CIVICHEALTH

Chronic Care Management Offers Challenges, Opportunities for Physicians

Treating people with chronic diseases accounts for 86% of our nation's healthcare costs

OVERVIEW

There is an epidemic in the United States that threatens our economy, our healthcare institutions and our citizens. It affects 25 percent of adults, and is especially pervasive among those over the age of 65, afflicting three out of four. Even children aren't safe — one in 15 suffer from the condition.[1]

This isn't an exotic disease or highly contagious virus — it's chronic conditions.

Chronic diseases are responsible for 7 of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation's healthcare costs.[2]

Chronic conditions last a year or more and require ongoing medical attention and/or limit daily activities. They may include physical conditions such as cancers, diabetes, cardiovascular diseases, asthma and arthritis. They also include mental and cognitive disorders such as depression, substance addiction and dementia.

These numbers are magnified for someone with multiple chronic conditions, called MCC. As an individual's number of chronic conditions increases, their ability to function on a daily basis diminishes. MCC contributes to frailty and disability and increases the risk of hospitalization and death.

Addressing the MCC Challenge

The cost of caring for MCC among Medicare beneficiaries is one of the key drivers for overall increases in Medicare spending. Approximately two-thirds of Medicare beneficiaries have two or more chronic conditions, and about one-third have four or more chronic conditions.[3]

According to the Congressional Budget Office (CBO), net Medicare spending grew from $446 billion in 2010 to $505 billion in 2014. The CBO projects it will climb to a whopping $866 billion by 2014.[4]

In order to address the rising costs of CCM, the Centers for Medicare & Medicaid Services (CMS) created a new code – 99490 – to reimburse physicians who coordinate care for Medicare beneficiaries with multiple chronic conditions. The code, which went into effect on January 1, 2015, offers healthcare providers an opportunity to be reimbursed for the time spent on chronic care management services.

While many physicians already provide these types of services, the new code encourages more care coordination from a primary physician – only one practitioner per patient can be reimbursed during a calendar month. One of the interesting caveats of the 99490 code is that it doesn't require in-person care; in fact, it specifically stipulates that the physician or other qualified healthcare professional spend at least 20 minutes per month on non-face-to-face care coordination.

These Medicare beneficiaries must fit these stipulations:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/ decompensation or functional decline
- Comprehensive care plan established, implemented, revised or monitored

Coordinated care can offer substantial benefits. In a Colorado study, healthcare providers that worked together to coordinate evidence-based hospital discharges saw a six percent drop in hospitalization and rehospitalization in just the first two years.[5]

The Benefit to Physicians

The "old days" when being a doctor equated with being rich are long gone. Primary care physicians have seen reimbursements shrink while they are forced to spend more time on documenting care with electronic health records (EHRs).

While the average Medicare reimbursement of around $42 per month per patient may seem like a pittance, when aggregated across multiple patients over the course of a year it becomes a more substantial income source, as shown in the following chart based on national data.

Potential Revenue per Provider

Description	Average
Annual number of unique patients[6]	3,279
% patients covered by Medicare[7]	21.85%
Annual number of unique Medicare patients	716
Medicare patients with 2+ chronic conditions[8]	68.6%
Annual number of unique CCM patients	491
CCM monthly payment	$42.60
Estimated gross revenue for family medicine physician	**$251,000**

The key to obtaining maximum benefit – while providing valuable services to your patient population – is using a technology solution that streamlines the care plan development, referral and tracking process required under the code.

Five Steps to Achieving Reimbursement

1. Care Provider Eligibility

According to CMS, physicians as well as the following non-physician practitioners are eligible to seek reimbursement under 99490:

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

CMS allows clinical staff to provide the CCM services incident to the services of the billing care provider under their general supervision rather than direct supervision. Non-clinical staff time is not applicable for this code.

2. Getting Started – Patient Agreement

Providers must first inform eligible patients of the CCM program and obtain their consent to participate prior to furnishing or billing the service. It is only necessary to obtain this patient consent once, at the inception of providing the CCM service.

According to CMS, these patient consent requirements include:

- Inform the patient of program availability and obtain written consent to participate, including authorization to electronically communicate medical information with other treating providers
- Document the explanation and offer of the CCM service in the patient's medical record and note the patient's decision to accept or decline the service
- Explain how to revoke the service
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month

3. Care Plan Development

The provider begins by creating a structured clinical summary that includes the patient's demographics, problems, medications and medication allergies. The next step is to create a patient-centered care plan that incorporates a wide range of elements, including physical, mental, cognitive, psychosocial, functional and environmental. It must also include a comprehensive plan of care for all health issues based on an inventory of resources to provide services.

