What Chronic Care Management Success Looks Like in 2024

Today's Presenters

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Disclaimer

This presentation is for informational purposes only and does not constitute legal, billing, or other professional advice.

Billing and coding requirements – especially in the telehealth space – can change and be reinterpreted often. You should always consult a medical billing professional prior to submitting claims for services to ensure that all requirements are met.

Presentation Agenda

- Introduction to chronic care management (CCM)
- Medicare coverage of CCM in 2024
  - Coding and billing rules
  - Reimbursement rates and potential earnings
- Launching and scaling a successful CCM program
  - Patient enrollment and engagement
  - Tips for care manager success
  - Evaluating program impact
- Building a *comprehensive* care management program
- Key takeaways
- Q&A

Introduction to CCM

Introduction to Chronic Care Management (CCM)

What is CCM?

CCM services are generally non-face-to-face services provided to Medicare beneficiaries with **two or more** chronic conditions expected to last at least 12 months. CCM includes the **creation of a comprehensive care plan and providing ongoing health support services**.

Who provides CCM services?

Physicians, qualified health professionals (QHPs), and “clinical staff” can provide CCM services to patients. Clinical staff operate under general supervision of a physician or QHP and may include:

- Medical assistants
- Social workers
- Pharmacists
- Registered dieticians
- And more

Source: CMS

Common CCM-Qualifying Conditions

Some of the noteworthy qualifying conditions provided by the Centers for Medicare & Medicaid Services (CMS) include:

- Alzheimer's disease
- Anemia
- Arthritis
- Asthma
- Cancer
- COPD
- Diabetes
- HIV/AIDS
- Hypertension
- Hyperlipidemia
- Osteoporosis
- Parkinson's disease

How CCM Programs Work

1. Provider **identifies patients** to manage remotely and launches program to offer CCM services to them.
2. Provider **determines a patient is eligible** for and would benefit from CCM, and provider orders/prescribes CCM **with patient's consent after an initiating visit**.
3. Provider/care team creates **a comprehensive care plan** for patient that is used and updated over the course of care management activities.
4. Care managers **interact remotely with patient** to coordinate care, offer guidance, discuss progress on care plan goals, and more.
5. Time spent interacting with patient and on care management activities is **logged and billed** at the end of each month, assuming time thresholds are met.

Value of CCM to Patients and Providers

Patients:

- ✓ Improves access to care team, other resources
- ✓ Helps patients better manage medications, symptoms
- ✓ Saves money on hospitalizations and costlier, reactive treatments
- ✓ Encourages patients to take more active role in their health

Providers:

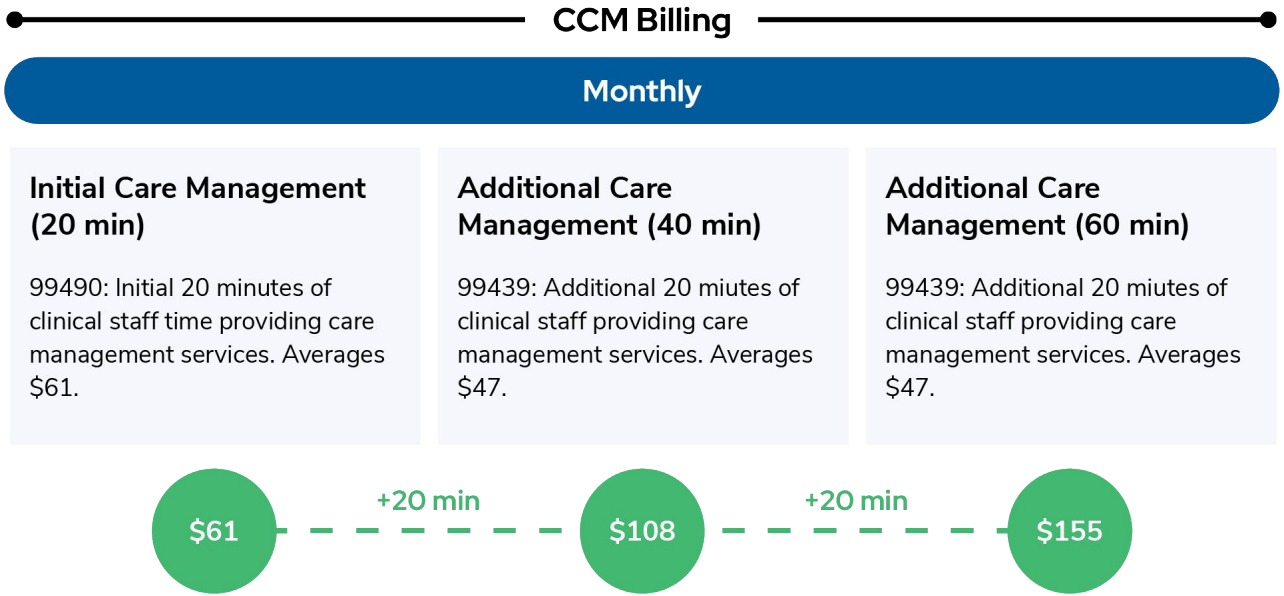
- ✓ Enables more comprehensive patient care
- ✓ Creates meaningful, recurring source of added revenue
- ✓ Builds patient loyalty, engagement
- ✓ Helps preserve in-office visits for patients who truly need them

