McKESSON

White Paper

Chronic Care Management Offers Enhanced Quality Care and Additional Revenue

Opportunities to Improve Care for Medicare Patients with Chronic Conditions

A historic transformation is underway in healthcare as value-based reimbursement (VBR) gradually supersedes the fragmented and costly fee-for-service care model long employed in the United States.

Both government and commercial programs are demonstrating that VBR's quality-driven approach can reduce costs, improve outcomes and enhance patient satisfaction. New incentives for preventive care, early intervention and care continuity are permanently altering the way medicine is practiced and paid for.

Now policymakers have begun applying the lessons learned from value-based purchasing to the sprawling and costly arena of chronic illness. In January 2015, the Centers for Medicare & Medicaid Services (CMS) began reimbursing clinicians for providing non-face-to-face care coordination services to Medicare's sickest beneficiaries.

The new reimbursement code reflects an acknowledgment by CMS that compensation for the chronic care management (CCM) duties central to new delivery models like accountable care are not included in traditional fee-for-service payments. At the same time, the move marks a critical first step in the long journey toward restructuring the most expensive and arguably the most disjointed segment of healthcare.

A path forward

Better management of chronic illness can improve patient quality of life; reduce complications, emergency room visits and hospitalizations; and strengthen patient engagement. For some clinicians, the new chronic care code creates an opportunity to generate revenue for services already being performed. With a reimbursement rate of approximately $40 per enrollee per month, the new code could produce an additional $100,000 annually for a physician practice caring for 200 qualified patients.[1]

Equally important from a business perspective, CCM offers a low-risk opportunity for practices to prepare for the future. Gaining experience and proficiency with population management and value-based reimbursement will become essential as Medicare shifts an ever-greater portion of its payments to these emerging methodologies.

In early 2015, CMS announced that it had established a goal of converting at least 50% of Medicare payments to VBR models by 2018.[2] And because commercial payers nearly always follow Medicare's lead, it seems likely that VBR will become far more prevalent among private insurers in the years ahead.

"Embracing chronic care management is the right thing to do because it can improve quality of care and patient quality of life, and it can also help rein in the enormous cost of chronic illness," said Jeb Dunkelberger, executive director of accountable care services and corporate partnerships for McKesson Business Performance Services (McKesson).

"But CCM also represents a way for providers to get paid for learning about value-based reimbursement and population management. This opportunity to gain confidence and competence with VBR is the real value proposition of the new CCM code. Those who become familiar with VBR in a low-risk environment will be able to adapt more quickly as the system continues to evolve."

Physicians who pursue Medicare CCM reimbursement must decide whether to rely on internal staff to execute the many clinical support duties associated with the code or turn these over to a qualified outsource vendor. Each approach has benefits. However, the decision may ultimately depend on whether the practice has the internal capability to perform the code's reimbursement requirements consistently.

The burden of chronic illness

Chronic diseases – defined as long-lasting conditions that can be controlled but not cured – cast an enormous shadow across the U.S. health system. About half of all adults, or 117 million people, had one or more chronic health condition in 2012, and about 25% had two or more chronic conditions, according to the Centers for Disease Control and Prevention (CDC).[3]

Among Medicare beneficiaries, 68% have two or more chronic conditions and 36% have four or more chronic conditions.[4]

Seven of the top ten causes of death in 2010 were chronic diseases, according to the CDC, while two of these – heart disease and cancer – together accounted for nearly half of all deaths.[5] Almost 50% of adults have diabetes or pre-diabetes, and approximately 71,000 die annually from complications associated with the illness.[6] All told, chronic disease is responsible for about 1.7 million deaths each year in the U.S.[7]

The costs associated with treating chronic illness are staggering. In 2010, 86% of all healthcare expenditures involved treatment for people with one or more chronic medical conditions[8] And in 2012, just 1% of the population accounted for 22.7% of healthcare spending of $1.35 trillion, while 5% accounted for 50% of total spending.[9]

Within the Medicare program, beneficiaries with multiple chronic conditions accounted for 93% of spending and 98% of all hospital readmissions.[10]

CMS broadly identifies chronic diseases as including, but not limited to: Alzheimer's disease, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, chronic obstructive pulmonary disease, depression, diabetes, heart failure, hypertension, ischemic heart disease and osteoporosis.[11]

The most common chronic conditions among Medicare beneficiaries in 2010 were:[12]

- High blood pressure (58%)
- High cholesterol (45%)
- Heart disease (31%)
- Arthritis (29%)
- Diabetes (28%)

Unless chronic diseases are managed more effectively, the future implications regarding morbidity, mortality, workplace productivity and healthcare costs are grim, according to a recent report by the Rand Corporation.

