MediCCM
Software Solution
to Chronic Care Management

How to Add Value to Value-Based Care

Chronic Care Management:

How Evidence Based
Patient Education Paves the way for
Physician Partnerships by facilitating
MACRA, Telehealth and Pre-Visit Planning

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How to add Value to Value-Based-Care

Chronic Care Management : How Evidence-based patient education paves the way for Physician Partnerships by facilitating ; MACRA , TeleHealth and Pre-Visit Planning

Basic and Complex Chronic Care Management

"The Centers for Medicare and Medicaid services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals." *Medicare Learning Network Jan 1, 2016* CCM was first implemented as a separately paid service in Jan 2015, and in Jan 2017 a new update initiated the addition of Complex CCM, designed to support patients who have higher acuity chronic conditions or transitions in care necessitating more patient/caregiver education or closer monitoring .

- Chronic Care Management (basic 99490) 20 min documented
- Chronic Care Management (complex 99487) 60 min documented
- Chronic Care Management (add on to complex-99489) 1 code per 30 min additional

CMS recognizes the value of Chronic Care Management including the Care coordination, Comprehensive assessment, Monitoring, patient education, caregiver support, transitional management and shared goal setting. They recognize that patients with more that one chronic illness are at high risk especially during transitions in care and exacerbations of illnesses. They encourage primary care providers to utilize these services because they have been shown to: encourage patients to learn self-management of their conditions, solve problems at the primary care level before they escalate to ER visits or hospitalizations, and teach family members and caregivers how to help; saving time, money and significantly impacting quality patient health outcomes.

A review of care coordination studies showed the following positive outcomes:

- 25% reduction in hospitalizations (Health quality partners, participant in Medicare Coordinated Care Demonstration)
- 28% reduction in ER visits (Health Quality partners)
- 36% reduction in readmissions (University of Pennsyvania)
- 26% fewer skilled nursing facility days (Johns Hopkins University)
- 29% decrease in home health episodes (Johns Hopkins University)

http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/care-high-need-high-cost-patients

Supporting MIPS Points in CCM: do you want to lose 4% of Medicare Reimbursement or Gain 12%?

