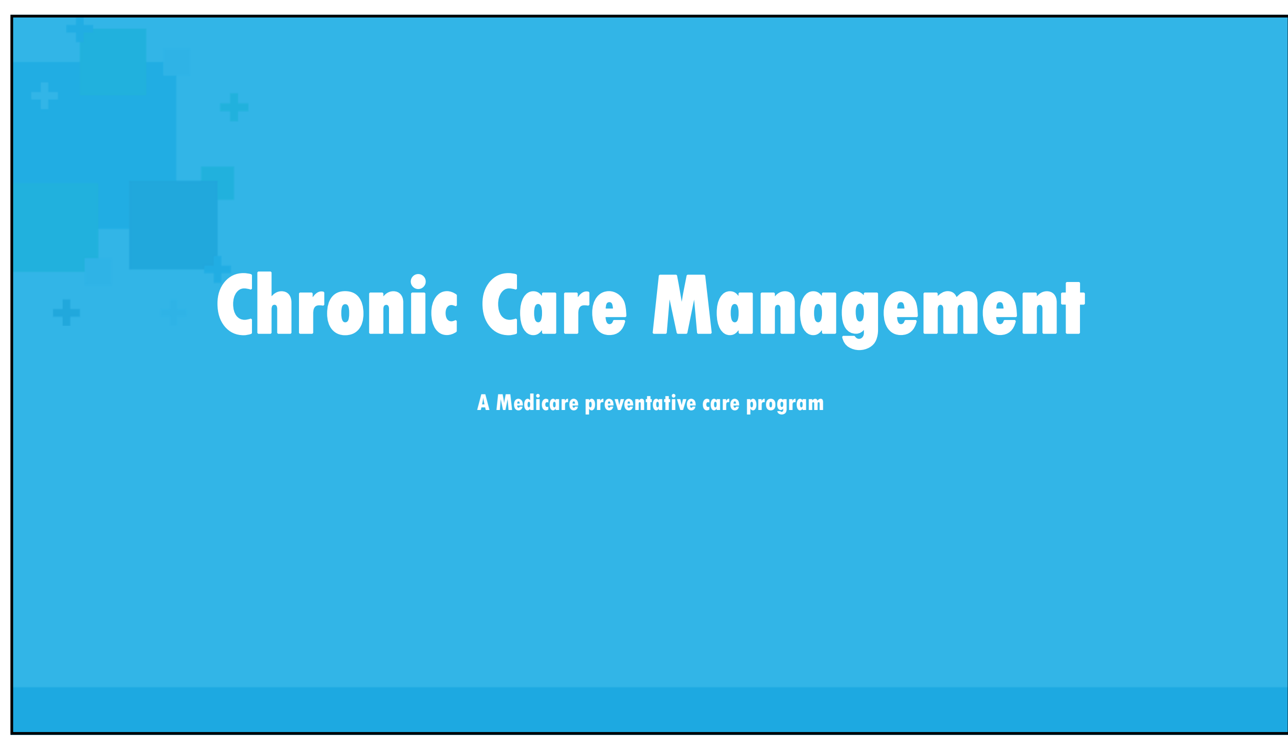

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