Medicare Coverage of CCM

2024 CCM CPT Coding and Billing

CPT / HCPCS code	Description	2024 Non-Facility Reimbursement Rate
99437	Each additional 30 mins of physician/QHCP providing care management services	$58.62
99439	Each additional 20 mins of clinical staff providing care management services	$47.16
99490	Initial 20 mins of clinical staff time providing care management services	$61.57
99491	Initial 30 mins of physician/QHCP providing care management services	$83.18
G0511	[FQHC/RHC-only] At least 20 mins of providing care management services	$72.98

Potential CCM Revenue Per Patient Per Month in 2024



Potential CCM Program Annual Revenue

Assuming 20 minutes of care management time per patient per month, a CCM program could annually generate:

100 enrolled patients	X	$61 per patient per month	X	12 months	=	$73,200 annual revenue
300 enrolled patients	X	$61 per patient per month	X	12 months	=	$219,600 annual revenue
500 enrolled patients	X	$61 per patient per month	X	12 months	=	$366,000 annual revenue

Launching and Scaling a Healthy CCM Program

Identifying and Enrolling Patients

To determine whether a patient is eligible for a CCM program, these are the questions to consider:

- ☑ **Medicare-enrolled? Medicaid?** To enroll in a CCM program in most states, patients must be a Medicare beneficiary. In some states, Medicaid covers CCM.
- ☑ **Two chronic conditions?** Patients must have at least 2 documented chronic health conditions.
- ☑ **Initiating visit?** CMS requires an initiating visit for new patients or patients who the billing practitioner hasn't seen within the past year. Initiating visit can occur during comprehensive evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physician exam (IPPE). CCM *must* be discussed with the patient for the visit to qualify as "initiating."
- ☑ **Consent?** Patients must give written or verbal consent for CCM services before you bill for them. Medicare beneficiaries have the usual Medicare Part B cost sharing 20% if they lack supplemental insurance. Most Medicare-Medicaid dual eligible beneficiaries are exempt from cost sharing.

Securing Patient Buy-in and Setting Expectations

To set your CCM program up for success, it's essential that patients are bought in and know what to expect. Recommended steps during enrollment:

1. Explain **what** CCM is. Consider creating patient education material.

2. Explain **time commitment** associated with participation and nature of that time commitment (i.e., speaking with care managers on the phone).

3. Explain **cost** associated with participation. If the patient objects, explain cost relative to expensive hospital visits, procedures, etc., they might be able to avoid.

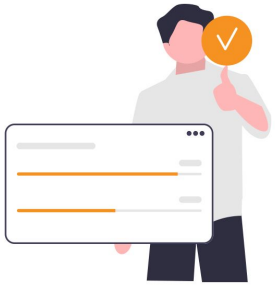
4. Explain **who** is going to be involved. This is a coordinated care team, not just their doctor.

5. Explain **value** of the program. These services will help keep them healthy, avoid adverse events, and navigate their care more easily (medications, specialist visits, etc.).

Patient Goal-Setting and Engagement

Maintaining patient engagement in your CCM program is not always easy. Some ways to keep patients on track and active in your program:

1. Set **SMART goals** that are specific, measurable, attainable, relevant, and timely.
    - Include patients in your goal setting!
2. Encourage patient **self-monitoring** (e.g., patients keep a journal of progress on a goal).
3. Consider using **Motivational Interviewing** techniques, which have proven to be effective at promoting behavior change.
4. Maintain **consistent communication**, preferably with the same care manager or small group of care managers to establish meaningful bonds.
5. **Celebrate successes** – big or small – and continuously remind patients *why* they're participating in the program.



Program Management and Staffing

Medicare allows CCM to be outsourced under general supervision.

