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Overview

Recognizing the value Chronic Care Management (CCM) can deliver in improving health outcomes and reducing healthcare spending, the Centers for Medicare and Medicaid Services (CMS) adopted a new service code in January 2015. CPT code 99490 reimburses physicians for delivering non-face-to-face care coordination to eligible Medicare beneficiaries with two or more chronic conditions.

The success of this code and feedback from physicians prompted CMS to introduce new CCM codes and more reimbursement in 2017, expanding the CCM program and its potential to impact a practice's bottom line. The changes also support the time and effort required to enroll patients into a CCM program and coordinate the care of those with complex needs.

With additional revenue opportunities available and the ability to provide care coordination services so closely tied to success with programs like MACRA, this is the perfect time to implement CCM in your practice or adjust your current CCM strategy to maximize reimbursements.

WHO IS THIS REPORT FOR?

This report, which will examine CCM and its potential value for patients and practices, is an important read for those who:

- Are ready to move forward with CCM, but don't know what steps to take next
- Recognize the value CCM brings to patients and the practice, but worry about the time and resources needed to meet the requirements
- Have implemented CCM, but now need a partner who can scale their program effectively and make it more value-driven
- Want to better understand the connection between CCM and other CMS initiatives
- Recognize that with 10,000 baby boomers turning 65 each day through 2029, there is a growing patient base prone to developing multiple chronic conditions
- Are participating in a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) and can now (also as of 2017) contract with third parties to deliver CCM

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Early Adoption of CCM

Medicare's CCM program began in 2015 with CPT 99490, which, at that time, reimbursed physicians approximately $41 per patient per month for providing at least 20 minutes of non-face-to-face care coordination activities to eligible Medicare beneficiaries with two or more chronic conditions.

The code offered an opportunity for physicians to build a new revenue stream by supporting the proactive, between-visit care of their Medicare patients. It also provided reimbursement for the extra time and effort they were already investing in caring for chronic patients outside of traditional office visits.

With every passing month, practices were missing out on CCM's potential revenue stream and patients were missing out on important, between-visit care.

CHALLENGES EARLY ADOPTERS FACED

At first, adoption of the CCM program was slower than expected. While there was significant interest in CPT 99490 and its reimbursements, there were significant challenges for implementing it. Practices that tried to do it on their own often found they could not adequately meet Medicare's requirements in time or scope.

Additionally, these early adopters struggled with physician engagement, patient education, and challenges with staffing, workflows, and technology.

To implement CCM without third party support, and to scale it effectively, it was estimated that a physician's practice would need to hire one full-time employee for every 200 to 250 Medicare patients who enrolled. Plus, the program required providing non visit-based care, 24/7 access to clinical staff, the creation of a comprehensive care plan for each patient, ongoing care management for all chronic conditions, and more. With physicians and their staff already feeling stretched thin, how could they possibly add to their workload?

But as daunting as implementing CCM seemed, doing nothing wasn't an option. With every passing month, practices were missing out on CCM's potential revenue stream and patients were missing out on important, between-visit care.

There was also another business perspective to consider. It was becoming clear that implementing CCM was a necessary stepping stone toward something larger: a precursor to the type of care physicians would need to demonstrate to achieve success with programs like MACRA (the Medicare Access and CHIP Reauthorization Act of 2015). This meant there was the very real possibility that practices that hadn't implemented CCM could be at a disadvantage as the industry continued its shift away from fee-for-service toward value-based care.

> SOME HAD TRIED TO IMPLEMENT CCM ON THEIR OWN AND FOUND THEY COULDN'T SUSTAIN OR SCALE IT. OTHERS HAD EXPERIENCED SOME SUCCESS WITH CCM, BUT NOW WANTED TO TAKE IT TO THE NEXT LEVEL AND MAXIMIZE THEIR REIMBURSEMENTS.

THE THIRD PARTY SOLUTION

From the onset of the code, CMS had recognized how strict and difficult the program's protocols could be, so it set the requirement as "indirect supervision" (except, at that time, for RHCs and FQHCs). This allowed physician practices to bring in a third party to provide CCM services to patients on the practice's behalf. The intent was to provide a viable option for practices to meet the protocols, while ensuring patients were not denied the benefit of CCM because a practice didn't have the infrastructure to provide it.

