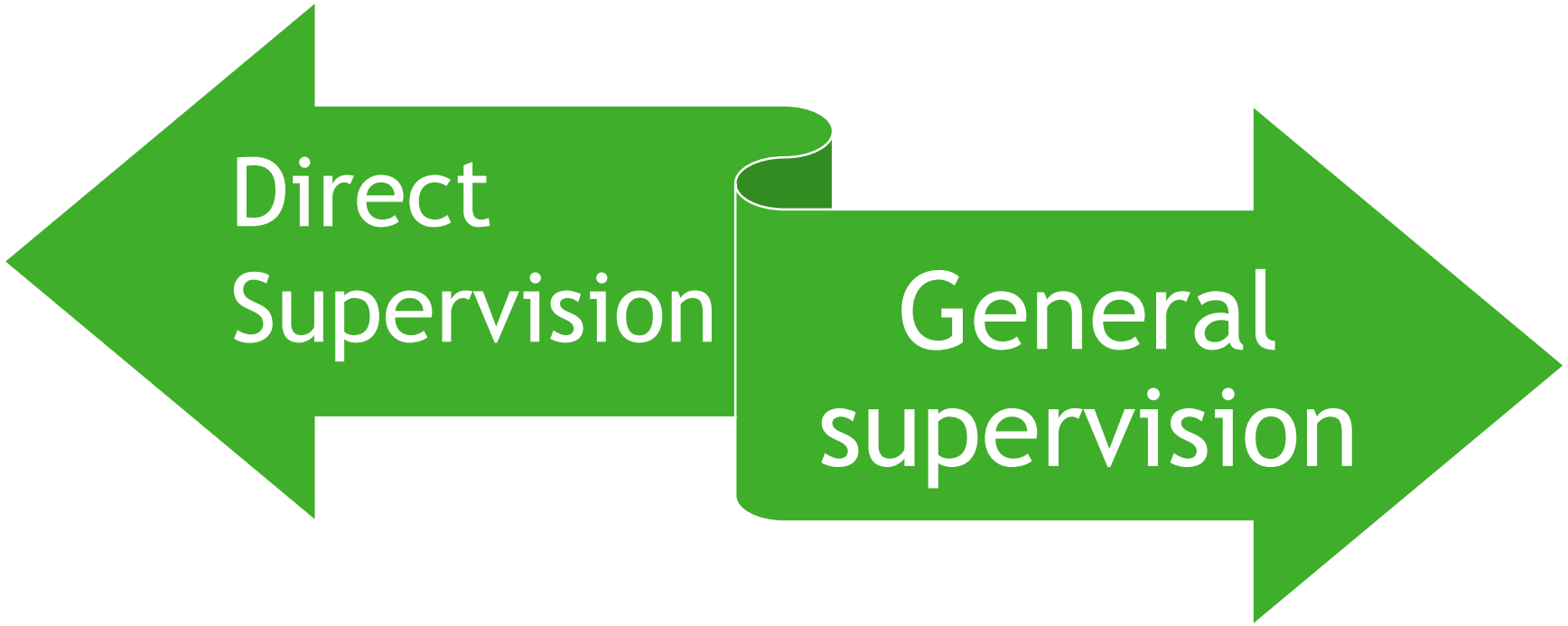
Supervision: FQHCs and RHCs



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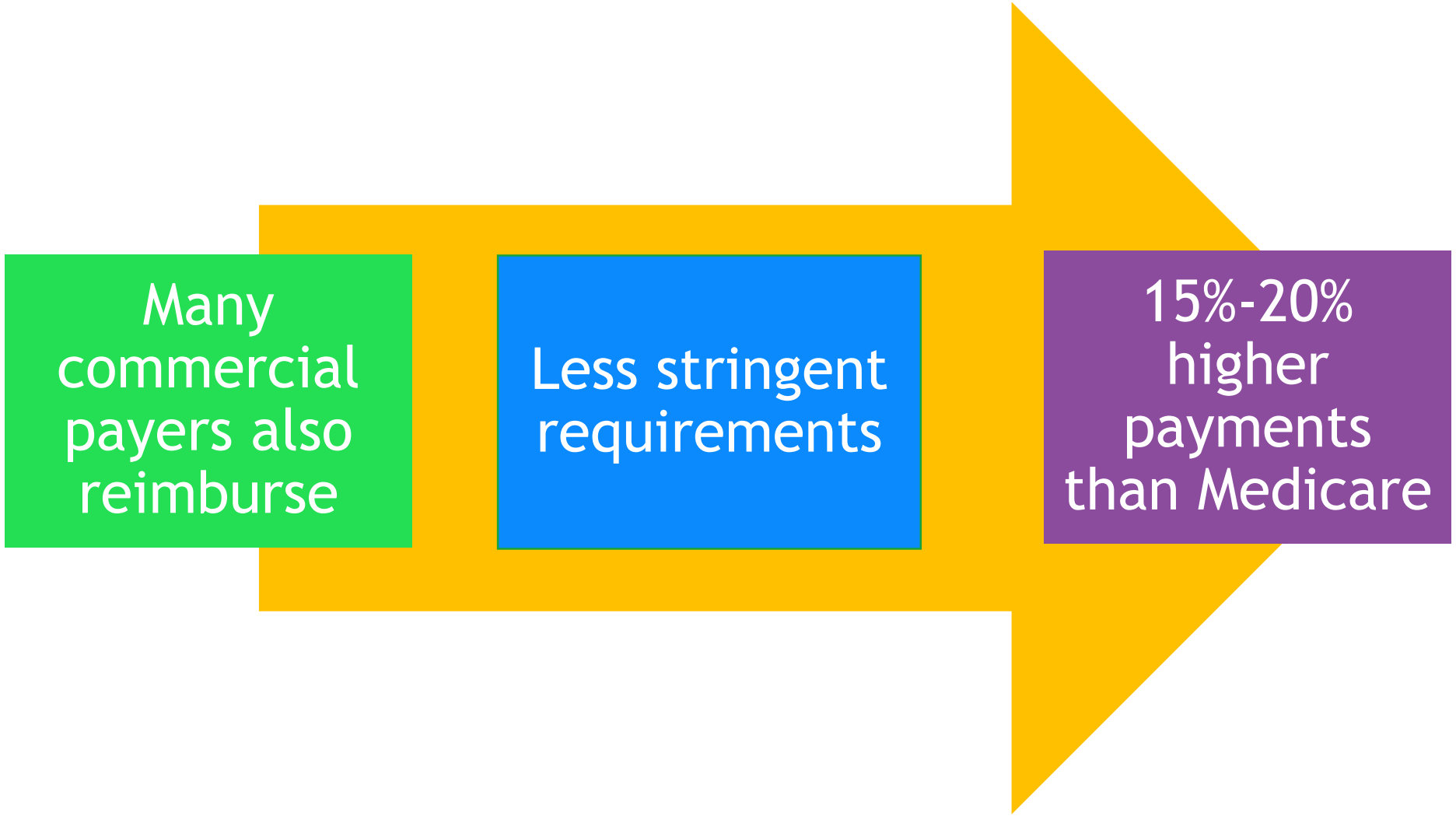
Commercial payers



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Succeeding in reimbursement reform

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Poll Question

Would you be interested in having a marketing development representative tell you more about CCM and Greenway's process?

a) Yes, I would like more information about the CCM fee

b) Yes, I would like more information about population health in general

c) Not at this time

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