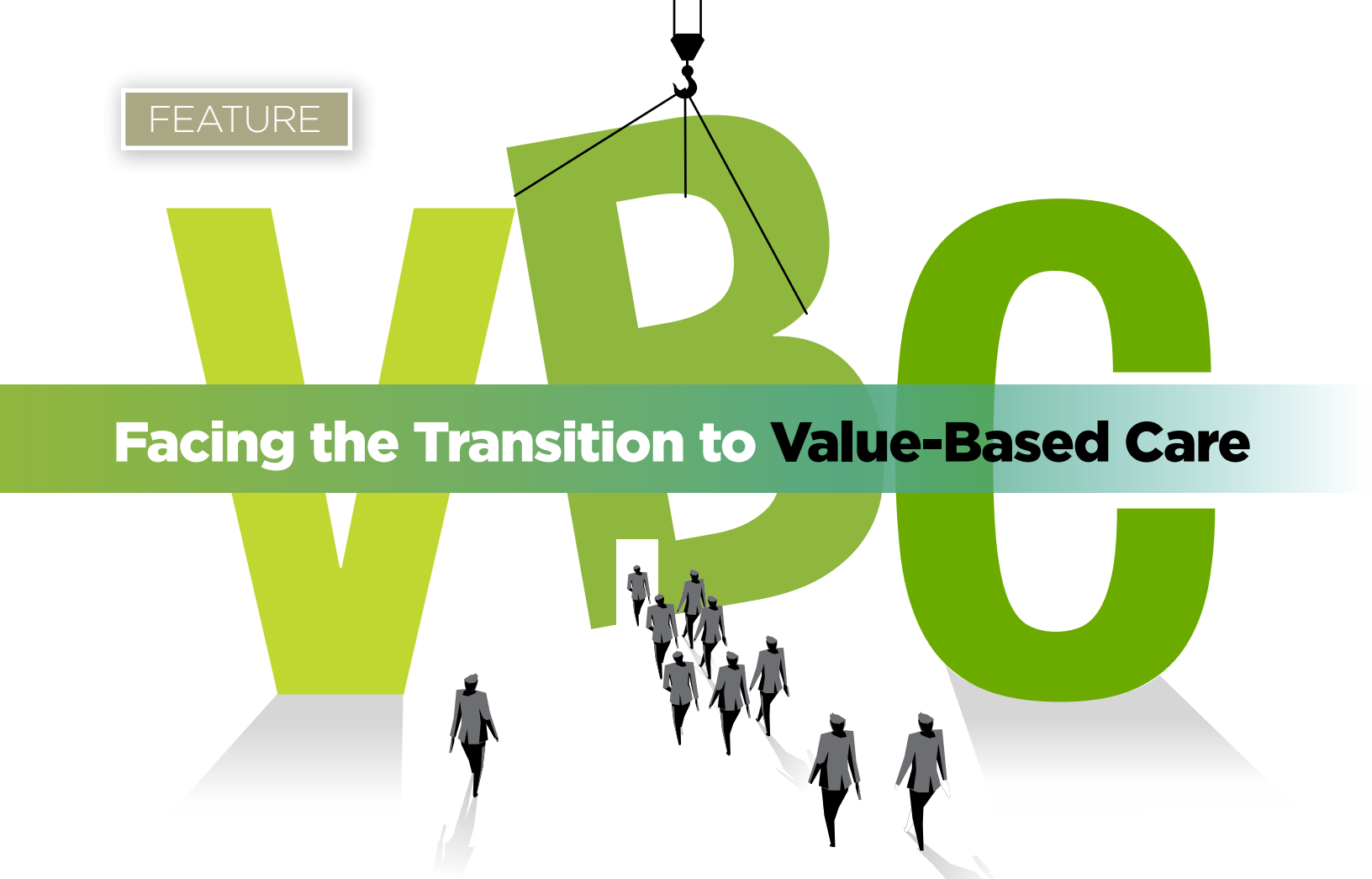
FEATURE

Facing the Transition to Value-Based Care



Transformation continues in health care as Value-Based Care (VBC) is gradually superseding the fragmented and costly fee-for-service care model. Both government and commercial programs are demonstrating that the VBC quality-driven approach can reduce costs, improve outcomes and enhance patient satisfaction. New incentives for preventive care, early intervention and care continuity are permanently altering the way medicine is practiced and paid for.

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

The new reimbursement code reflects an acknowledgment by CMS that compensation for the chronic care management (CCM) duties central to the new delivery models, like accountable care, are not included in traditional fee-for-service payments.

