CCM AND TCM: IT'S A WIN-WIN

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Today's Presenters

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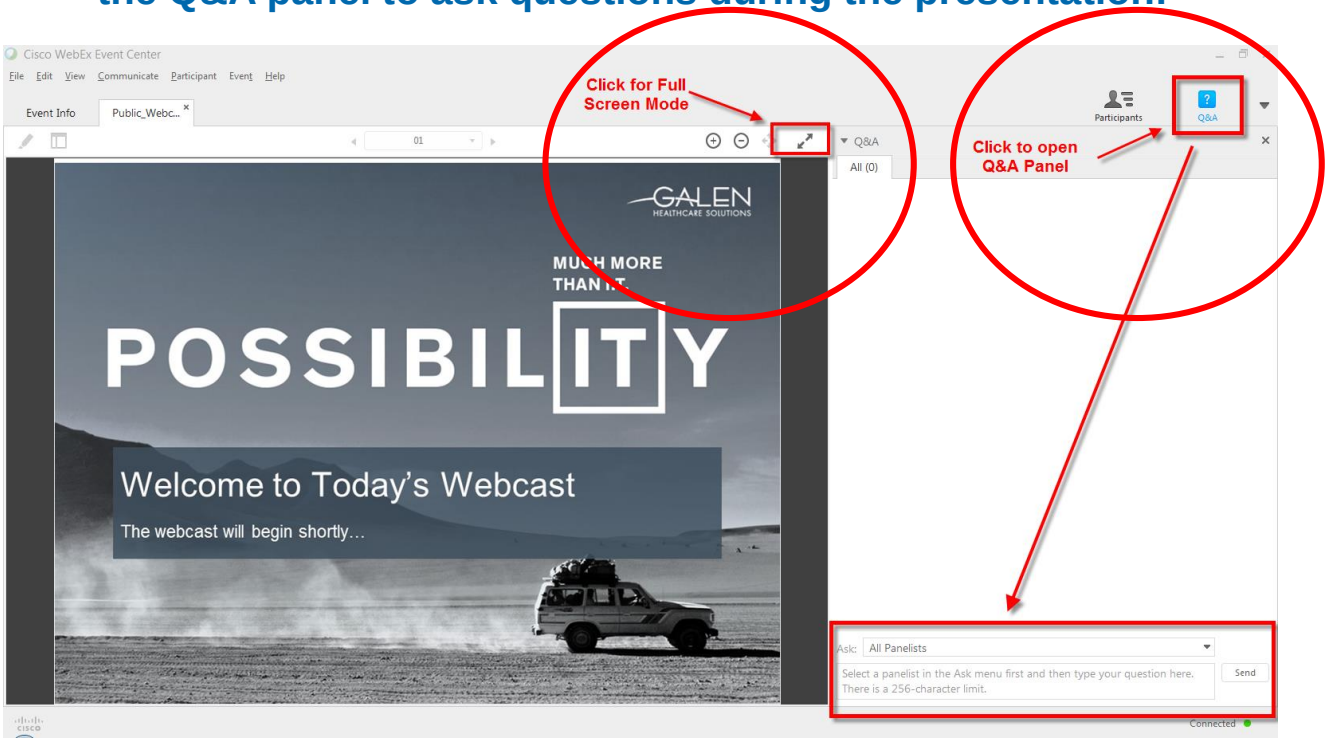
Your phone has been automatically muted. Please use the Q&A panel to ask questions during the presentation!



Chronic Care Management (CCM) and Transitional Care Management (TCM) Programs

- Why is it important?
- What is it?
- How to do it?

"To date, CMS has acknowledged only about 100,000 claims for eligible beneficiaries out of a pool of upwards of 35 million eligible (0.29%)."

100,000

35,000,000

TCM

- Why is it important?

Organizations can bill **99495** or **99496** (CPT code) to increase quality patient care post discharge from inpatient care settings.

Goal to decrease inpatient re-admissions!

TCM

Why is it important?

Revenue potential

E/M Coder versus **TCM Code**

50% more potential revenue

TCM

What is it?

Within initial 30 days post discharge

- ✓Patient contact within 2 business days of discharge
- ✓Non-face-to-face services (review of discharge instructions, care coordination)
- ✓Follow up appointment within 7 or 14 days

Support staff non-face-to-face services

Communication with patient, caregiver, with other community services utilized by the patient

Education provided to the patient or family

Assessment and support for treatment regimen and medication management

Identification of available community and health resources and facilitating access to those resources needed by the patient and/or family

Physician non-face-to-face services

Reviewing discharge information

Reviewing/Follow Up on pending diagnostic tests and treatments

Interaction with other qualified health care professionals

Education of patient, family, guardian and/or caregiver

Referrals and arrangement of needed community resources

Required follow-up with community providers and services

CCM

- Why is it important?

As of 1/1/15, organizations can bill **99490** (CPT code) for non-face-to-face time to Medicare beneficiaries with 2 or more chronic diseases.

Total = $42.50*/month per patient

CCM

What is it?