1. **Insourcing:** oversee all care management patients internally
    - Full share of reimbursement, largest required workload
2. **Outsourcing:** hire a third party to oversee all care management patients on your behalf
    - May share in reimbursement, lowest required workload
3. **Hybrid:** share responsibilities between internal and third-party resources
    - Trade-off between reimbursement and workload. Share reimbursement potential and responsibilities with your partner of choice.

Setting Up Care Managers for Success

Effective and efficient care managers are critical to healthy CCM programs. Ways to ensure your care managers are set up for success:

1. **Educate** care managers on conditions and social determinants of health they may encounter.
2. Establish and train on **easy-to-follow** care plan templates, disease state protocols, and call scripts. Ensure care managers understand escalation criteria and processes.
3. Provide **technology tools** for easy documentation and logging of time spent on care management activities.
4. Closely **monitor staff workload** and ensure each care manager has a patient panel they can realistically manage.
5. Consider offering **incentives** tied to productivity and/or effectivity so care managers share in program success.

Measuring Program Success

There are 5 pillars to program success that we will touch on. Specifics of what these will look like will vary by organization and patient population, but understanding and tracking these tenants is paramount.

- Compliance
- Patient Satisfaction
- Financial
- Productivity
- Clinical Outcomes

Measuring Program Success: Patients

Definition of CCM program “success” may vary based on your specialty, patient panel, and other factors. Some key performance indicators we look at are:

Compliance

☑️ *% of enrolled patients billable each month*

Target: 90%

☑️ *Identify non-compliant patients regularly, maintain internal protocols for program dismissal when necessary.*

Satisfaction

☑️ *Average satisfaction rate of patients*

Target: 80%

☑️ *Patient attrition rate*

Target: 15%

☑️ *Average program duration*

Target: Varies by population and program goals

Clinical Outcomes

☑️ *Care plan adherence and goal completion*

☑️ *# of doctor visits/hospitalizations related to acute exacerbations*

☑️ *Changes in core lab or vital sign values over time*

Target: Varies by individual

Measuring Program Success: Operational/Financial

Definition of CCM program “success” may vary based on your specialty, patient panel, and other factors. Some key performance indicators we look at are:

Financial

☑️ *% of enrolled patients billable each month*

Target: 90%

Productivity

☑️ *% of care manager hours worked spent on reimbursable activities*

Target: 80%

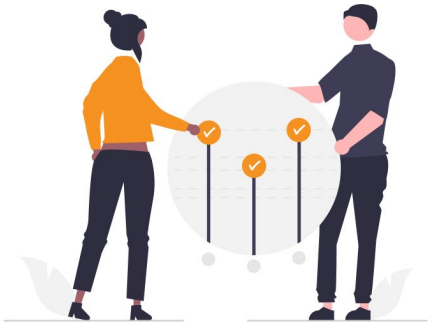
Clinical Outcomes

☑️ *Hospitalization rate for enrolled patients*

☑️ *# of enrolled patient doctor visits related to acute exacerbations*

☑️ *Medication adherence rate*

Target: Varies by organization

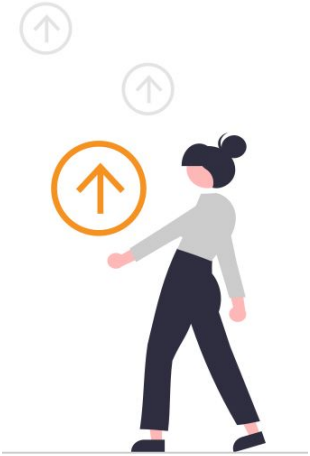


Building a *Comprehensive* Care Management Program

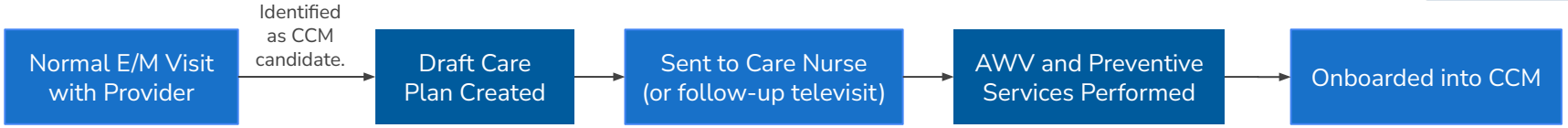
Enhancing Initiating Visits

Before CCM services can start, an “initiating visit” is required. This can be any comprehensive E/M visit or an AWV in the last year.

