Physicians share their actual experiences, successes, and stumbles as they implement CCM in their practices.

Chronic Care Management in the Real World

David Twiddy

The Centers for Medicare & Medicaid Services began paying physicians for providing chronic care management (CCM) services in January, but more than halfway through the year, questions remain: Are patients embracing this new benefit? Are physicians billing for it? Is Medicare actually paying for it? Are private payers getting on board?

To get a better feel for how CCM is affecting physicians and to help readers learn from others' experiences, *Family Practice Management* spoke to physicians in situations ranging from solo practices to large health care groups. We asked how successful they have been at getting patients to opt in, how much staff time it is taking to provide the services according to Medicare requirements, how the additional documentation requirements are handled, whether they have encountered any difficulties in getting paid, and whether they feel the extra work has been or soon would be worth it.

The physicians' responses, although not necessarily representative of all practices, were mixed. Some physicians said they saw a significant, almost immediate, increase in revenue with relatively little additional work, while others reported having stopped billing for CCM, at least temporarily, bogged down in compliance issues or combatting patient skepticism.

CCM is still evolving. But in the meantime, physicians wanting to incorporate the new payments and requirements into their practice can learn from these physicians' experiences to make their own way easier. ➤

About the Author

David Twiddy is associate editor of *Family Practice Management*. Author disclosure: no relevant financial affiliation disclosed.

© RON CHAN

Downloaded from the *Family Practice Management* website at www.aafp.org/fpm. Copyright © 2015 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the website. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

Several physicians said they initially performed financial analyses on CCM payment and whether it made economic sense for their practice to pursue.

Getting started

Most practices interviewed said they began recruiting patients and billing for CCM as soon as it became available in January 2015. For these early adopters, it required extensive preparation, including studying and understanding the long list of program rules and determining which of their eligible patients were most likely to benefit from more focused management of their chronic conditions.

Physicians are having mixed success incorporating Medicare's chronic care management (CCM) into their practices.

Leisa Bailey, MD, a solo family physician in Bonifay, Fla., said she was looking forward to finally getting paid for work she was already doing for her patients.

"Every time something comes up that gives you an opportunity to be rewarded for what you do, you have to grab it because you're having so many things taken away in other areas," Bailey said, referring to reductions in Medicaid reimbursements and increased staff time dedicated to prior authorization and similar tasks.

Practices should fully understand the CCM rules and whether they will need to hire additional staff or buy new technology to meet billing requirements.

Several physicians, including Bailey, said they initially performed financial analyses on how much they potentially could make from CCM payment and whether it made economic sense for their practice to pursue. This often was done by estimating how many Medicare patients had the requisite two or more chronic conditions, multiplying by the Medicare reimbursement rate for CCM in their region, multiplying by 12 months, and then subtracting current salaries of staff expected to provide the CCM services. This also led them to determine if they needed to add staff or have existing staff dedicate a portion of their time to CCM work.

In Bailey's case, she determined she could afford to hire a part-time phlebotomist who could free up a nurse to spend half of each day providing CCM services.

Some physicians also said a practice should determine early on whether their electronic health record (EHR) system can comply with the requirement that physicians electronically communicate with patients and specialists or whether they will have to buy or upgrade equipment or software. In some cases, the EHR can help to track time spent on CCM services or otherwise assist with billing.

Patients need their physician to explain the value of CCM services before they will sign up for the service.

Getting patients on board

CMS requires that before a physician can bill for CCM he or she must inform the patient of the availability of CCM and obtain verbal or written agreement to have the services provided, not-ing in the patient's record whether he or she consented. For some practices, getting that approval represented their first and largest hurdle.

Some physicians sent letters to all of their Medicare patients, explaining CCM and requesting that they respond to indicate whether they were interested in receiving CCM services. This was typically followed by a face-to-face visit where patients could ask the physician questions, sign the CCM documents, and help provide input into their care plan. Other physicians contacted only those patients most likely to benefit from CCM. Others discussed CCM only with patients who came in for regularly scheduled visits.