As physicians partnered with third parties, implementation of CCM grew. Where once there had been mostly single-physician practices actively seeking support for CCM, there were now larger practices recognizing the potential of partnering with care coordination companies.

Some had tried to implement CCM on their own and found they couldn't sustain or scale it. Others had experienced some success with CCM, but now wanted to take it to the next level and maximize their reimbursements.

INFORMATION SPURS IMPLEMENTATION

> Practices that haven't implemented CCM could be at a disadvantage as the industry continues its shift away from fee-for-service toward value-based care.

CCM was very new to physicians at the beginning of 2015, but by 2016, there was far more information about CCM circulating. This included data that proved assumptions about the program's value. Testimonials about the revenue generated, the improved health outcomes, the cost savings, and even examples where CCM helped save lives increased physician engagement and subsequent adoption.

A review of several studies[2] showed care coordination resulted in:

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

Additionally, research from a care coordination solutions company showed recipients of CCM services benefited in the following ways:

- 64% avoided one or more duplicate tests in a year
- 65% said they felt more engaged in their healthcare experience
- 84% said it helped them remember important follow-up items they had forgotten after an appointment
- 49% reported finding a medical error and 33% of those errors were significant enough to potentially cause an adverse effect
- 9% avoided serious drug interactions

Social media sources, articles from organizations like AARP, and patient resources in doctor's offices also fostered patient education regarding CCM and care coordination. This helped make enrollment easier.

[2] Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis, The Commonwealth Fund, October 2015

Four Events Put the Spotlight on CCM

In January 2017, many practices that had delayed implementing CCM began to feel increasing pressure to take action in the wake of four events. In no particular order, these included:

EXPANSION OF THE CCM PROGRAM

When CMS announced it was expanding the CCM program, many healthcare providers were relieved to see some of their primary concerns with the program addressed.

CMS introduced additional codes that supported complex CCM cases and offered higher reimbursements in general. This made implementation far more attractive and profitable.

CMS eased certain restrictions that dramatically simplified the enrollment process. Patients can now give verbal consent to CCM enrollment rather than written consent, as long as their decision is documented in their patient record. Additionally, the requirement that patients be enrolled in CCM during a face-to-face qualifying visit is now only required if the patient is new or has not had a face-to-face encounter in the past 12 months. Otherwise, the patient can be enrolled by phone.

Finally, CMS established an add-on code that supports the extra time physicians take in person to create a comprehensive care plan and initiate CCM services, time that would not have been part of the typical office visit. This initiating visit is not part of the CCM service and is separately billed.

CMS EASED CERTAIN RESTRICTIONS THAT DRAMATICALLY SIMPLIFIED THE ENROLLMENT PROCESS.

CHANGES TO REQUIREMENTS FOR RHCS AND FQHCS

In 2015, RHCs and FQHCs were unable to participate in CCM. In 2016, they could participate in CCM, but any non-face-to-face care coordination services had to be furnished by clinical staff under direction supervision. This meant they had to provide these services while present in the same office as the supervising practitioner who had to be immediately available to provide assistance.

RHCs and FQHCs can bill for CCM via HCPCS code G0511. Medicare reimburses $62.28 per patient per month.

For most RHCs and FQHCs, this presented a considerable challenge. The clinical staff was overwhelmed by trying to make time for CCM during regular office hours, practitioners were burdened with providing direct supervision after-hours, and many felt it was simply unrealistic to meet CCM requirements given their practice's budget, human resources, and time constraints.

Recognizing the need to not only remove obstacles to widespread implementation of CCM, but also ensure requirements for RHCs and FQHCs were "not more burdensome than those for practitioners billing under the PFS," CMS made changes to CCM requirements as they apply to RHCs and FQHCs.

RHCs and FQHCs can realize potential annual revenue of $747,360 per 1000 patients enrolled.

The first change gives RHCs and FQHCs the ability to have general supervision of clinical staff, which allows them to now contract with third parties to deliver effective CCM programs and services on their behalf under **HCPCS code G0511**.

The second change was to the requirement that CCM patients have 24/7 direct access to RHC and FQHC practitioners. Instead, the requirement is now 24/7 access to auxiliary personnel who have the means to contact those practitioners.