- ✓ **2 or more chronic conditions** expected to last at least 12 months
- ✓ **20 minutes** of clinical staff time per month under direction of provider
- ✓ Chronic conditions placing a patient at risk (death, exacerbation, or functional decline)
- ✓ **Comprehensive care plan** developed, reviewed, and monitored
- ✓ **Provided under general supervision**

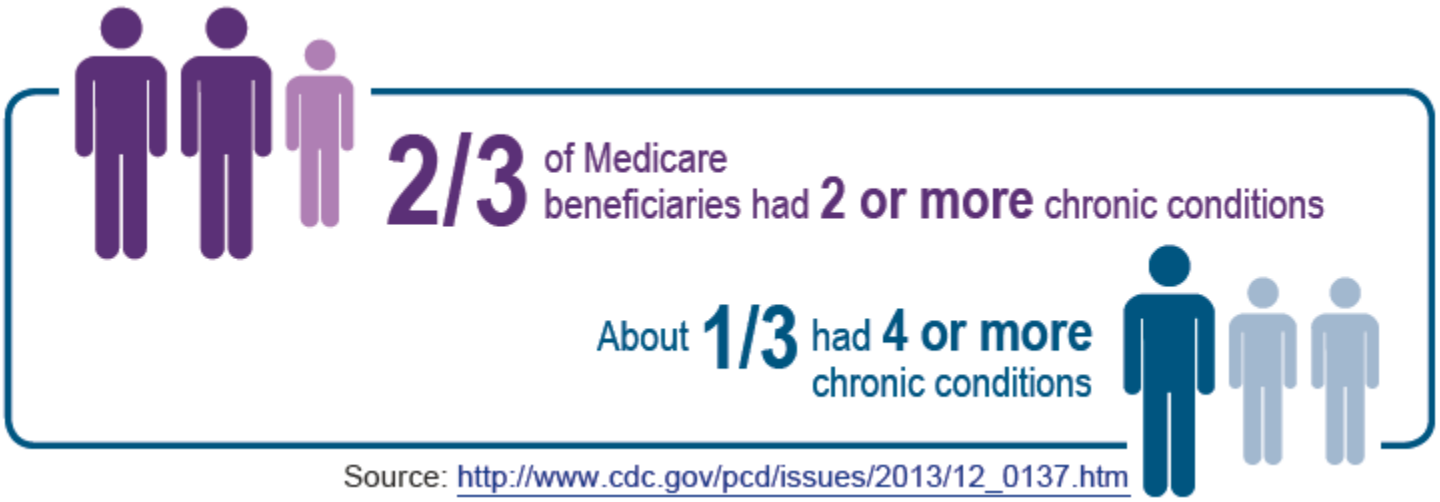
CCM

- ✓ **Patient Signed Consent**
- ✓ **1 provider per patient** can claim the CCM program enrollment
- ✓ **Primary or Specialty** care can utilize program
- ✓ **EHR used must be MU-certified**
- ✓ **24/7 access required**

Billable Services

- ✓ **Health Coaching**
- ✓ **Care Coordination/Referrals**
- ✓ **Medication Management**
- ✓ **Providing Education**

CCM



CCM- Chronic Condition Examples

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorders
- Cancer
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Ischemic Heart Disease
- Osteoporosis

CCM

Reimbursement single provider

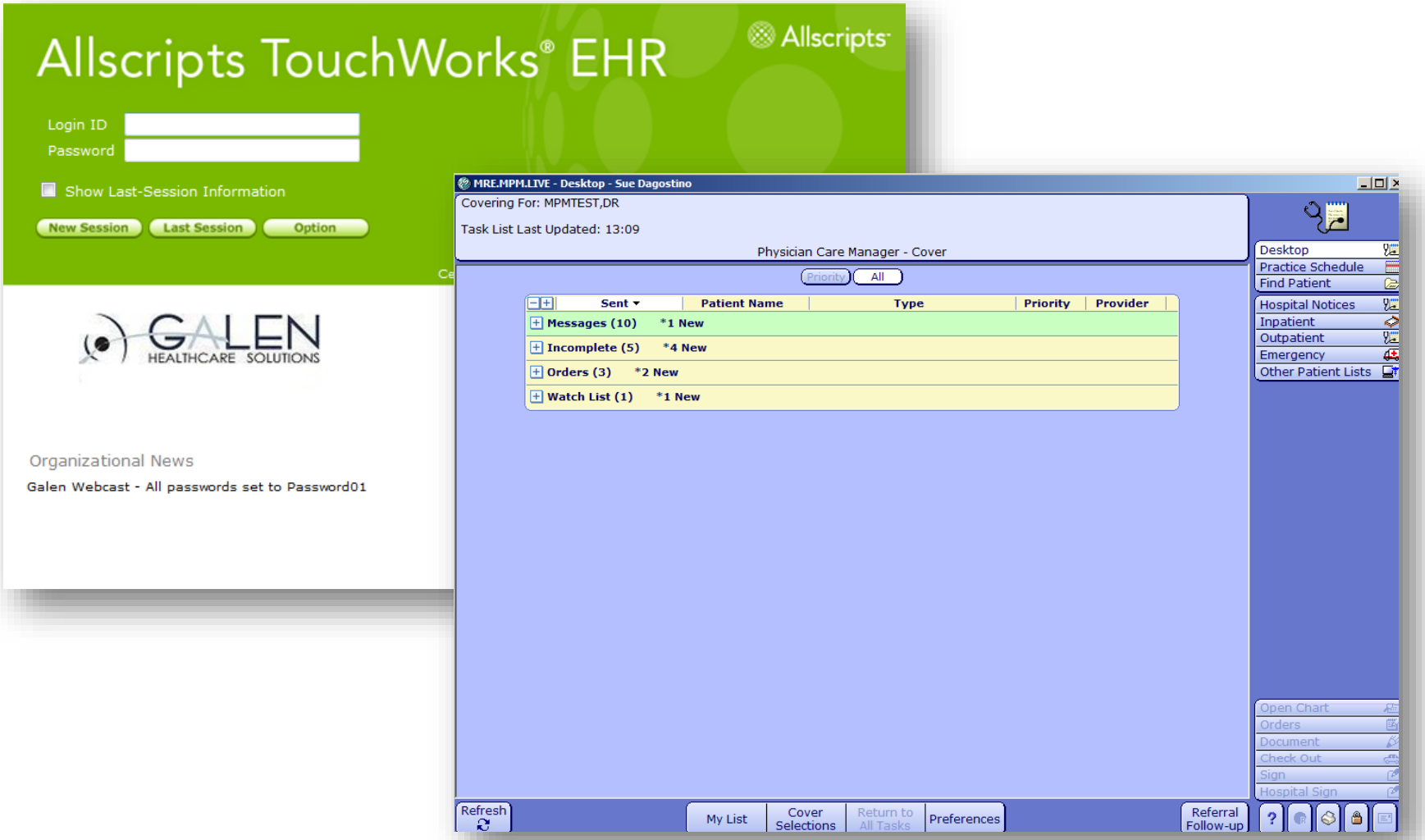
- Patient population = 2,500 patients
- 30% of this total population is Medicare = 750 patients
- 70% of Medicare are fee-for-service (FFS) = 525 patients
- 70% of this FFS group have 2 or more conditions = 368 patients
- 75% of patients consent to participate = 276 patients
- Each patient can be billed 1x each month = $42
- Monthly recurring revenue per physician for 276 patients = $11,596