Although each approach had varying degrees of success, the physicians agreed that it was important to explain to patients what services CCM covers and how those services enhance the treatment of their chronic conditions. Some practices sold the program's value, detailing services the physician may otherwise charge for separately, such as filling out medical forms. Others described how CCM can keep the practice and patient in near-constant contact and potentially lead to better, more coordinated care.

Some practices used traditional tools for marketing CCM, such as brochures available in the office and messages on their websites. Floyd "Tripp" Bradd III, MD, a solo family physician in Front Royal, Va., created a

three-minute CCM video for patients (http://bit.ly/1NlCeJ8) that is available for viewing on tablet computers in his waiting area. He says this video cuts down on the time he and his staff have to spend explaining the program.

Another key lesson that emerged from family physicians' experiences is that the physician must be directly involved in explaining what CCM services are and recommending that a patient sign up for them.

Kenneth O'Neil, MD, vice president of clinical integration at Lakeland Healthcare in St. Joseph, Mich., said his system signed up just 18 patients in the first three months of the program, many fewer than the 80 they had expected. Although O'Neil said the system hasn't performed a post-mortem on why their efforts stumbled, one possibility is that they used a dedicated care manager to call patients and ask them to sign up for CCM instead of involving the patients' regular physicians. Also, the care manager was working with patients in three locations, which made it impossible for physicians in two of those locations to introduce their patients to the care manager or have her provide more clarity on the CCM program face-to-face.

Even physicians who could personally explain CCM to patients had to somehow address the fact that patients were now being asked to pay for services that had been provided at no charge for several years. Because of this, combined with the likelihood that patients would face a small copay (or a larger bill if their deductible was not yet met), some physicians said they faced resistance.

Dorothy Serna, MD, an internist in Cypress, Texas, remembered explaining CCM to an elderly couple and their adult daughter. Both patients were good candidates for CCM because of their multiple chronic conditions. Serna explained all the services CCM covers and how her practice already worked to be proactive and prevent the couples' conditions from getting worse. When she explained that there was a copay of $8 a month, which may or may not be picked up by the couple's secondary coverage, the daughter spoke up. "She said, 'Mom, don't sign. They do that anyway. Save your eight dollars.' I was beside myself, but that's the problem," Serna said.

Serna has had success stressing with patients how CCM can help identify care gaps and monitor their condition between scheduled visits. In this instance, Serna said that once the patients' daughter left the exam room, the wife ended up signing an agreement to receive CCM services.

Still, concerns about copays can be a deal-breaker for patients. Even patients who have secondary insurance may need verification that their insurance will cover the copay before they agree to the benefit.

Most physicians said they still planned to provide or continue providing at least some of the CCM services for patients who decline the CCM benefit.

Some patients will resist having to pay an additional copay for CCM.

Practices need to decide if they will continue providing CCM services if a patient opts out.

Doing the work

CCM payment comes with a long list of documentation and billing requirements, of which several are key:

Patient-centered care plan. First, the physician must develop a patient-centered care plan based on the physician's judgment and the patient's choices and values. The fact that CMS hasn't dictated a format for the care plan has forced physicians to be creative. In some cases, they have developed their own care plans reflecting the patient's chronic conditions, their measurable goals, a list of the patient's other care providers, and health maintenance items for the near future. Other physicians have modeled their care plans after the required elements of the "Welcome to Medicare Exam" or have used published tem-

RELATED RESOURCES FROM *FAMILY PRACTICE MANAGEMENT*

Articles:

Chronic Care Management and Other New CPT Codes: http://www.aafp.org/fpm/2015/0100/p7.html

Answers to Your Questions About Chronic Care Management: http://www.aafp.org/fpm/2015/0500/p7.html

Tools:

Frequently Asked Questions: Medicare's Chronic Care Management (CCM) Services: http://bit.ly/1WH4qcp

Agreement to Receive Medicare CCM Services: http://bit.ly/1LmRtRG

Letter to Patients Regarding Medicare CCM: http://bit.ly/1G1jLcs

Medicare CCM Services Log: http://bit.ly/1G3LEQY

plates, such as the patient-centered care plan template published by *Family Practice Management* (http://bit.ly/1TVGp2t). For more CCM-related articles and tools, see "Related resources from *Family Practice Management*," page 37.