The third change is the most significant. CMS combined all care management services including Transitional Care Management, Chronic Care Management and Behavioral Health Integration into one HCPCS code G0511. This code can be billed one time per month.

With these changes in place, RHCs and FQHCs are now much better positioned to improve the overall health of their patients and generate new revenue for their practice through **HCPCS Code G0511** (RHCs and FQHCs are not able to participate in the new complex CCM codes or add-on code).

OFFICIAL IMPLEMENTATION OF MACRA

A big boost for CCM adoption was the official implementation of MACRA. January 1, 2017, was the start of the first performance year under MACRA, which is a complete game changer for the healthcare industry.

MACRA will have a dramatic impact on the way Medicare pays physicians moving forward. Yet, a survey by research and consulting giant Deloitte revealed that as late as June 2016, nearly half of U.S. physicians were unfamiliar with MACRA, at a time when the program was only six months away from its implementation. And many hadn't adopted a CCM program yet, which would have helped prepare them for what was and still is to come.

Now, as government deadlines draw closer and the threat of negative payment adjustments from Medicare loom, physicians are increasingly turning to third parties to help them implement CCM. As more physicians acknowledge the connection between CCM services and major initiatives such as MACRA, there is a growing understanding that implementing CCM creates a foundation for success with MACRA and a greater ability to demonstrate quality and performance-based measures.

ROUND 1 OF CPC+

The same holds true for the implementation of Comprehensive Primary Care Plus (CPC+), a national advanced primary care medical home model. The care coordination services behind CCM are also behind programs like CPC+. As Round 1 of this new care delivery and payment model for primary care began on January 1, 2017, it became increasingly clear to participants how much familiarity with and implementation of CCM would go a long way toward setting practices up for success. In fact, providing CCM to patients can serve as a precursor to attribution in CPC+ and certain fees in the program are intended to pay for CCM covered services.

CCM creates a foundation for success with MACRA and a greater ability to demonstrate quality and performance-based measures.

The Current CCM Program: Where We Are Today

With the expansion of the CCM program, CMS now offers more opportunity to help patients achieve optimum health while putting physicians and practices in the best possible position to receive reimbursement for their care coordination efforts. The following describes what the CCM program consists of, as of June 2017.[4]

CPT CODE 99490

As described earlier, CPT 99490 reimburses physicians for providing non-face-to-face care coordination to eligible Medicare beneficiaries. CCM services include at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:

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

CMS now offers more opportunity to help patients achieve optimum health.

CMS maintains a Chronic Condition Warehouse with common chronic conditions listed to provide beneficiary, claims, and assessment data, but it did not limit the chronic conditions allowable under the CCM program. Chronic condition status is left to the discernment of the provider.

CMS increased the reimbursement for CPT 99490 by about 5% in 2017 to an average of $43 per patient per month.

[4] Chronic Care Management Services Changes for 2017, CMS

COMPLEX CCM CODES

> Chronic condition status is left to the discernment of the provider.

In the first two years of the CCM program, it became clear that for some patients, CCM requires additional care coordination time and more complex medical decision-making that many felt was not covered by reimbursement through CPT 99490. CMS addressed this by implementing separate payment for Complex Chronic Care Management using CPT codes 99487 and 99489.

CPT 99487 reimburses approximately $94 for 60 minutes of non-face-to-face care coordination and CPT 99489 reimburses approximately $47 for each additional 30 minutes (CPT 99489 can only be reported in conjunction with CPT 99487).

Complex CCM shares common required service elements with CCM, but additionally requires the establishment or substantial revision of a comprehensive care plan, as well as moderate or high complexity medical decision-making by the medical provider.

ADD-ON CODE FOR ENROLLMENT

> FQHC and RHCs are not eligible to bill add–on code G0506.

In 2017, CMS introduced add-on code G0506 to reimburse physicians for the extra time it takes to create a comprehensive care plan and initiate CCM services...time that would not have been part of the typical office visit.

This add-on code is for practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code.

The average reimbursement rate is $64 for this one-time code and must take place during the initiation of CCM services.