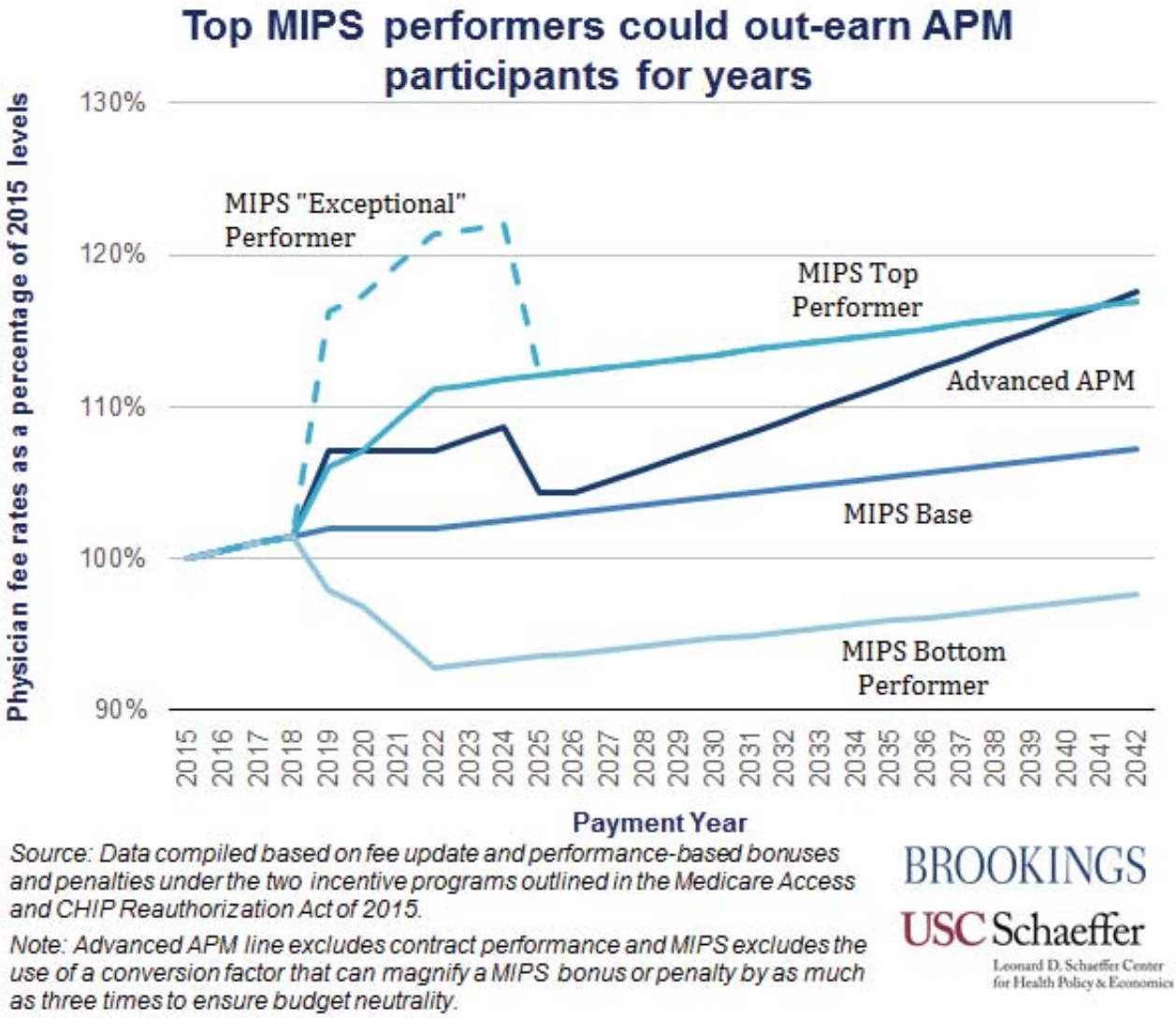
Chronic Care Management can be designed to meet MIPS criteria and to add "points" . Starting in Jan 2018, physicians need to be reporting MIPS "points". By 2019 If they don't' report clinical improvement activities and quality measures they may have up to 4% Medicare funds taken away from their baseline, and if measures are chosen and regularly reported on they have the potential to gain 12% above the baseline. If CCM is used in conjunction with evidence based care-plans based on chronic illness, goals, interventions, and outcomes, there is a potential to meet all of the reportable clinical improvement activities and several of the quality measures. This is accomplished within the clinician's flow of work

As a partner in CCM you have the potential to bring value in the overall Medicare physician reimbursement via MIPS reporting, in addition to the CCM reimbursement codes.

Patients with chronic illness' will be going in and out of complex CCM with exacerbation of conditions, the goal is to monitor and manage in the patients current setting and try to stabilize conditions with whatever community support mechanisms needed. CCM clinicians can work with the provider to coordinate care, and support caregivers to keep the patient as stable as possible. CCM clinicians can follow the patient though hospitalization, SNF, home care episode and in-home with supportive caregivers, bridging the transitions which have been shown to be the weakest link in patient care.

Beyond these basic services additional support codes have been added all of which, if managed correctly, can benefit MACRA - MIPS points for "back end" reimbursement.

Value added with MIPS Tracking



Source: Data compiled based on fee update and performance-based bonuses and penalties under the two incentive programs outlined in the Medicare Access and CHIP Reauthorization Act of 2015.

Note: Advanced APM line excludes contract performance and MIPS excludes the use of a conversion factor that can magnify a MIPS bonus or penalty by as much as three times to ensure budget neutrality.