Annual revenue per physician = $139,104

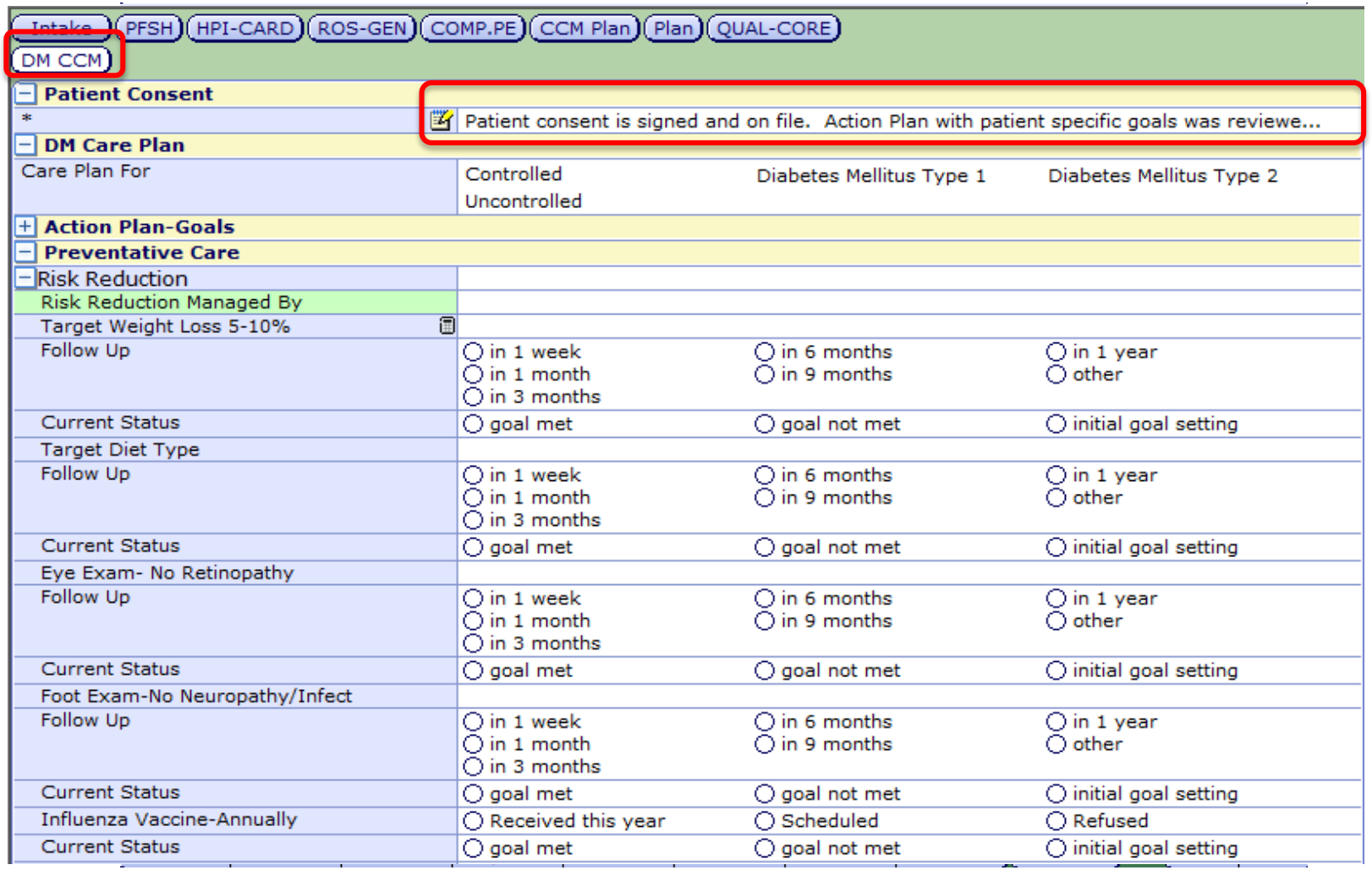
If a group has 100 physicians, annual revenue would total $13,910,400.