- Initiating visit is an opportunity to make sure the patient is fully aware of the program and what their obligations and care plan will entail.
  - Setting patient expectations can make or break a program.
  - Initiating visit is a separately billable event from the CCM program.
- Most CCM programs just check to see if the patient was seen in the last year and then get consent and onboard the care plan separately.
  - This can be a missed opportunity.
- Setting up an appropriate CCM initiating visit and onboarding workflow can create stronger programs, give care managers a broader view of the patient, and increase practice revenue.



Example Initiating Visit Workflow



Above is a sample CCM-only onboarding workflow that incorporates care plan creation (G0506), an AWV (G0439), and preventive services.

- Preventives may include social determinants of health assessment (G0136), alcohol screening (G0442), cardio risk counseling (G0446), depression screening (G0444), tobacco counseling (99406), obesity counseling (G0447), advance care planning (99497), and more.

There are a lot of benefits to a robust onboarding process.

- Provides a comprehensive view of the patient's conditions, environment, and social determinants of health.
- Increases patient understanding, buy-in, and compliance.
- Adds new practice revenue and can factor positively into value-based care measures.
  - Assuming only 3 needed preventive services from above, ~$245 additional revenue over the E/M visit.

Expanding within CCM Services

- Majority of current programs focus solely on clinical staff-performed traditional CCM under the 99490 and 99439.

- Adding the capability and documentation needed to also include provider time CCM and complex CCM allows practices to bill for different units of care time spent and to get paid for CCM provider time when needed.

- Example: A patient on CCM has a rough month. Normally, only clinical staff provide care management, but this month the provider was looped in. There ended up being 31 minutes total care management time spent.
  - If your workflow and system tracks things appropriately, this would generate a 99491 (~$83)
  - Many (most) programs would just bill this as a single 99490 (~$61)

- Majority of patients will get a 99490 each month in the majority of programs, but being able to track outliers and bill them appropriately encourages physician participation when needed and leads to more accurate coding with higher reimbursement.

Expansion to other Care Management Services

Medicare has created multiple new care management services since introducing the original CCM codeset in 2015. For context, this is an abbreviated timeline:

- 2017: Adds complex CCM (99487/9)
- 2018: Adds behavioral health integration (99484)
- 2019: Adds remote physiological monitoring (99454/7)
- 2020: Adds principal care management (99426/7)
- 2021: Adds remote therapeutic monitoring (multiple)

Each year since 2016, there has been a new care management service introduced, a major update to an existing one, or both.

Despite all the new services and specialized codes, most programs still focus exclusively on the original CCM clinical staff service.

Common Care Management Services

- ✓ Remote patient monitoring
- ✓ Remote therapeutic monitoring
- ✓ Chronic care management
- ✓ Principal care management
- ✓ Behavioral health integration
- ✓ Chronic pain management
- ✓ Community health integration - *new for 2024*
- ✓ Principal illness navigation - *new for 2024*

Common Service Combinations

Patient who qualifies for CCM may also qualify (and get benefit from) other concurrent care management services:

- CCM + remote physiologic monitoring (RPM)
  - CCM patients with a condition where vital measurement tracking would be beneficial.
- CCM + behavioral health integration (BHI)
  - CCM patients with a behavioral or mental health condition use a validated rating scale to track their condition concurrently with CCM.
- CCM + remote therapeutic management (RTM)
  - CCM patients with an RTM-eligible condition can be given a connected device to track non-physiologic measurements.

Other services might be replacements for CCM when specific criteria are met:

- Principal care management
  - In an otherwise CCM-only program, patients with only one chronic condition or who are getting CCM from another provider are often eligible for PCM.

Adding Remote Patient Monitoring

What is RPM?

Remote patient monitoring, or “remote physiologic monitoring,” services include the **collection of data from connected patient devices**, like blood pressure monitors, that is **electronically transmitted to providers** for oversight and reference in care management activities. RPM is Medicare-reimbursable and supported by a growing list of state Medicaid and commercial payers.

Adding RPM to CCM

- Example Patient 1: Has primary hypertension and obesity
  - Enrolled into CCM for longitudinal management of both conditions.
  - Given a connected blood pressure monitor for an initial 3 months of medication titration with a medium-intensity notification protocol.
  - After 3 months, continues to take blood pressure with lower-intensity protocol. Care management moves from a focus on blood pressure monitoring to diet, exercise, and social determinants of health.

- Example Patient 2: Has controlled hypertension, apnea, and obesity.
  - Initially enrolled solely into CCM.
  - After 4 months, determined that medical weight loss would benefit the apnea/patient wellbeing.
  - As part of the care management plan with exercise and diet changes, a connected weight scale is ordered for the patient. If the patient has a Fitbit or Apple watch, the data is connected to the program as well.
  - Care management team uses the physiologic data from the weight scale and Fitbit to monitor and encourage progress.