This plan becomes the basis for care coordination not only with the patient – who should receive a written or electronic copy – but within the practice as well as with outside resources providing services. CMS stipulates that it must be available and shared electronically.

4. Access to Care

The goal of the CCM program is to increase care coordination across the care continuum with the goal of improving outcomes for this medically fragile population. To ensure appropriate care is delivered in the appropriate environment, providers are required to provide 24/7 access to care management services. Patients must be able to contact a healthcare practitioner within the practice who has access to the patient's electronic care plan in order to address urgent chronic care needs.

To foster a relationship between the patient and care provider and ensure continuity of care, the patient must be able to get successive routine appointments with a designated member of the care team. Enhanced opportunities for patient and other caregivers to communicate with the practitioner about the patient's care via telephone, secure messaging, secure Internet or other non-face-to-face methods (in compliance with HIPAA) is the final component of care access.

5. Care Management

Once this platform is established, care providers need only spend a minimum of 20 minutes per month on non-face-to-face care management. This might include:

- Monitor beneficiary's condition
- Ensure beneficiary receipt of preventive care services
- Medication reconciliation
- Oversight of beneficiary self-management of medications

Care transitions are notably perilous times for medically complex patients, requiring coordination and collaboration between multiple providers. Program participants are charged with managing these transitions, including referrals to other providers. Providing follow-up after an emergency department visit or post-discharge from hospitals, skilled nursing homes or other healthcare facilities can help prevent readmissions and ensure care continuity.

Leveraging Technology

Some physicians feel the documentation and reporting required for reimbursement under 99490 is too onerous. Many are trying to cobble together care plan development and care management using existing technology. While a certified EHR is required for reimbursement, adjunct technology can streamline the fulfillment of primary program mandates.

Groups that are using an Excel spreadsheet to track their team members' time are unproductive and making it difficult, if not impossible, to properly document time and prevent miscounting errors for an audit. A platform that specifically supports CCM streamlines the process of executing and documenting the provisions stipulated to receive reimbursement.

EHRs were designed to support clinical care, and most make it difficult to achieve interoperability and the effective electronic exchange of information. These care management systems often don't support collaborative referrals and provide no simple, productive and electronic connection with community resources.

A Proven, Comprehensive Solution

CivicHealth has over a decade of experience in innovative solutions to help healthcare providers address the management of chronic care patients. The CivicHealth CCM technology supports every step of care management, including care plan development, coordination with community services, interoperability, referrals, patient engagement and compliance.

Requirement	CivicHealth's Solution
Care Plan	
Create a care plan	Guides you through each step of creating a comprehensive care plan that is required for each patient
Share with others	Share electronically across the care continuum
Share with patient	Create patient portal with access to care plan
Monitor progress	Track compliance with the care plan and the patient's progress
Collaborate	Allow anyone on the care team to view, update and edit
Provision of Services	
Patient tracking	Evaluate each patient against expected outcome and prognosis
Proof of services	Document provision of monthly non-face-to-face services
Referrals	Make closed-loop referrals and track patient progress
Documentation	Easily document and report on all CMS-required patient communications
Data integration	Pull data from your EHR to eliminate duplicate keying and can have single sign on with the EHR to provide easy and quick access by the physician
Interoperability	Securely share electronic documents on a HIPAA-compliant platform
Outside resources	Connect with community and human service agencies
Medications	Provide for medication management
Coordination	Facilitate smooth transitions of care
Prevention	Ensure beneficiary receives preventive care services
Messaging	Support HIPAA-compliant messaging for internal stakeholders

CivicHealth's CCM solution is not only well proven, but it is also easy to install, intuitive to use and affordable, allowing patients to benefit from a coordinated approach to chronic care management, and more physicians to receive reimbursement for providing these critical services.

[1]Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Woods Johnson Foundation, 2010.

[2]Centers for Disease Control and Prevention, http://www.cdc.gov/chronicdisease/index.htm.

[3]Department of Health and Human Services, Centers for Medicare and Medicaid Services, Chronic Care Management, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

[4]The Henry J Kaiser Family Foundation, Facts on Medicare Spending and Financing, kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/.

[5]http://www.techadvisory.org/2013/01/the-benefits-of-coordinated-care/.

[6]MGMA Cost Survey for Single Specialty Practices: 2013 Report Based on 2012 Data specific to the specialty of family medicine. Includes Medicare A/B and Medicare Advantage.

[7]CMS.gov - County Level Multiple Chronic Conditions (MCC) Table: 2012 Prevalence, National Average.

[8]Chronic Conditions among Medicare Beneficiaries, Chart Book, Baltimore, MD: Centers for Medicare & Medicaid Services, 2011.