Things To Know About CCM

CMS recognizes the importance of taking care of the patient all of the time, not just at the point of care. Therefore, CCM services are typically provided outside of face-to-face patient visits and focus on characteristics of advanced primary care such as:

- A continuous relationship with a designated member of the care team
- Patient support for chronic diseases to achieve health goals
- 24/7 patient access to care and health information
- Receipt of preventive care
- Patient and caregiver engagement
- Timely sharing and use of health information

CMS recognizes the importance of taking care of the patient all of the time, not just at the point of care.

The following summarizes CCM service elements and other important aspects of CCM.

PRACTITIONER ELIGIBILITY

CCM services are per calendar month and must be directed by a physician or other qualified healthcare professional. With some limitations, physicians and the following non-physician practitioners may bill CCM services: certified nurse midwives; clinical nurse specialists; nurse practitioners; and physician assistants.

As CMS has noted, CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.

SUPERVISION

CCM codes are assigned general supervision under the Medicare PFS, which means when the service is not personally performed by the billing practitioner, it is performed under their overall direction and control, but they do not need to be physically present. Clinical integration into provider workflow is essential for this to happen fluidly.

INITIATING VISIT

Medicare requires initiation of CCM services to take place during a face-to-face visit with the billing practitioner (an Annual Wellness Visit, Initial Preventive Physical Exam, or other face-to-face visit with the billing practitioner, i.e. 99212-99215) for new patients or patients not seen within one year prior to the commencement of CCM services. Otherwise, enrollment of eligible beneficiaries may take place by phone. This initiating visit is not part of the CCM service and is separately billed.

PATIENT CONSENT

Advance consent for CCM services is necessary and helps to ensure the patient is engaged and aware of applicable cost sharing. When enrolling a patient in CCM, the provider must inform the patient of the following:

- The availability of CCM services (describe the CCM program and the way the services will be provided)
- Applicable cost-sharing is involved (copays or deductibles apply)
- Only one practitioner can furnish and be paid for CCM services during a calendar month
- The patient has the right to stop the CCM services at any time (effective at the end of the calendar month)

Consent may be verbal or written, but it must be documented in the patient's medical record that the required information was explained and whether the patient accepted or declined the services.

BILLING

CCM should not be reported for services furnished during the 30-day Transitional Care Management service period.

Only one practitioner may be paid for CCM services for a given calendar month. This practitioner must only report either complex CCM or non-complex CCM (CPT 99490) for a given patient for the month, not both. As sourced from CMS documentation, additional billing restrictions include:

- CCM cannot be billed during the same service period as codes G0181/G0182 (home healthcare supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services)
- CCM should not be reported for services furnished during the 30-day Transitional Care Management service period (CPT 99495, 99496)
- Complex CCM and prolonged Evaluation and Management (E/M) services cannot be reported the same calendar month
- Consult CPT instructions for additional codes that cannot be billed concurrent with CCM
- There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program (for example, Medicare will not make duplicative payments for the same or similar services for patients with chronic conditions already paid for under the CPC+ initiative)
- Time that is reported under or counted toward the reporting of a CCM service code cannot also be counted toward any other billed code

PAYMENT

CMS pays for CCM services separately under the Medicare PFS. To find payment information for a specific geographic location by code, access the Medicare PFS Look-Up Tool.

Additionally, don't forget about other payers that reimburse for CCM, including payers for dual eligible Medicare/Medicaid beneficiaries, Medicaid (we've seen this paid in approximately 15 states), and Medicare Advantage Plans.

STRUCTURED RECORDING OF PATIENT HEALTH INFORMATION

There must be structured recording of the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31 of the calendar year preceding each Medicare PFS payment year. A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.

24/7 ACCESS TO CARE AND CONTINUITY OF CARE

24/7 access to physicians or other qualified healthcare professionals or clinical staff must be provided. This includes providing patients (and caregivers as appropriate) with a means to make contact with healthcare professionals in the practice to address urgent needs regardless of the time of day or day of week.

Continuity of care must be provided with a designated member of the care team with whom the patient can schedule successive routine appointments.