CCM/TCM strategies

- Assessment of patient population and gap analysis of CCM/TCM program requirements
- Develop of CCM/TCM program processes
- Configuration of all CCM/TCM workflows/set up
- Training to provider/clinical staff
- Implementation of CCM/TCM program



CCM Care Plan Examples



Intake | PFSH | HPI-CARD | ROS-GEN | COMP.PE | CCM Plan | Plan | QUAL-CORE

DM CCM

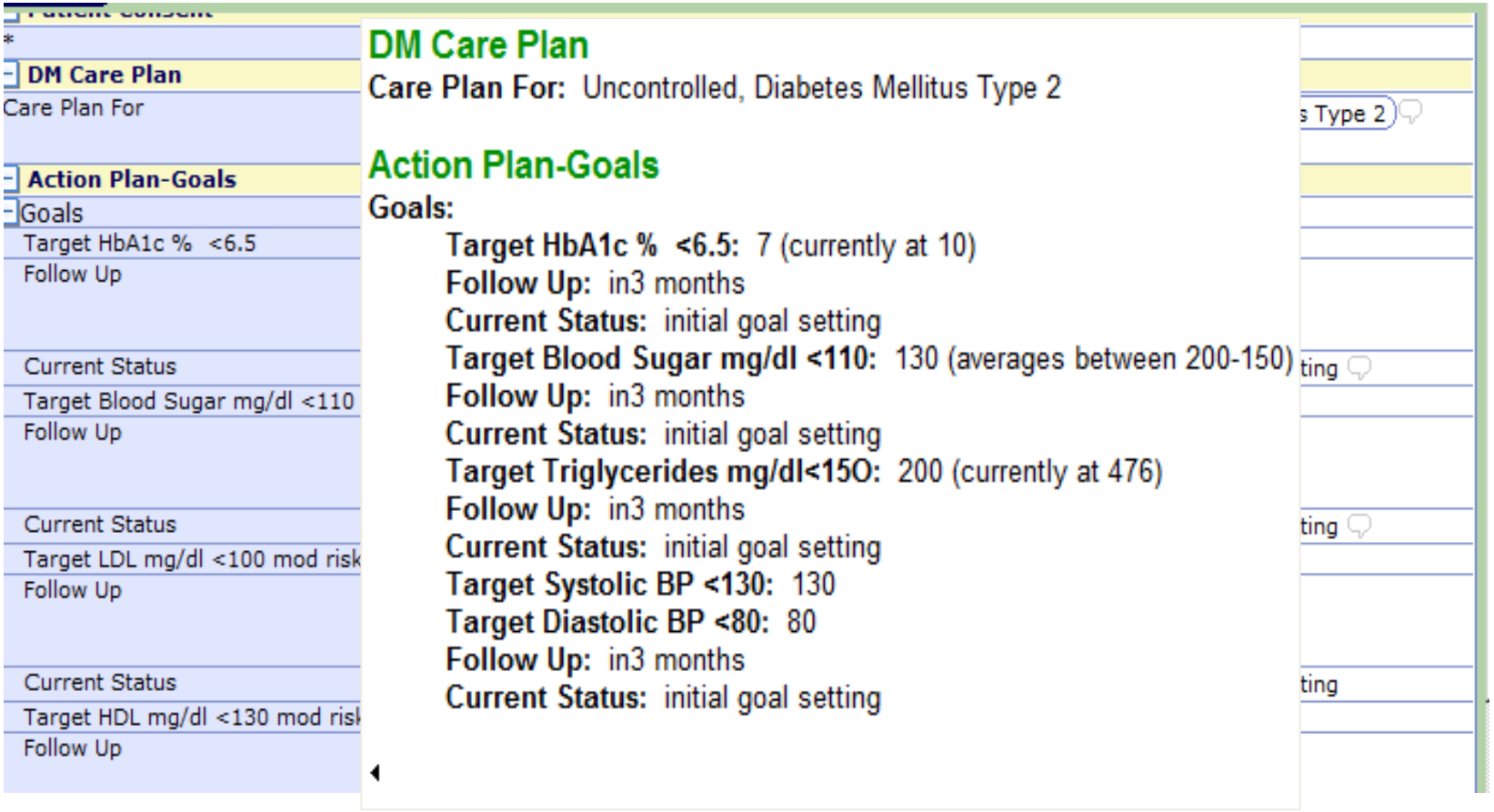
Patient Consent

* Patient consent is signed and on file. Action Plan with patient specific goals was reviewe...