Ideally, the care plan form should be turned into an EHR template for easier completion. The length of time to complete a care plan might range from as little as 8 minutes to more than 30 minutes, depending on how much information must be captured.

Bailey said building each care plan gave her a rare chance to study each patient's chart in depth, which allowed her to notice a surprising number of care gaps, such as missed wellness exams, pneumonia shots, or mammograms. She makes sure to add these services to the list of follow-up items included on the form.

Not all care plans went smoothly. For some clinics at Oregon Health & Science University's Department of Family Medicine in Portland, the question of who should complete and update the care plans is one of several issues that has prevented physicians from moving forward with CCM.

Eric Wiser, MD, who is at the system's Gabriel Park clinic, said the practice has created patient-centered care plans for several years as part of its participation in the Comprehensive Primary Care Initiative (CPCI), a four-year program of the Center for Medicare & Medicaid Innovation that pays population-based care management fees and offers shared savings opportunities to practices in seven U.S. regions. The clinic provides these care plans both for Medicare patients enrolled in CPCI, who aren't eligible for CCM, and for Medicare patients who are not. Those care plans have traditionally been developed by nurses with physician oversight and treated as highly dynamic, changing from month-to-month. The CCM requirement that physicians create the care plans has led the health system's compliance officers to seek clarification from Medicare officials. Based on the answers received, the clinic may begin billing CCM this fall.

CCM services. To comply with Medicare's CCM billing requirements, even practices that already provide CCM-type services and have efficient systems in place will likely need to give more attention to how they document what was done and when.

Bailey said she creates a list of initial services when she first builds the patient's care plan. Her nurse refers to that list and calls the patient to schedule any necessary procedures or other services and to provide patient education as needed. This is recorded as part of the CCM services to be billed that month. Bailey also makes sure all CCM patients are flagged in the EHR so that if they call with a question, with a referral request, or to coordinate care between specialists, the nurse who speaks with the patient can be reminded to log her time as CCM when appropriate.

Physicians need to find their own model for drafting the patient-centered care plan.

Preparing a care plan can help identify gaps in the patient's care.

The care plan guides what CCM services to provide and record each month.

LESSONS LEARNED

1. Work on your elevator speech. Eligible patients will want to know quickly and clearly why they should sign up for chronic care management (CCM) and agree to the associated cost-sharing.

2. Increase your knowledge of the CCM rules. This will ease compliance and payment.

3. Do your part. Although physicians will not do most of the CCM work, they are instrumental in securing patient agreement.

4. Empower staff. Taking on CCM responsibilities can boost staff morale as they see that their work directly generates income; this may help them accept the additional documentation requirements.

5. Have a back-up plan. If you choose to have certain staff dedicate some or all of their time to CCM, be sure the practice is prepared to provide uninterrupted services and billing in their absence.

6. Make sure your electronic health record enables communication among staff members, patients, and your patients' other providers to facilitate care coordination.

7. Start small. Enroll and serve a limited number of patients and fine-tune clinical and billing processes before offering CCM services to all those who are eligible.

It is important to explain to patients what services CCM covers and how those services enhance the treatment of their chronic conditions.

Samuel Church, MD, in Hiawassee, Ga., said he developed lists of potential CCM services by looking at what kind of help patients requested between visits. He also looked at services he and his staff had tried to provide without the patient coming in to the office. This approach has also helped his staff with their previsit planning.

Staffing. Most practices will need to have dedicated staff to handle CCM services, either full- or part-time. This makes training and workflow easier than having everyone involved in CCM. Other staff can then focus on more routine tasks and care for patients not enrolled in CCM. Flexibility is also important, particularly in the midst of unexpected staffing changes.

O'Neil's group hired a dedicated care manager to handle CCM, but the employee moved out of town about three months after starting. That forced the system to assign those CCM patients to care managers who were already working on other initiatives, such as implementing the patient-centered medical home model and transitional care management.

"They've got a lot on their plates," he said. "I suspect that if we pulled those patients' charts we'd find CCM is not happening."