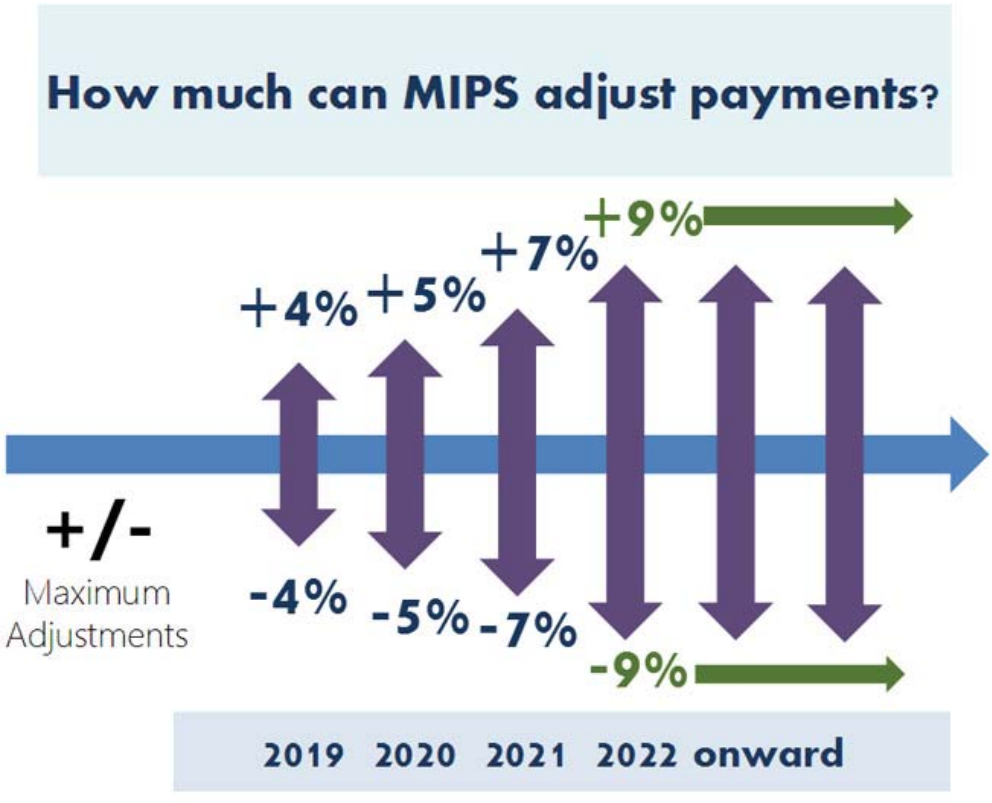
BROOKINGS
USC Schaeffer
Leonard D. Schaeffer Center for Health Policy & Economics

https://www.brookings.edu/research/how-the-money-flows-under-macra/

MACRA ready content support MIPS points

MACRA Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)is the new Medicare payment system with incentives for value based care. MACRA will have a dramatic impact on the way that Medicare will be paying physicians in the future, yet many are not yet familiar with it. MIPS (merit based incentive payment system) is a division of MACRA that sets "point" criteria for value based reimbursement. Chronic Care Management is an opportunity to try value based care, and to build MIPS points in activity improvements and quality measures, and advancing care information, as well as preparing providers for more MACRA value-based care to be introduced in the future. CCM can be managed directly by the primary care provider or managed by "incident to" delegation within the provider office or contracted with partner clinicians.

Patient educational MACRA ready content not only helps the patient/caregiver dyad in managing symptoms and maximizing function with chronic illnesses, but also allows Physicians and support staff to track their MIPS points. It also helps clinicians to categorize and document changes in acuity to accurately bill for complex CCM . and to be MACRA ready to report on clinical improvement activities and quality measures tracked in CCM.



(Graphic from the Centers for Medicare & Medicaid Services.)

Pre-visit Planning supports CPT G0505, G0506 and more

Pre-visit planning is a way to support providers with standardized tools completed with patient and clinician, and to prepare the patients with data to present and questions to ask at their provider visits. A CCM program with evidence-based content and standardized tools has the potential to create templates to prepare for:

- Annual wellness visits
- Cognitive impairment assessment (G0505)
- Comprehensive assessment and care planning (G0506)
- Health risk assessment patient-focused (96160)
- Health risk assessment caregiver-focused (96161)
- Population management – review and schedule Health Maintenance
- Primary care focused visits
- Specialist visits

Not only can CCM clinicians partner with providers by preparing valuable pre-visit planning, they can also follow up to teach and support the patient and caregiver after the visit reinforcing valuable information. Pre-visit planning saves time for the provider by preparing patient data to be used to complete the evaluation, the provider then uses the examination and medical decision making to complete the service. The patient has a list to address concerns and questions prepared ahead so that patient and provider make the best use of their time together.