One estimate projects that the number of Americans with one or more chronic conditions will reach 171 million by 2030, while the number of people with diabetes will double to 42 million by 2034.[13] The cost of diabetes treatment alone is expected to triple to $336 billion, the Rand study notes.

Similarly, the American Heart Association has estimated that by 2030, 40% of the U.S. population will have some form of cardiovascular disease, with the related healthcare cost tripling from the current level of $273 billion to $818 billion, the study states.[14]

Partnering with the patient

The idea of improving chronic disease outcomes and controlling costs through proactive interventions and more effective patient engagement first emerged from case management and managed care. In recent years, numerous commercial vendors and health plans have initiated a range of disease management protocols and services. CMS also has conducted a series of disease management and care coordination demonstration projects.

The best disease management programs represent partnerships between providers and patients that are grounded in evidence-based care and focused on prevention and early intervention. Because patient involvement is critical to success, identifying strategies to help ensure ongoing communication and sustained patient engagement are essential.

A recent survey by the Healthcare Intelligence Network of 119 provider organizations found that 75% believed CCM programs have improved self-management levels in enrolled patients, and almost half – 46% – indicated that CCM has decreased hospitalizations in the populations served by the programs. Significantly, 92% of those queried said they expected the new CMS CCM code will influence private payer reimbursement in the future.[15]

Medicare's CCM Payment Program – Reimbursement Requirements

The new code, known as CPT 99490, was launched on Jan. 1, 2015, and marks Medicare's first Physician Fee Schedule payment for non-face-to-face care coordination and management services. Among the program's key requirements:[16]

- **Practitioner Eligibility**
  Clinical participants can include primary care physicians, as well as specialists, nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives.

- **Patient Eligibility**
  Participating patients must have:
  - Multiple (two or more) chronic conditions that are 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.

- **Patient Agreement Requirements**
  A practitioner must inform eligible patients of the availability of the CCM services and obtain consent before furnishing or billing for the service. Consent requirements include:
  - Obtaining a written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
  - Documenting the discussion about CCM in the patient's medical record and noting the patient's decision to accept or decline the service.
  - Informing the patient that only one practitioner can furnish and be paid for the service during a calendar month.
  - Explaining how the service works, how information will be shared, and what co-insurance and/or deductibles the patient will be required to pay.
  - Explaining how to revoke the service.

- **Practitioner Scope of Service Elements – Highlights**
  - Conduct a systematic assessment of the patient's medical, functional and psychosocial needs, including an annual wellness visit.
  - Record the patient's demographics, problems, medications and medication allergies in a structured clinical summary record using certified EHR technology.
  - Create a comprehensive, patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental assessment and inventory of resources.

- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.
- Ensure 24-hour-a-day, seven-day-a-week access to care management services.
- Provide patients with at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional per calendar month.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner via telephone, secure messaging, secure Internet or other asynchronous non-face-to-face consultation methods.
- Conduct a medication reconciliation to review adherence and potential interactions as well as oversight of patient self-management of medications.
- Manage care transitions between and among providers and settings.
- Conduct follow-ups to emergency department visits, hospital discharges, skilled nursing facility discharges and other healthcare facility encounters.

In-house or outsource?

Like most CMS policies, the new CCM requirements reflect policymakers' best efforts to balance larger policy aims with realistic compliance expectations. Yet even the most well-intentioned rules don't necessarily take into account the resource constraints many providers face in today's healthcare environment.

"It's no secret that bandwidth is an enormous challenge for everyone," said McKesson's Dunkelberger. "Between fulfilling the requirements of CMS programs like meaningful use and the Physician Quality Reporting System and meeting the day-to-day obligations of clinical documentation, coding and revenue cycle management, most physician groups already are at capacity when it comes to juggling regulatory and administrative responsibilities."

Practices that elect to seek reimbursement for the CCM 99490 code therefore need to think carefully about resource allocation and how best to accomplish the range of duties associated with managing eligible populations. Hiring new staff is an option, assuming the projected patient revenue will support additional payroll expense.

However, one risk associated with boosting staff is that CMS could at some point sunset, terminate or otherwise fundamentally overhaul the CCM program. While this seems unlikely given the agency's commitment to value-based purchasing, the fact remains that CMS has made unexpected decisions in the past that have had substantial negative consequences for provider organizations.

Talk time

Perhaps the most significant time demand providers face in billing for 99490 is the program's centerpiece: The 20-minute minimum per patient per month console. This communication is non-face-to-face and can be accomplished via telephone, Internet or other telemedicine contrivance.