COMPREHENSIVE CARE MANAGEMENT

Care management for chronic conditions must include:

- Systematic assessment of the patient's medical, functional, and psychosocial needs
- System-based approaches to ensure timely receipt of all recommended preventive care services
- Medication reconciliation with review of adherence and potential interactions
- Oversight of patient self-management of medications

COMPREHENSIVE CARE PLAN

At the core of the CCM program, physicians must maintain a regularly updated, person-centered, electronic care plan. It must:

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- Be created, revised, and/or monitored
- Be based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment of the patient
- Include all health issues, with particular focus on the chronic conditions being managed
- Include an inventory of resources and supports (for example, care planning tools and resources publicly available from a number of organizations, such as diabetes information from the American Diabetes Association)

The CCM provider must at least electronically capture care plan information and ensure the care plan can be shared electronically (as of 2017, this can include fax) in a timely manner with individuals involved in the patient's care. A copy of the care plan must be given to the patient and/or caregiver.

According to CMS, a comprehensive care plan for all health issues typically includes, but is not limited to, the elements shown in the graphic on the following page.

MAJOR ELEMENTS OF A COMPREHENSIVE CARE PLAN

Coordinated Care Is **Better Care**

Source: CMS

TRANSITIONAL CARE MANAGEMENT

There must be management of care transitions between and among all healthcare providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, and follow-up after discharges from hospitals, skilled nursing facilities, or other healthcare facilities. The CCM provider must create and exchange/transmit continuity of care documents in a timely manner with other practitioners and healthcare providers.

HOME- AND COMMUNITY-BASED CARE COORDINATION

Coordination with home- and community-based clinical service providers is required and communication to and from those providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record.

ENHANCED COMMUNICATION OPPORTUNITIES

This requirement is about making sure patients and any caregivers have enhanced opportunities for communicating with the practitioner regarding the patient's care. Telephone access is not enough. They must also be able to communicate through the use of secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal).

There must be management of care transitions between and among all healthcare providers and settings.

MEDICAL DECISION-MAKING

Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).

WHY CCM IS SO IMPORTANT

BECAUSE CHRONIC DISEASE IS A FORMIDABLE ENEMY

One of the primary reasons CCM is so important is that it helps all stakeholders in healthcare (patients, physicians, and payers alike) deal with the serious and costly problem of chronic disease.

The U.S. Department of Health and Human Services (HHS) defines chronic conditions as conditions "that last a year or more and require ongoing medical attention and/or limit activities of daily living." They include physical conditions such as type 2 diabetes, stroke, cancer, and heart disease, as well as "mental and cognitive disorders, such as ongoing depression, substance addiction, and dementia." [5]

According to the Centers for Disease Control and Prevention (CDC), chronic diseases and conditions are among the most common and costly of all health problems. They are also among the most preventable of all health problems; yet, they are the leading causes of death and disability in the U.S.[6]

[5] https://www.hhs.gov/ash/about-ash/multiple-chronic-conditions/about-mcc/index.html, accessed June 2017.

[6] https://www.cdc.gov/chronicdisease/overview/, accessed June 2017.

> CCM HELPS ALL STAKEHOLDERS IN HEALTHCARE DEAL WITH THE SERIOUS AND COSTLY PROBLEM OF CHRONIC DISEASE.

Chronic Disease in AMERICA

As many as 3 out of 4 persons **age 65 and older** have multiple chronic conditions