A path forward

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

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

The burden of chronic illness

Chronic diseases – defined as long-lasting conditions that can be controlled but not cured – cast an enormous shadow across the U.S. health system. About half of all adults, or 117 million people, had one or more chronic health conditions in 2012, and about 25 percent had two or more chronic conditions, per the Centers for Disease Control and Prevention (CDC).[2] Among Medicare beneficiaries, 68 percent have two or more chronic conditions and 36 percent have four or more chronic conditions.[3]

Seven of the top ten causes of death in 2010 were chronic diseases, according to the CDC, while two of these — heart disease and cancer — together accounted for nearly half of all deaths.[4] Almost 50 percent of adults have diabetes or prediabetes, and approximately 71,000 die annually from complications associated with the illness.[5] All told, chronic disease is responsible for about 1.7 million deaths each year in the U.S.[6] Within the Medicare program, beneficiaries with multiple chronic conditions accounted for 93 percent of spending and 98 percent of all hospital readmissions.[7]

CMS broadly identifies chronic diseases as including, but not limited to: Alzheimer's disease, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, chronic obstructive pulmonary disease, depression, diabetes, heart failure, hypertension, ischemic heart disease and osteoporosis.[8]

Driving patient engagement

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

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

A survey by the Healthcare Intelligence Network of 119 provider organizations found that 75 percent believed CCM programs have improved self-management levels in enrolled patients, and almost half — 46 percent — indicated that CCM has decreased hospitalizations in the populations served by the programs.

The CCM code, CPT 99490, is Medicare's first Physician Fee Schedule payment for non-face-to-face care coordination and management services. Among the program's key requirements:[9]

- **Practitioner Eligibility**— Clinical participants can include primary care physicians, as well as specialists, nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives.
- **Patient Eligibility**— Participating patients must have:
  - Multiple (two or more) chronic conditions that are expected to last at least 12 months or until the death of the patient.
  - Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline.
- **Patient Agreement Requirements** — A practitioner must inform eligible patients of the availability of the CCM services and obtain consent before furnishing or billing for the service.
- **Practitioner Scope of Service Elements** — Highlights include a patient care plan, 20 minutes of clinical staff time per month, 24-hour access to care management services.

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

CONTINUED NEXT PAGE

CONTINUED FROM PREVIOUS PAGE

Bandwidth is an enormous challenge. Between fulfilling the requirements of the CMS Merit-based Payment System (MIPS) program and meeting the day-to-day obligations of clinical documentation, coding and revenue cycle management, most are at capacity when it comes to juggling regulatory and administrative responsibilities. Practices that elect to seek reimbursement for the CCM 99490 code need to think about resource allocation and how best to accomplish the range of duties associated with managing eligible populations.

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

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

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

The decision about whether to support CCM in-house ultimately turns on two questions: Would it be profitable to do so, and if the in-house option is pursued, can the practice be assured that all compliance requirements will be consistently and appropriately met?

Outsourcing through a qualified vendor can alleviate many time demands the program imposes on practitioners. An outsourcing vendor can aid with most of the intermediate and ongoing steps required to satisfy CCM's requirements. This includes the 20-minute per patient per month consults via telephone. Options vary, but a qualified vendor should be able to offer a full spectrum of services, some of which must be conducted or provided by a trained clinician.

A bridge to the future

It is important to note that CMS' requirements for managed chronic conditions are similar to the obligations associated with the Patient-Centered Medical Home (PCMH). However, the approximately $40 monthly CCM payment is substantially more than most PCMH initiatives offer, according to a recent article in the *New England Journal of Medicine*.

This opportunity should encourage those who are looking for staffing efficiencies and those who have invested in PCMH infrastructure but are struggling to maintain it.

CCM is not an endpoint but merely a step in the journey toward a more rational, efficient and effective health care system. In the years ahead, as new features, requirements and incentives are added to the chronic care code and value-based care generally, those who are already participating will have an advantage over those who are not. ◆

---

[1] Samuel T. Edwards, Bruce E. Landon, "Medicare's Chronic Care Management Payment – Physician Reform for Primary Care," New England Journal of Medicine, Nov. 27, 2014, http://www.nejm.org/doi/full/10.1056/NEJMp1410790

[2] "Chronic Disease Overview," Centers for Disease Control and Prevention, Aug. 26, 2015, http://www.cdc.gov/chronicdisease/overview/index.htm

[3] Kimberly A. Lochner, Christine S. Cox, "Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010," Preventing Chronic Disease, Vol. 10, April 25, 2013, http://www.cdc.gov/pcd/issues/2013/12_0137.htm

[4] "Chronic Disease Overview," Centers for Disease Control and Prevention, Aug. 26, 2015, http://www.cdc.gov/chronicdisease/overview/index.htm

[5] Robert Glatter, "Half of Adults in the U.S. Have Diabetes or Pre-Diabetes, Study Finds," Forbes, Sept. 8, 2015, http://www.forbes.com/sites/robertglatter/2015/09/08/50-percent-of-adults-in-u-s-have-diabetes-or-pre-diabetes-study-finds/

[6] "What is Chronic Disease?," fact sheet, University of Michigan Center for Managing Chronic Disease, 2011, http://cmcd.sph.umich.edu/what-is-chronic-disease.html

[7] "Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition," Centers for Medicare & Medicaid Services, https://www.cms.gov/ 1 Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/2012ChartBook.html

[8] "Chronic Care Management Services," Medicare Learning Network, Centers for Medicare & Medicaid Services, 2014, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ ChronicCareManagement.pdf

[9] "Chronic Care Management Services," Medicare Learning Network, Centers for Medicare & Medicaid Services, 2014, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ ChronicCareManagement.pdf