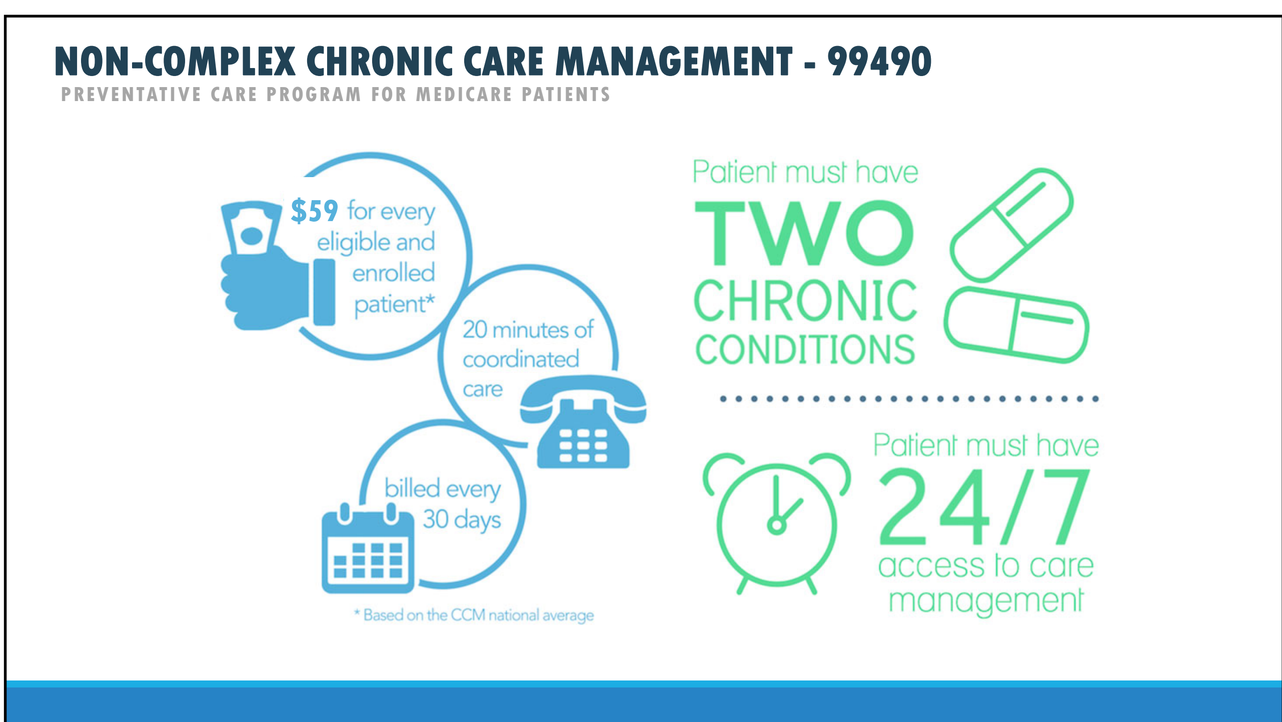
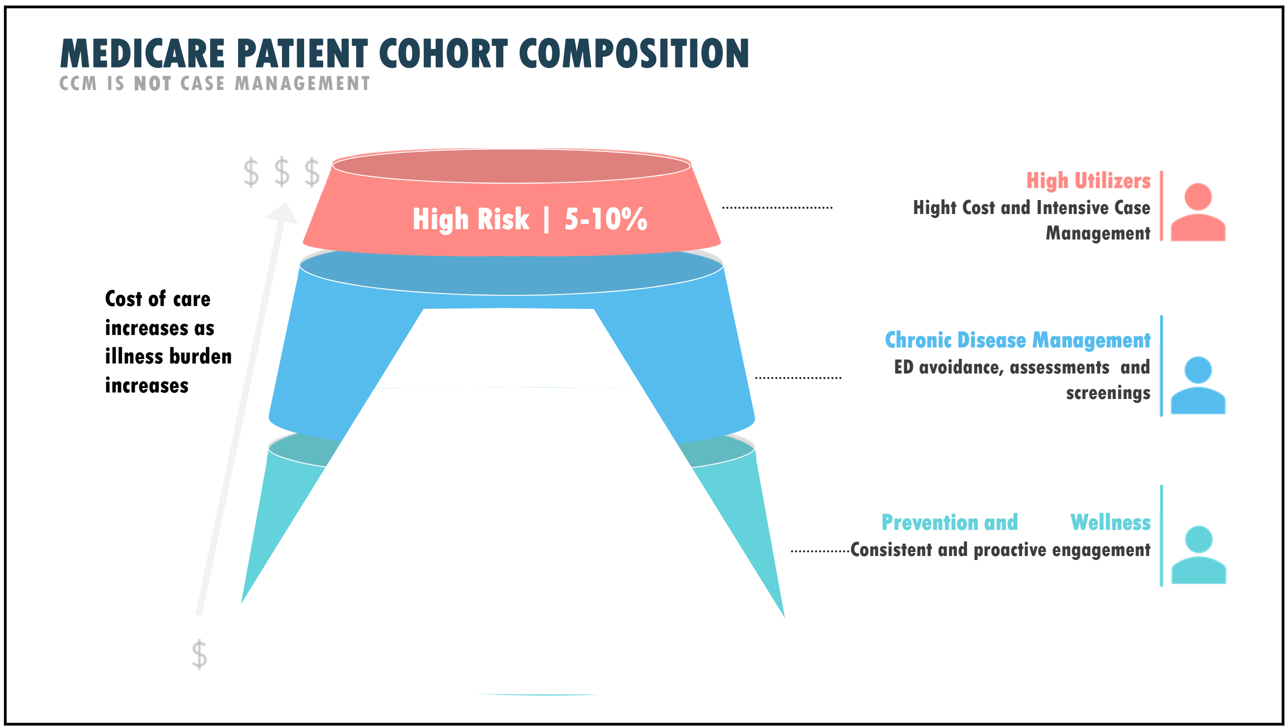
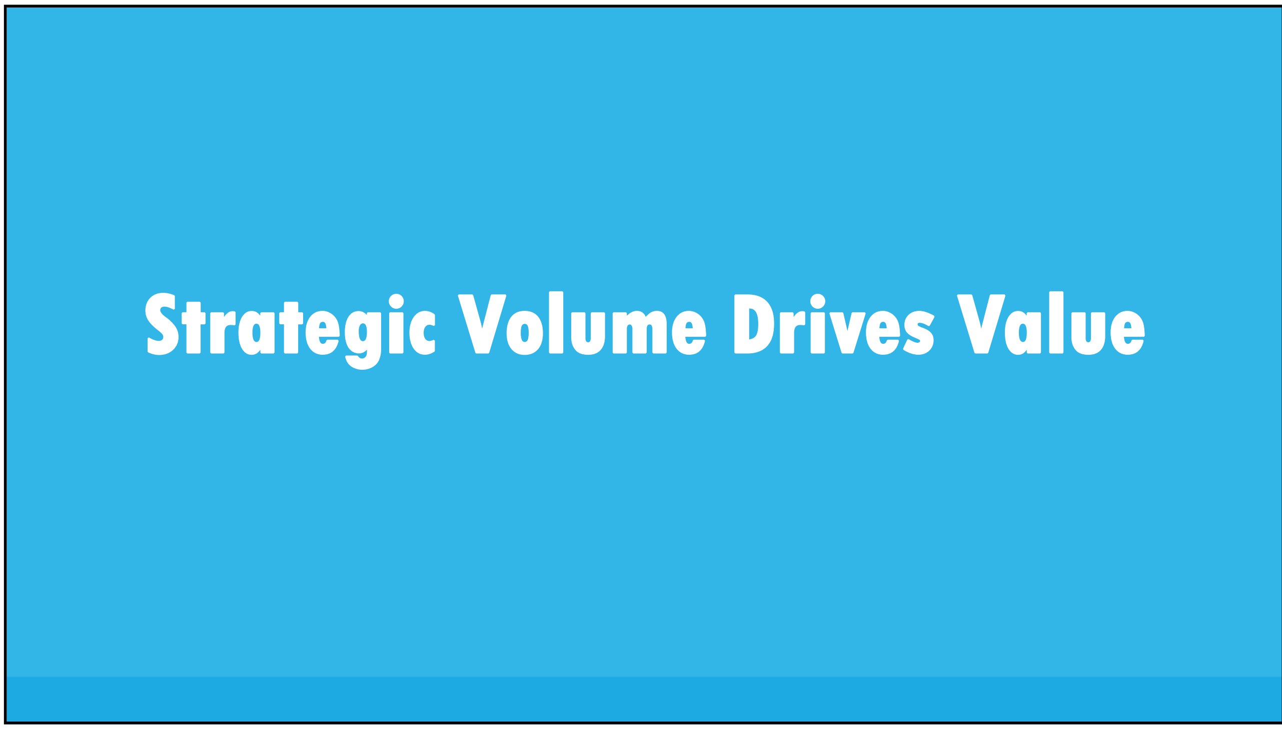