Annual Wellness visit

The annual wellness visits, both initial and subsequent, are started with a questionnaire and several screening tools that can be pre-populated with a non-face-to-face assessment and evaluation. If these standardized tools are included in the CCM program the pre-visit planning can be a seamless transition for the provider review and complete the evaluation and patient plan.

Medicare Billing Codes

"If your practice doesn't provide chronic care management (CCM) services, consider the cost-benefit opportunity of increasing revenue to support needed practice transformation or quality improvement projects. Medicare began paying for CCM codes on January 1, 2015."

-AAFP

CPT 99490*	Chronic Care Management Services: Non face to face clinical staff time	$42.60
CPT 99091*	Telehealth: Collection and interpretation of physiological findings	$59.92
CPT 99487*	Complex Chronic Care Management Services	$94.00
CPT 99489*	Complex Chronic Care Management: Additional clinical time	$47.00
CPT 96160	Patient-focused health risk assessment: health hazard appraisal	$4.67
CPT 96161	Caregiver-focused health risk assessment: depression inventory	$4.67
G0505	Cognitive Impairment Assessment	$238.30
G0506	Comprehensive Assessment and Care Planning	$ 63.68

* denotes CPT codes that can be used once per month

Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Cognitive Impairment Assessment

Patients who qualify for this code G0505 include those who have been diagnosed with Alzheimer's, other dementias, or mild cognitive impairment. It also includes those without a clinical diagnosis, who, in the clinician's opinion is cognitively impaired. This covers a large cross-section of patients who are currently enrolled in Chronic Care Management. This G-code is anticipated to become a permanent CPT code in 2018. Although this is considered to be a face-to-face visit code, there are substantial Pre-visit planning assessments and standardized tools that can be prepared prior to the visit, creating a great partner benefit to the PCP. These pre-visit assessments can substantially save time for the PCP they include:

- Dementia staging-using standardized instruments
- Medication reconciliation and review for high risk medication
- Depression assessment – using standardized instruments
- Identification and documentation of Caregivers, including their abilities, social supports, and willingness for caregiver to take on caregiving tasks
- Referrals to Community resources-

CCM clinicians partner with physicians by providing valuable pre-visit planning, saving time and giving data to the provider as they complete the evaluation and examination and use medical decision making to complete the service. The CCM clinicians can also follow up to teach and support the caregiver of a cognitively impaired patient, as dyad support (patient and caregiver together) is supported with CCM.

Telehealth Remote Monitoring and Management (99091)

Telehealth 99091 has been instituted as an independent charge for physicians to bill beginning Jan 2018. CCM of has been trialed in the past few years and found to be one of the most effective and cost-effective methods of improving patient outcomes in a home or facility setting. It follows the same requirements as Chronic Care Management (CCM) and can be managed and billed concurrently. In other words, basic CCM 99040 (20 min of non-face-to-face time) or Complex CCM 99487 (60 min of non-face-to-face time) along with additional blocks of 30 min increments can be bundled as needed 99489; along with telehealth 99091 for 30 minutes of remote monitoring. Remote monitoring is considered to be 30 minutes of time spent in accessing, reviewing and/or interpreting data. This 30 minutes of time also includes subsequent modifications to the care plan based on accessed data, communication with the patient/caregiver and any associated documentation.

Tele-health can be instituted in many ways: a full telehealth monitoring unit that transmits data together to CCM software; a group of independent "wearable items" that transmit data to their App and are subsequently imported to the physician accessible CCM software; and a patient portal/app that allows patients and or caregivers to manually load data i.e.: blood pressure, blood sugar, heart rate, "activity steps", SpO2, weight.

This new code to be used in conjunction with CCM is a huge step forward in remote assessment and managing of chronic illness. If it is integrated into the CCM flow of work and independently time tracked, the CCM clinician brings an integrated view of the patient's condition and corroborating data when reported to the provider for evaluation and management. At the same time the 2 codes are independently time tracked and prepared for billing.