While the requirement is straightforward enough, time obligations can quickly add up for groups with large numbers of enrollees. A practice consulting with 200 patients on a monthly basis would require over 60 hours of staff time, or more than three hours a day. And that estimate assumes none of the consults would extend beyond 20 minutes, a notion most clinicians would probably dismiss as unrealistic.

However, groups may prefer to retain CCM responsibilities internally to better accommodate the not-insignificant information technology demands associated with code compliance. Because clinical data must be made available to both providers and patients, and because staff is presumably adept at operating their electronic health record (EHR) efficiently, this consideration is a valid one.

The case for outsourcing

The decision about whether to support CCM in-house ultimately turns on two questions: Would it be profitable to do so, and if the in-house option is pursued, can the practice be assured that all compliance requirements will be consistently and appropriately met? If the answer to either question is unclear, practices should give serious thought to outsourcing their CCM program.

Outsourcing through a qualified vendor can alleviate the majority of time demands the program imposes on practitioners. This does not mean, of course, that the physician or authorized provider is relieved of all obligations. They remain responsible for enrolling patients in the program and, in so doing, must convince the patient that a modest, annual co-pay is money well-spent. They also conduct the participating beneficiaries' initial screenings.

"Essentially, the practitioner is the quarterback and they must act if the situation demands it," Dunkelberger said. "They can't just see this as another administrative headache, or the outsource provider as just another vendor."

What an outsourcing vendor can do is provide assistance with most of the intermediate and ongoing steps required to satisfy CCM's requirements. Significantly, this includes the 20 minute per patient per month consults via telephone. Options vary, but a qualified vendor should be able to offer a full spectrum of services, some of which must be conducted or provided by a trained clinician. Vendor services can include:

- Conducting claims queries to identify potential CCM patient candidates.
- Providing patient directed literature explaining the program's requirements and benefits.
- Providing oversight of beneficiary self-management of medications.
- Electronically sharing the patient care plan as appropriate with other practitioners and providers.
- Providing the beneficiary with a written or electronic copy of the care plan and document its provision in the EHR.
- Facilitating referrals to other providers.
- Coordinating with home and community-based service providers.
- Ensuring timely receipt of all recommended care services.

Services provided via a licensed practical nurse (LPN) or similarly qualified clinician should include:

- Performing initial CCM assessment.
- Performing medication reconciliation with review of adherence and potential interactions.
- Initiating a care plan based on initial assessment and priorities established by the participating clinician.
- Updating care plans monthly or when a change in status is noted.
- Providing immediate outreach and ongoing communication with the provider in the event of a hospitalization to determine and recommend appropriate length of stay and post-discharge needs.
- Follow-up after ER visit, hospital discharge, skilled nursing discharge or discharge from other inpatient facility.

> "The CCM code is not an end-point but merely a way station on the journey toward a more rational, efficient and effective healthcare system." – Dunkelberger

A bridge to the future

It is important to note that CMS' requirements for managed chronic conditions are similar to the obligations associated with the Patient-Centered Medical Home (PCMH), an expanding alternative delivery approach that is designed to provide more efficient, accessible and coordinated care.[17] The difference is that the CCM reimbursement does not require that providers undergo the sometimes costly and time-consuming process of being formally recognized as a PCMH.[18] Moreover, the approximately $40 monthly CCM payment is substantially more than most PCMH initiatives offer, according to a recent article in the New England Journal of Medicine.

The article goes on to call the CCM code "the most important broadly applicable change" made in Medicare primary care payments to date and a "critical first step forward" in recognizing that the desired features of primary care – continuity, whole-person focus, comprehensiveness, serving as the patients' first contact for new health issues, and coordination – are not effectively supported by the fee-for-service model.[19]

By creating a bridge between fee-for-service and value-based reimbursement, CCM offers a low-risk entry point for both primary care physicians and select specialists to engage in alternative delivery and payment. This opportunity should encourage traditional practices to adopt more advanced primary care functions and, at the same time, provide critical reimbursement support to those who have invested in PCMH infrastructure but are struggling to maintain it.[20]

Most importantly, physicians who engage with CCM today will be better prepared to succeed as the health system continues to evolve.

"The CCM code is not an end-point but merely a way station on the journey toward a more rational, efficient and effective healthcare system," said Dunkelberger. "In the years ahead, as new features, requirements and incentives are added to the chronic care code and value-based reimbursement generally, those that are already participating will have a major competitive advantage over those that are not."

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McKesson Business
Performance Services

McKesson
5995 Windward Parkway
Alpharetta, GA 30005

ccmservices@mckesson.com
800.877.0171

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