Serna has had the opposite problem. Although her dedicated CCM staff person stayed, other clinic employees left, forcing the CCM manager to drop what he was doing and lend a hand. After providing CCM services for one month, Serna had to let it lapse during the second month so her clinic situation could stabilize.

Twenty minutes per month. Physicians interviewed said they didn't have any trouble determining which services counted toward the 20 minutes that must be provided in a month to bill for CCM. To document that time, most practices used some combination of paper and electronic recordkeeping. In some cases, it was as simple as the nurse noting the number of minutes he or she spent with a patient over the phone or otherwise coordinating care and later uploading this number to the EHR. Others took advantage of time-tracking features available in their EHRs. Bradd, who has used an EHR in his practice since 1993, developed his own online registry that documents and timestamps the individual and cumulative amount of time spent on CCM services. At the end of each month, Bradd's practice exports the registry to an Excel spreadsheet. This informs his staff which patients have received enough CCM services for billing purposes. Bradd put together a free e-book (http://emrvillage.com/othpgs/CCM/)that shows how he developed this registry.

Practices could also use their EHR's private message function to track time spent. A colleague of Bradd's set up a CCM message account that each staff member messages after providing eligible services, listing the patient and the number of minutes spent. At the end of the month, staff access the account, tally the minutes, and bill CMS accordingly.

Time reporting can be an obstacle for practices that haven't done it in the past. Bradd instructed his staff to bill their time as if they were paralegals working on a case. "This allows our clinical staff to actually become income generators," Bradd said, which has boosted morale.

Wiser said that although his clinic is not yet billing CCM, he has discussed the 20-minute requirement with staff and developed a paper-based timekeeping system that will be automated later.

24/7 electronic and patient access. CMS requires that patients receiving CCM services be able to make timely contact with health care providers in the practice to address urgent chronic care needs at any time of the day or week. The practice must also make the patient's care plan accessible 24/7 to all providers in the practice who might provide CCM services as well as to any providers

- Staff need dedicated time and flexibility to deal with CCM services.
- Practices can use written or electronic systems for tracking the required 20 minutes of CCM services each month.
- Staff will need additional reminders to record their time spent on CCM tasks.

The primary care physician must be directly involved in explaining what CCM services are and recommending that a patient sign up for them.

outside the practice caring for the patient.

Physicians interviewed said their EHRs fulfilled the requirement of electronic access with patients, although a few said they had to ask their EHR vendor to turn on the patient portal function to enable secure electronic communication. However, some practices were thwarted in sharing patient records with outside physicians because of a lack of interoperability between the EHRs used by their practice and other providers, such as the local hospital. The large health care systems said their affiliated hospitals, clinics, and specialist offices all used the same EHR software, so interoperability wasn't a concern.

Several physicians said they have always provided their patients information for contacting them at all hours, have relied on a call service, or have used technology to route after-hours calls to their phones immediately. Some also said they have patient portals available for messaging but acknowledged that their portals aren't monitored at night or on weekends.

Bailey has had her information technology contractors develop a dedicated email address for CCM patients, which she and her chronic care nurse can access, and she plans to hand out refrigerator magnets listing the email address and 24/7 phone number. She also has a patient portal, but relatively few patients have shown interest in using it. Many of her patients refuse to call her during off-hours, she said.

"We're trying to do more education and let them know to please call," she said, telling them, "I'd much rather you bother me on a weekend than come in three days later and I have to put you in the hospital and have to come in and do rounds on you every day."

Electronic communication can help satisfy 24/7 contact requirements.

Reimbursement for CCM can represent a significant boost to practice revenues.

Billing for CCM may require some trial and error and additional education for patients.

Getting paid

Whether because of concerns that the CCM requirements are overly confusing or a general skepticism regarding physician payment, some physicians have questioned whether CMS would actually pay physicians for providing CCM services.

Bailey and Bradd said they have had no problems with reimbursement. Bailey started slow, billing around 80 patients a month for around $2,500 in total reimbursement. She expects to increase that to around 100 patients per month once she has streamlined her process and staffing changes enable her CCM nurse to dedicate more of her time to working with patients. Bradd said Medicare has processed claims promptly and some of the secondary insurers in his market are covering the copay. He's negotiating with some local commercial providers who also may pay the CCM code in the future. Bradd estimated that he will soon be providing CCM services to 100 patients a month, which at his market's average reimbursement of $33 per encounter "is not a small chunk of change and helps pay for a lot of things," he said.