1 in 4 have two or more chronic conditions

7 out of 10 deaths each year in the U.S. are from chronic diseases

117 million U.S. adults have a chronic condition

Chronic disease costs **$2.9 trillion** annually to treat

99% of Medicare spending is on patients with chronic conditions

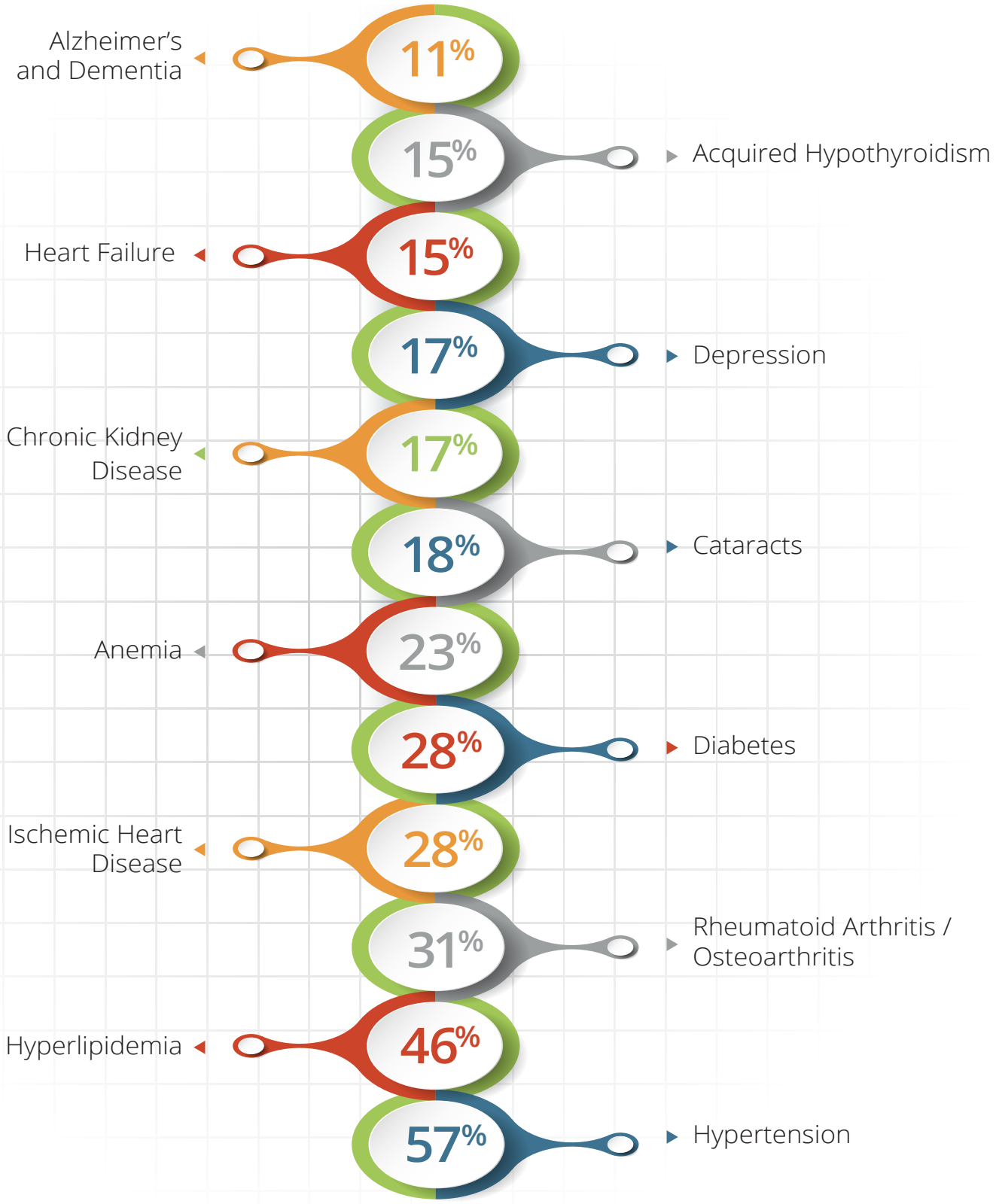
Chronic disease accounts for **86% of all healthcare** spending

66% of healthcare spending is for care of individuals with **multiple chronic conditions**

Sources: CMS, HHS, CDC

Common Chronic Conditions Among

MEDICARE PATIENTS



Source: CMS Chronic Condition Warehouse

BECAUSE OF THE PERSON BEHIND THE CHRONIC CONDITIONS

Individuals with multiple chronic conditions often need more support than they can get in the traditional office setting.

Individuals with multiple chronic conditions often need more support than they can get in the traditional office setting. The physical symptoms and mental frustrations associated with experiencing chronic conditions can be difficult enough to deal with. But, according to the HHS, individuals living with multiple chronic conditions[7]:

- Are at increased risk for mortality and poorer day-to-day functioning
- May have conditions that make them more susceptible to frailty and disability
- Can experience functional limitations that complicate access to healthcare, interfere with self-management, and create reliance on caregivers
- Face substantial out-of-pocket costs for their care, including higher costs for prescription drugs

In addition, as an individual's number of chronic conditions increases, so does their risk for hospitalizations that could have been avoided, receiving conflicting advice from healthcare providers, and even death.