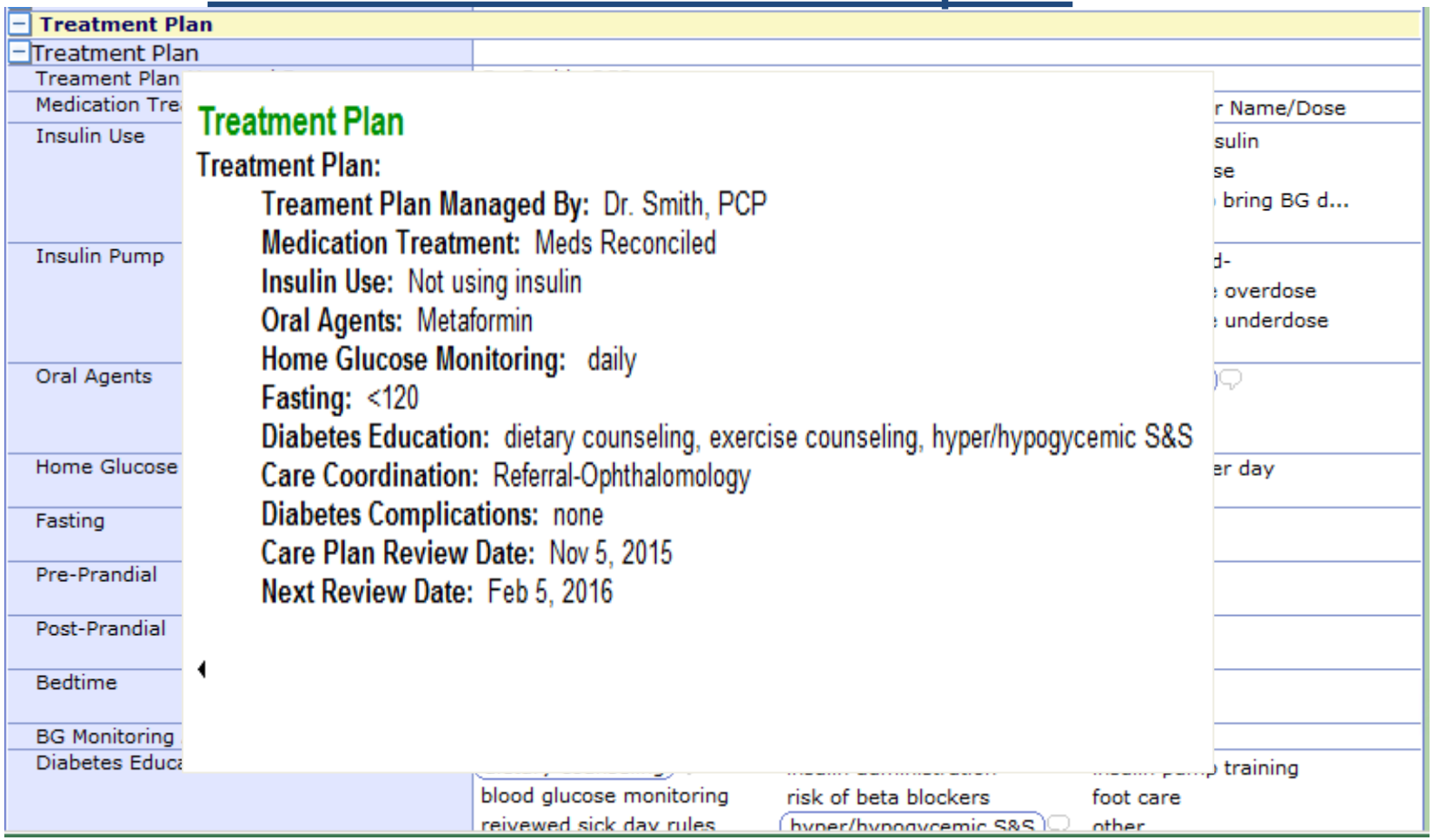
DM Care Plan

Care Plan For	Controlled Uncontrolled	Diabetes Mellitus Type 1	Diabetes Mellitus Type 2
Action Plan-Goals			
Preventative Care			
Risk Reduction			
Risk Reduction Managed By			
Target Weight Loss 5-10%			
Follow Up	◯ in 1 week ◯ in 1 month ◯ in 3 months	◯ in 6 months ◯ in 9 months	◯ in 1 year ◯ other
Current Status	◯ goal met	◯ goal not met	◯ initial goal setting
Target Diet Type			
Follow Up	◯ in 1 week ◯ in 1 month ◯ in 3 months	◯ in 6 months ◯ in 9 months	◯ in 1 year ◯ other
Current Status	◯ goal met	◯ goal not met	◯ initial goal setting
Eye Exam- No Retinopathy			
Follow Up	◯ in 1 week ◯ in 1 month ◯ in 3 months	◯ in 6 months ◯ in 9 months	◯ in 1 year ◯ other
Current Status	◯ goal met	◯ goal not met	◯ initial goal setting
Foot Exam-No Neuropathy/Infect			
Follow Up	◯ in 1 week ◯ in 1 month ◯ in 3 months	◯ in 6 months ◯ in 9 months	◯ in 1 year ◯ other
Current Status	◯ goal met	◯ goal not met	◯ initial goal setting
Influenza Vaccine-Annually	◯ Received this year	◯ Scheduled	◯ Refused
Current Status	◯ goal met	◯ goal not met	◯ initial goal setting