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MACRA ready
Integrated Telehealth
Evidence Based Patient Education

MediCCM Brings More Value to Chronic Care Management

	Standard Medicare fee-for-service care	Basic CCM value-based care	MACRA Ready CCM value-based care with Integrated Telehealth and Evidence Based Patient Education	
MIPS Quality Measures : Tracking			●	M
MIPS Improvement Activities : Tracking			●	M
MIPS Advancing Care : Tracking			●	M
Doctor Portal			●	M
Patient Educational Tools			●	M
Telehealth			●	$
Patient/Family Portal			●	$
Screening Tools			●	$
G0505 Previsit Planning			●	T
G0506 Previsit Planning			●	T
Patient/ Caregiver Engaged		●	●	$
Designated Provider		●	●	$
Easy 24/7 Access to Providor		●	●	Q
Comprehensive Care Plan		●	●	$
Annual Wellness Exam	●	●	●	$
Population Health	●	●	●	$
Pay only as needed	●	●	●	$

Values: M-increase MIPS points
T- saves Provider time
Q- improves quality of care
$- increase revenue

MediCCM Brings more Value to Value-Based Care

Our cloud based system for CCM technology includes the ability to support basic and complex chronic care management. MediCCM also integrates and supports the new Telehealth CPT code with all the requirements and time tracking. Additional pre-visit planning with validated standardized assessment tools for providers to more easily complete and bill new assessment codes. This can bring the provider significantly more Medicare funds both on the front end with directly billed codes and on the back end with meeting MIPS points and qualifying for up to 12% increase in reimbursement (rather than 4% discount).

This intuitive user design and interface for both computer and app make it easy for providers and coordinating clinicians to document encounters as well as review care plans, goals, outcomes and comments.

Key features and Benefits:

- Support basic CCM and supports and documents criteria for Complex CCM
- Integrate Evidence-based disease specific patient education
- Document Goals, interventions and outcomes of disease specific education
- Track MIPS clinical improvement activities (IA) mapped to goals and interventions
    - Creates reports based on patient IA, addressed in patient encounters
    - Creates reports including
- Support Telehealth (99091) and integrate with CCM
    - Multiple modes of data entry
    - Independent time tracking and line item billing
    - Patient facing portal, and App, so patient can monitor themselves
    - Provider facing portal- can adjust parameter per patient and monitor
    - "Stop light "style data views for greater understanding
- Structure pre-visit planning for visits and special CPT codes
    - Annual wellness visits
    - Cognitive impairment assessment (G0505)
    - Comprehensive assessment and care planning (G0506)
    - Health risk assessment patient-focused (96160)
    - Health risk assessment caregiver-focused (96161)
    - Population management – review and schedule Health Maintenance
    - Primary care focused visits
    - Specialist visits
- Includes Standardized assessment tools integrated into encounter workflow
- Comprehensive Care assessments – auto generated from ICD-10 codes
- Individualized care plans -Goals, interventions and outcomes
- Disease specific health education material

- Patient education paper tools matched to computer plans
- Secure messaging
- Patient portal (and phone app)
- Physician portal (and phone app)
- Reports
    - Productivity with time and billing for CPT codes : 99490, 99487, 99489
    - Health maintenance
    - Pre-Visit planning reports including standardized assessments
    - MIPS points per patient and per clinic
    - Patient monthly report of interventions and goals met

Clinician work dashboard

- Patients assigned to clinician
    - Time spent with NF2F contact- per month
    - Completed requirements for billing –per month
- Disease specific Care plan with guided encounters including:
    - Individualized goals, interventions and Outcomes
    - Ability to adapt Care Plan as needs change and outcomes are met
- Sort patients by: acuity, time logged, disease/ chronic illness
- Coordination with providers via provider portal and app
- Coordination with patient via:
    - Patient portal
    - iphone and Android supported patient/ family App
    - Secure messaging
- Coordination with provider via:
    - Provider portal
    - iphone and Android supported provider App
    - Secure messaging

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