They must also "rely on a healthcare system that is not designed to adequately assess and meet their complex care needs," as an HHS June 2015 report stated. They "usually require holistic healthcare that is not disease-specific, but instead addresses multiple health problems. However, current healthcare and research approaches focus on single diseases, and are often fragmented in relation to the complexity of care that is necessary" for those living with multiple chronic conditions. As a result, they "must balance care delivered by multiple providers, including numerous medications, often in the absence of coordination of care within and across settings."[8]

This brings us to another primary reason CCM is so important...

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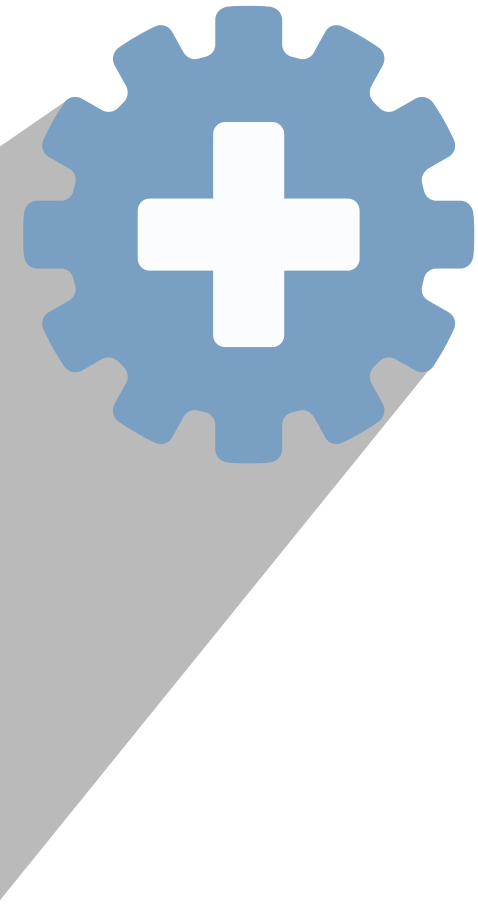
[7] About the Multiple Chronic Conditions Initiative, HHS, and Multiple Chronic Conditions: A Framework for Education and Training, HHS, accessed June 2017

[8] Multiple Chronic Conditions: A Framework for Education and Training, HHS

BECAUSE THE HEALTHCARE SYSTEM IS FRAGMENTED



It's hard to navigate care in a fragmented healthcare system. Individuals need support along their patient journey.

Between office visits, between different providers, or during transitions in care, patients are often navigating a fragmented healthcare system on their own. In turn, physicians miss out on vital information, having to rely on patients to tell them if they saw a different doctor, experienced an emergency, or started taking a new medication. These voids in communication, care, and guidance are often called the dark spaces in healthcare.

Care coordination, which is at the heart of Medicare's CCM program, helps shed light on these dark spaces. When practices choose a trusted partner to deliver CCM services on their behalf, their patients are no longer alone on their healthcare journey, and every stakeholder in healthcare stands to benefit from the results.

Patients know care coordinators will be there for them 24/7/365 to answer their questions, help them understand their conditions, and guide them every step of the way through the highs and lows of managing chronic disease.

Family members and caregivers can rest easier, knowing there is an additional source of support for the patient, better communication among all members of the care team, and genuine inclusion in the decision-making process.

Physicians gain access to each patient's full clinical picture and can feel confident knowing experienced care coordinators are reconciling medications, ensuring care plan adherence, and flagging them to areas of concern.

Practices experience a new revenue stream with minimal disruption to their workflow and benefit from achieving better health outcomes for patients and a greater ability to demonstrate value-based care.