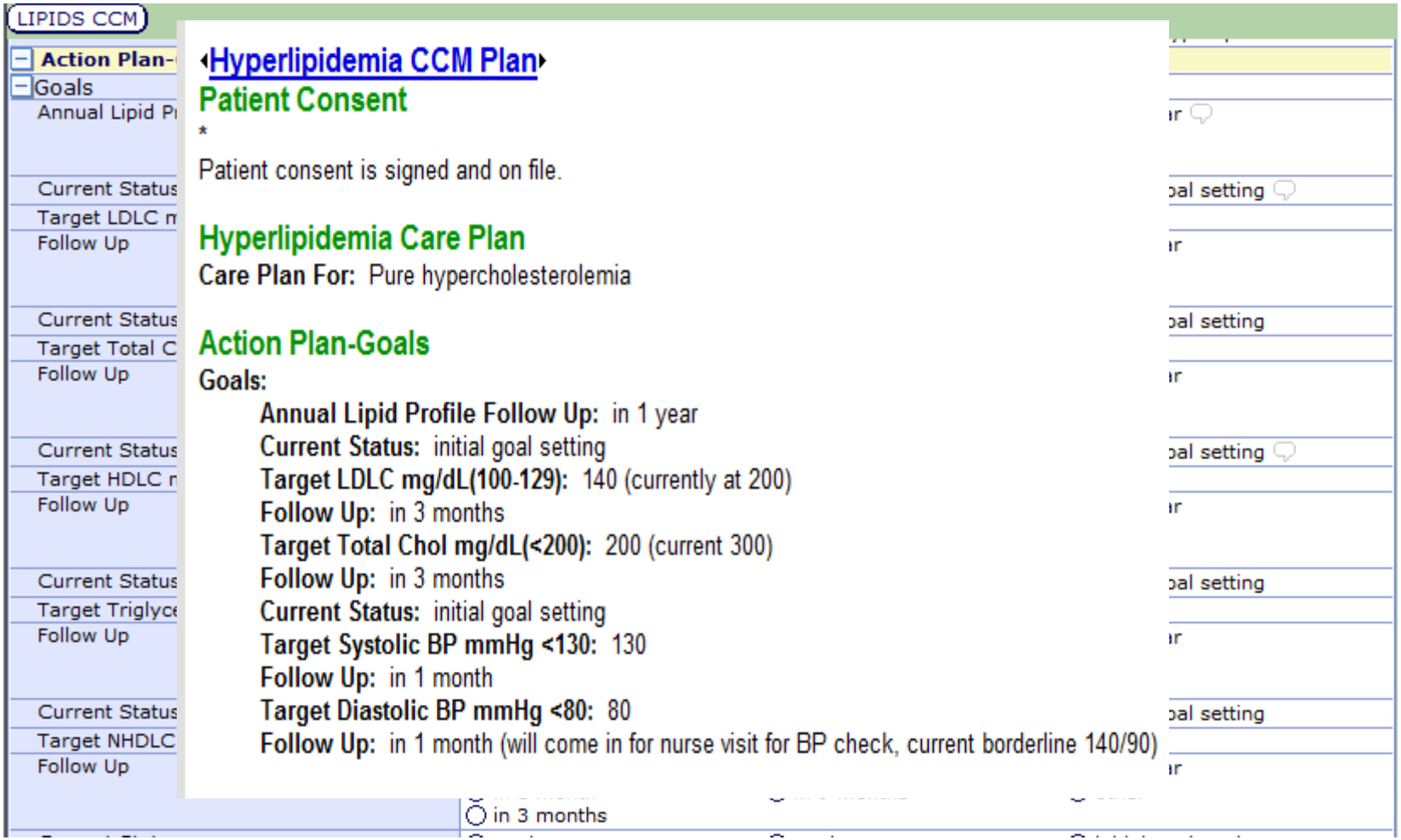
CCM Care Plan Examples



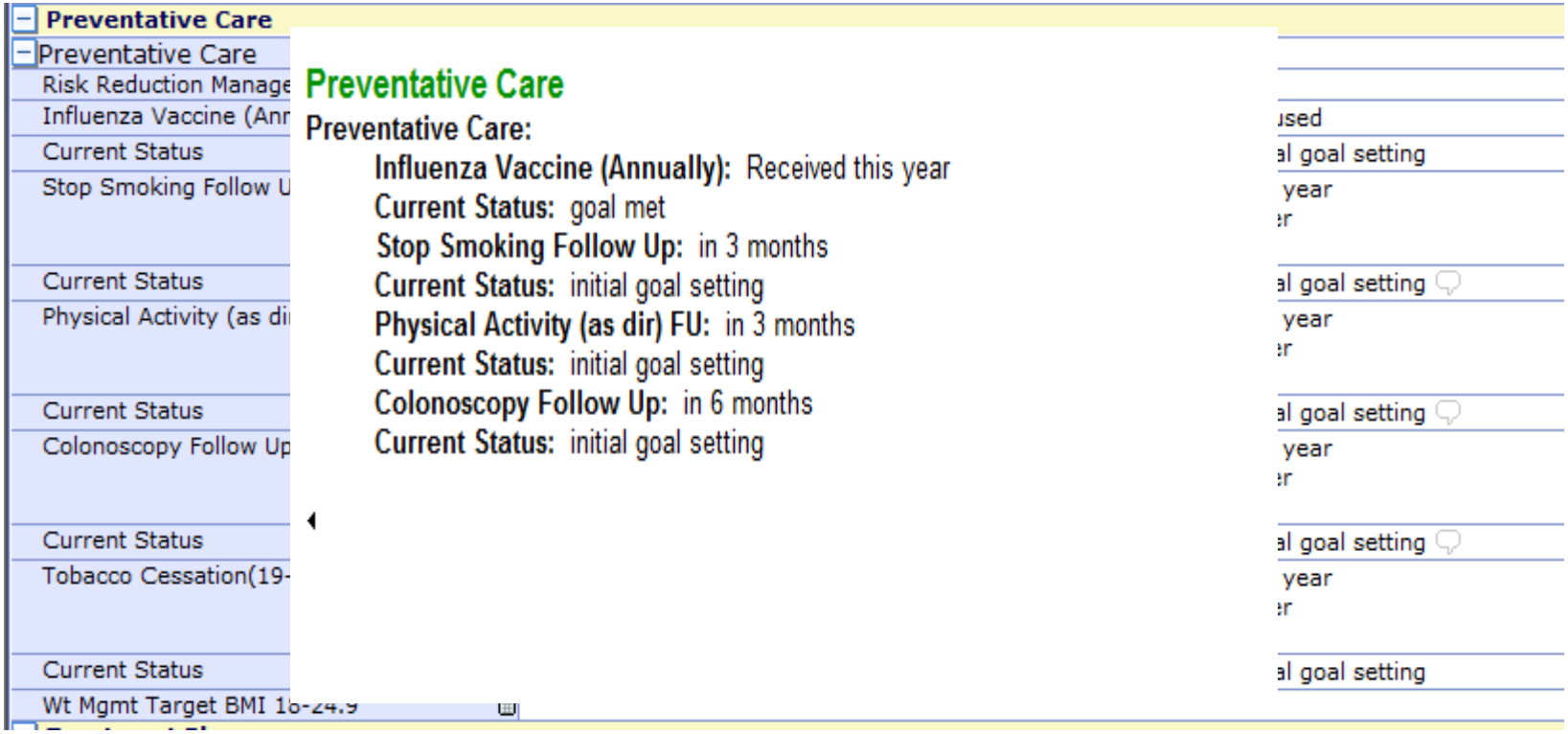
CCM Care Plan Examples



CCM Care Plan Examples



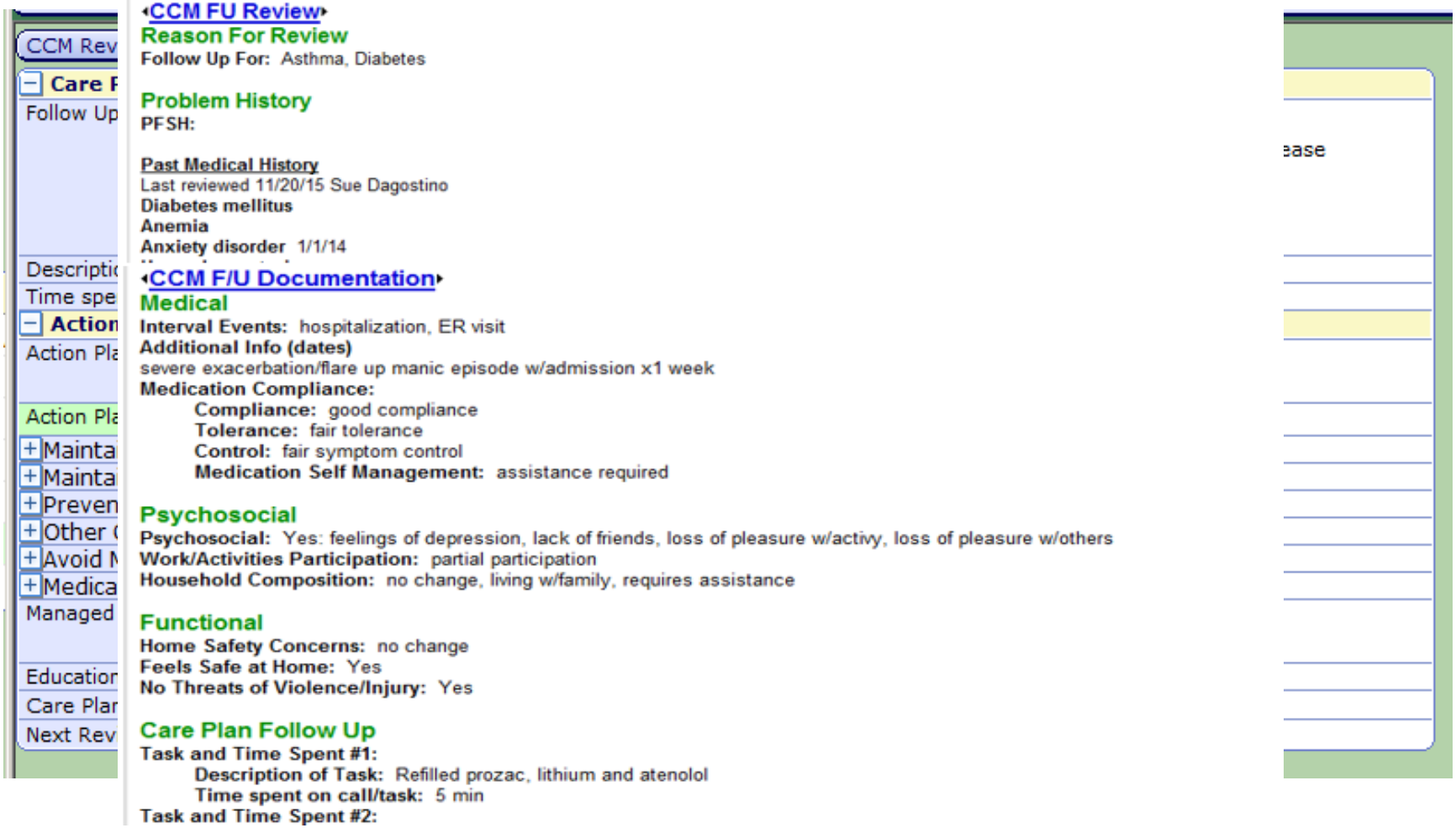
CCM Care Plan Examples



Review of CCM Care Plan

- Electronic summary of: Physical, Cognitive, Psychosocial, Functional, Environmental assessments
- Record of all recommended preventative care services
- Med Rec and review of adherence, interactions and self management of meds
- Inventory of clinicians, resources, and supports specific to the patients

CCM Follow Up Note



HOW GALEN CAN HELP

Starting a CCM Program

- **Step 1- Figure out potential ROI**

Medicare Chronic Care Program

Total Patient Population	ROI
Total Unique Medicare Patients	2500
Percent with 2+ chronic conditions	66%
Annual Number of Unique CCM Medicare Patient	1650
CCM Monthly Reimbursement per patient/per month	42.50
Total Revenue Medicare CCM	**841,500**