CCM has also helped him improve his efficiency by identifying those patients who receive the most chronic care services – in some cases, 50 to 100 minutes a month – and have them come in for face-to-face visits more often.

Church said his first claims were rejected because he had used the wrong codes. He resubmitted the claims to his Medicare administrative contractor with codes for two chronic conditions and the CCM code 99490, and they were paid. Church billed only a handful of patients as he learned his way around CCM but said he has determined his staff could handle up to 280 patients a month.

"I had 100 patients signed up when I started this in January, but you can start if you have five," he said. "You can then scale your staffing as you need it."

Serna reported more billing hassles and submitted bills for January only, even though she continued to provide CCM and recruit patients. Staff turnover in February made it difficult to properly bill, but she also had

to reevaluate her strategy after patients expressed confusion and even anger after getting billed for their copay or deductible in January. Although Serna had explained CCM to them when the patients opted in, many received their "explanation of benefits" and couldn't understand what they were paying for.

She'll be sending out a new round of letters to patients who received the bills, once again explaining what CCM provides, and then will bill for the subsequent months. Some patients' secondary insurers did not initially recognize the code, which added to patient frustration when the copays weren't covered. Serna said she didn't have any problems getting paid by Medicare and has approached some commercial payers about CCM reimbursement with some success. She plans next year to concentrate more heavily on expanding with commercial payers, showing how their patients could benefit from CCM. Although Serna has had to pay for consulting and software upgrades to implement CCM, she expects CCM to break even for her practice by the end of this year.

"If you look at it as making a small investment to get paid for what you're already doing, that's OK too," she said.

Wiser's clinic has not yet billed for CCM as it awaits approval from compliance officials. But the clinic is preparing for CCM. He estimates the clinic will initially be able to cover 120 eligible patients. That number could go up dramatically in 2017 when some 280 patients currently enrolled in CPCI and receiving chronic care services are scheduled to leave the program and become eligible for CCM.

O'Neil's system, as explained earlier, has suspended its CCM program amid staffing concerns and a lack of patient engagement. Still, he said the potential benefits of CCM for the system would allow four care managers to cover between 200 and 250 patients each.

"If this becomes easy and profitable, I see this as a way to certainly increase our staffing," he said.

Looking ahead

This article touches on the experiences of a handful of practices that have sought to implement CCM, and their outcomes are influenced by factors such as practice size, patient panel characteristics, technology capabilities, and physician leadership. Although it is hard to generalize, it is clear from these practices' experiences that physicians are getting paid for providing CCM and some are optimistic about providing the services to a growing number of patients in the coming months and years. Physicians are also encountering barriers that have hampered or even prevented their ability to bill for CCM.

Nevertheless, these physicians viewed the new CCM code as a welcome opportunity to finally be compensated for the hours of work performed outside of patient visits to better care for some of their sickest patients. As more and more individual practices and health care systems test the CCM waters and share their experiences, their successes and failures will give others the information they need to move forward and decide what works best for their own practices. FPM

Send comments to **fpmedit@aafp.org**, or add your comments to the article at **http://www.aafp.org/fpm/2015/0900/p35.html**.

Preserve Your **Independence.** Protect Your **Success.**

Has managing your practice grown more complicated and frustrating? Perhaps you are considering hospital employment, but concerned it may cost the independence you love and the success you've earned.

There is an alternative.

As a recognized leader in practice management, population health management and clinical integration, Continuum enables providers to achieve outstanding operational, clinical and financial results, and delivers new revenue opportunities for independent physician groups.

Learn more by downloading our Healthy Revenue Checklist or Clinical Integration Whitepaper at **page.challc.net/success.**

continuum™ HEALTH ALLIANCE
Transforming the Practice of Medicine
A PHYSICIAN ENABLEMENT COMPANY

402 Lippincott Drive
Marlton, NJ 08053
P: 856.782.3300 x2419
www.challc.net

©Continuum Health Alliance, LLC