BECAUSE CCM IS A POWERFUL SOLUTION

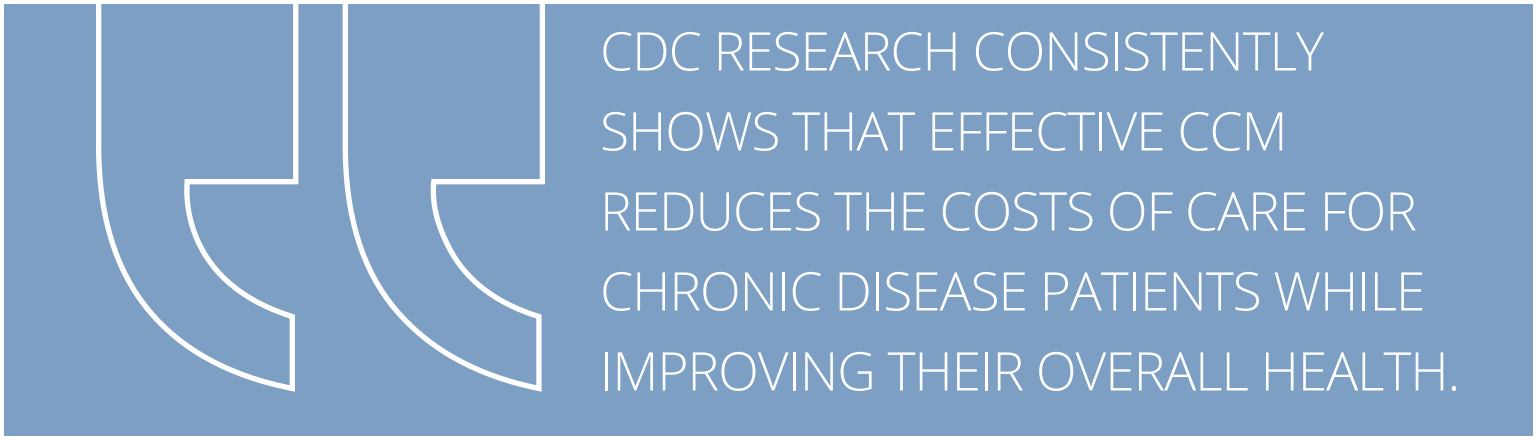
Indeed, chronic disease is a significant problem, but CCM helps to provide solutions.

CDC research consistently shows that effective CCM reduces the costs of care for chronic disease patients while improving their overall health. CMS has stated that CCM may help patients avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.[9] And a 2017 Health Intelligence Network survey of healthcare executives in healthcare companies with CCM programs found that two-thirds of respondents observed a drop in hospitalizations that they attributed to CCM and 92% reported improvements in healthcare quality as a result of CCM.[10]

In addition, CCM is about support. Having a care coordinator manage a patient's medical appointments, remind them to follow up on doctor's instructions, be there when they have a question or concern, find them a support group for emotional needs, or provide education about a condition that helps them manage it better can do wonders for someone who is struggling with an illness or feeling alone in doing so.

[9] Chronic Care Management Services, CMS, December 2016

[10] Top 2017 Chronic Care Management Modes and 13 More CCM Trends, Health Intelligence Network



A Full Care Coordination Strategy

CCM is only one piece of the care coordination puzzle. Other pieces, like Annual Wellness Visits, Transitional Care Management, and success with MACRA (MIPS or Advanced APM path) and CPC+ are all part of a larger goal of proactively managing chronic conditions before they become a bigger threat to patient and population health, and have a more costly impact on the U.S. economy.

It is a full care coordination strategy that Medicare has been advancing year after year, as it is critical to the success of achieving the "Triple Aim" of providing better care, lower costs, and improved health.

DID YOU KNOW

CCM services help practices generate revenue beyond what CCM codes provide. When done correctly, CCM provides contextual engagement with patients, collects important between-visit data, and can help spot potential concerns early. **This relationship-based and proactive approach to care helps to encourage patients to seek preventive care and drives patients back into the office and/or into the correct channels to address healthcare concerns as needed.** Additionally, with the industry's latest reimbursement models, there is tremendous value in the way CCM can improve patient satisfaction and health, which can lead to better quality and performance scores.

NOW IT'S YOUR TURN

Choose a trusted partner with the experience, resources, and proven capabilities to deliver CCM services on your behalf. With *Vital Health Links*, you get:

- Services delivered based on your preferences and protocols
- Medical records requested from all recent healthcare providers
- Seamless integration with your certified EHR
- Medication reconciliation and adherence
- Care plans that are specific to the patient, built from the provider's assessment and plan
- Increased patient engagement and follow through on referrals and tests
- Reporting on key quality metrics and identification of potential risk measures
- Proven enrollment tools and customized training
- Billing consultation and implementation support
- Care coordination solutions for Annual Wellness Visits, Cognitive Assessment and other programs
- Industry-leading patient retention
- The staff, capability, and scalability to deliver what we promise

Trust the leader in Chronic Care Management.

Contact *Vital Health Links* today to learn more.

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