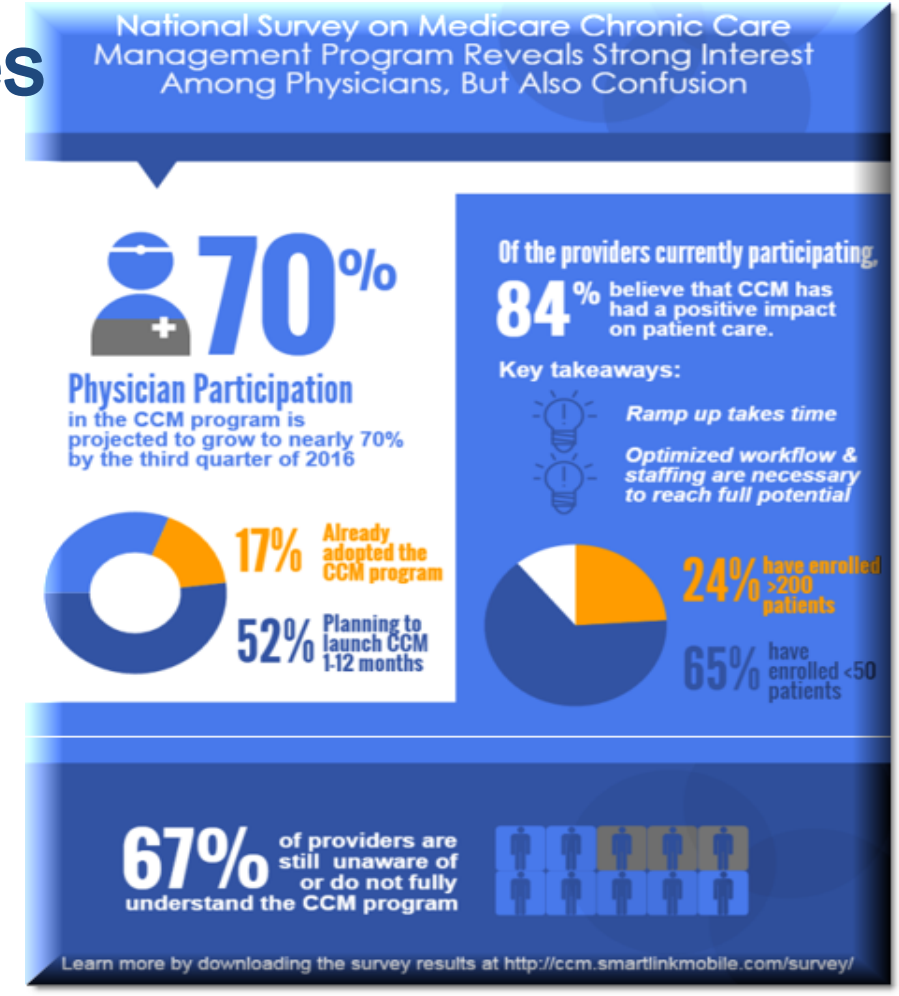
Population Based on Acceptance Level	ROI- Annual
Annual Number of Unique Medicare Patients	2500
Percent with 2+ chronic conditions	66%
Annual Number of Unique CCM Medicare Patient	1650
Percent acceptance into CCM Program	60%
Total CCM Enrolled Patients	990
CCM Monthly Payment	$ 42.50
Estimated Annual Revenue	**$ 504,900**

Starting a CCM Program

- Step 2- Know Hurdles

Per CMS, 35 million Medicare beneficiaries are eligible, only 100,000 beneficiaries submitted to date.

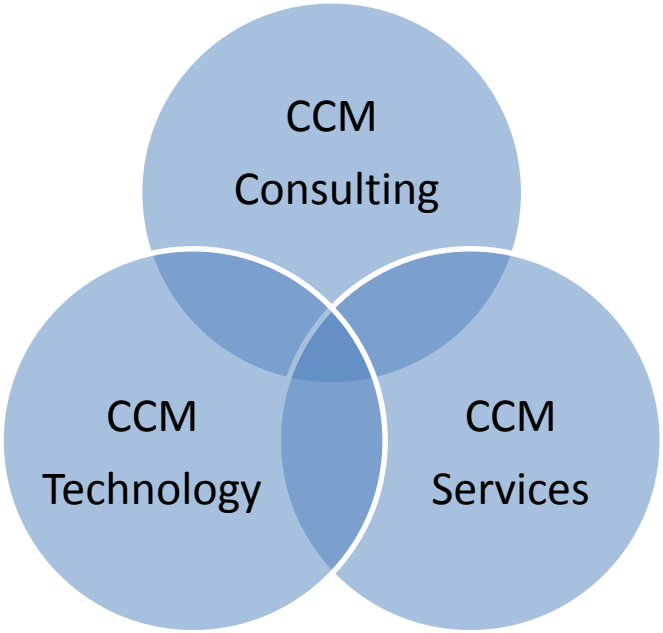
http://www.modernhealthcare.com/article/20151013/NEWS/151019975?utm_content=20151013-NEWS-151019975



Starting a CCM Program

- **Step 3- Identify gaps**
- **Step 4-Build your CCM Team**
- **Step 5- Define pilot CCM group**

Galen CCM Solution



CCM Consulting

- ❑ Program gap analysis and requirements review
- ❑ Policy/procedure development
- ❑ Target patient population analysis
- ❑ Staffing/role definition
- ❑ Program manager

CCM Services

- ❑ Configuration
- ❑ Workflow design
- ❑ Testing of CCM build
- ❑ End user training
- ❑ Implementation/go live support

CCM Technology

- Automation of patient identification
- Tasking and charge automation to support CCM workflows
- Reports of population and non-face-to-face time

Why Galen's CCM solution?

KLAS® ACCURATE. HONEST. IMPARTIAL.

Utilizes EMR, no additional software required

Maintain patient relationship

Increased ROI

transformation@galenhealthcare.com

MUCH MORE THAN I.T.

GALEN HEALTHCARE SOLUTIONS

SOLVING FOR TODAY.
PREPARING FOR TOMORROW.

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