CCM and RPM Together

Historical CPT 99490 (CCM) reimbursement:

2022: $64.02

↓

2023: $62.69

↓

2024: $61.57

↓

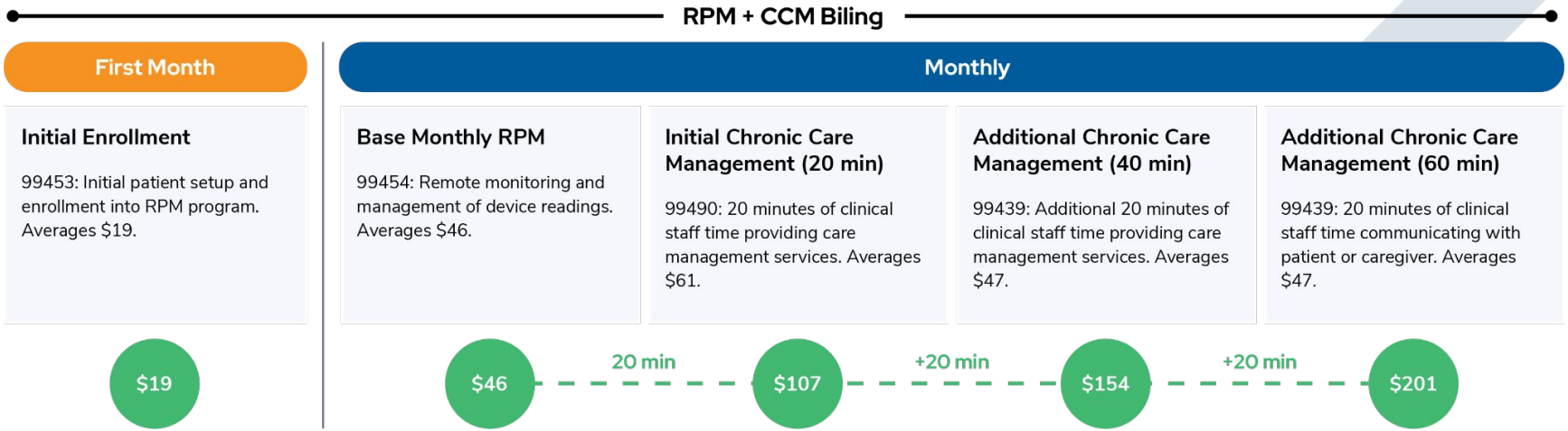
2025: ???

Patient with two or more chronic conditions could be enrolled in a “dual” RPM and CCM program (i.e., comprehensive care management program). Practice provides the patient with an at-home device, creates a comprehensive care plan, and offers ongoing CCM support – enabling more comprehensive care.

2024 RPM Coding and Billing:

CPT / HCPCS code	Description	2024 Non-Facility Reimbursement Rate
99453	Initial patient setup and enrollment into RPM program	$19.65
99454	Remote monitoring and management of device readings	$46.50
G0511	[FQHC/RHC-only] Remote monitoring and management of device readings	$72.98

CCM + RPM Billing Flow



CCM + RPM Revenue Example

	CCM-only ($46 x 12 months)	RPM + CCM ($107 x 12 months)
100 enrolled patients	$73,200 annual revenue	$128,400 annual revenue
300 enrolled patients	$219,600 annual revenue	$385,200 annual revenue
500 enrolled patients	$366,000 annual revenue	$642,000 annual revenue

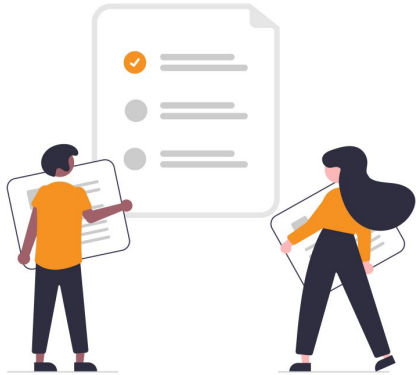
Key Takeaways

CCM Works for Providers, Practices, and Patients

1. Effective CCM programs help **keep patients healthy** and **generate meaningful, sustainable revenue**.

2. Ensuring care managers are **trained and well-supported** is critical to program success.

3. **Adding RPM to an existing CCM program** can help your organization provide more comprehensive patient care while adding significant reimbursement opportunities.



Q & A

Thank you