CHRONIC CARE MANAGEMENT KEY MILESTONS

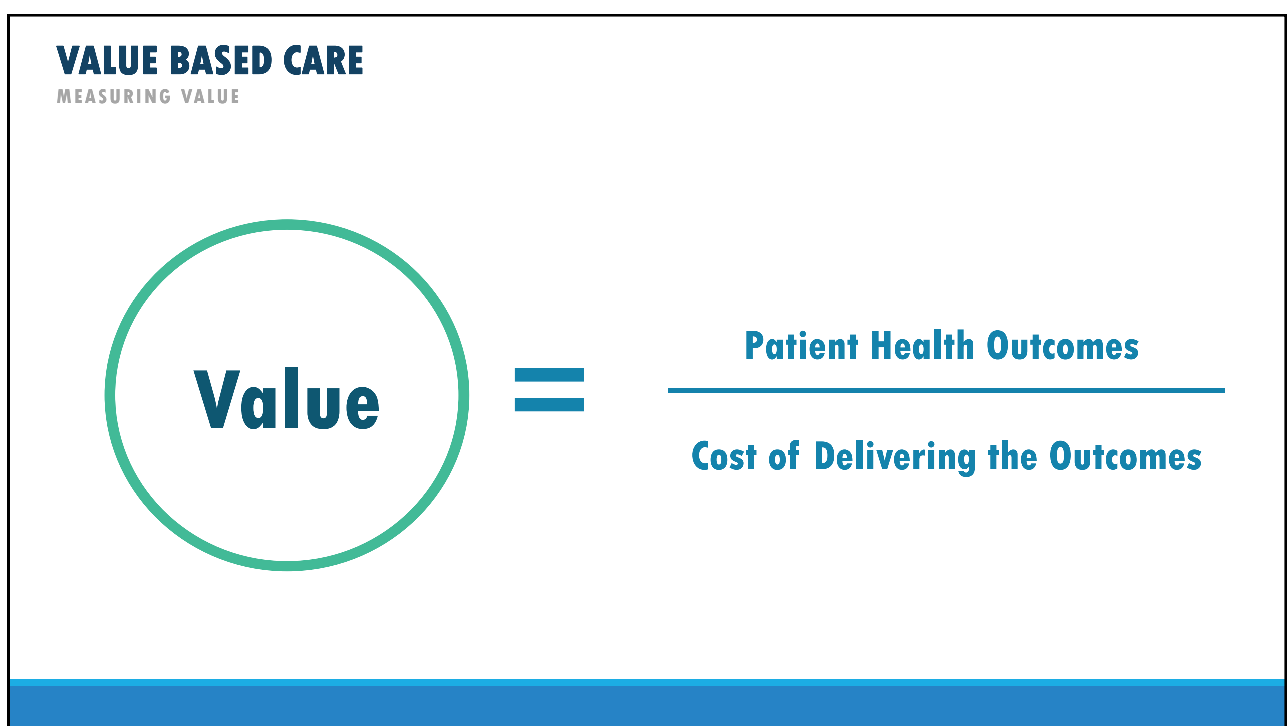
RAPID EXPANSION OVER A 9 YEAR PERIOD

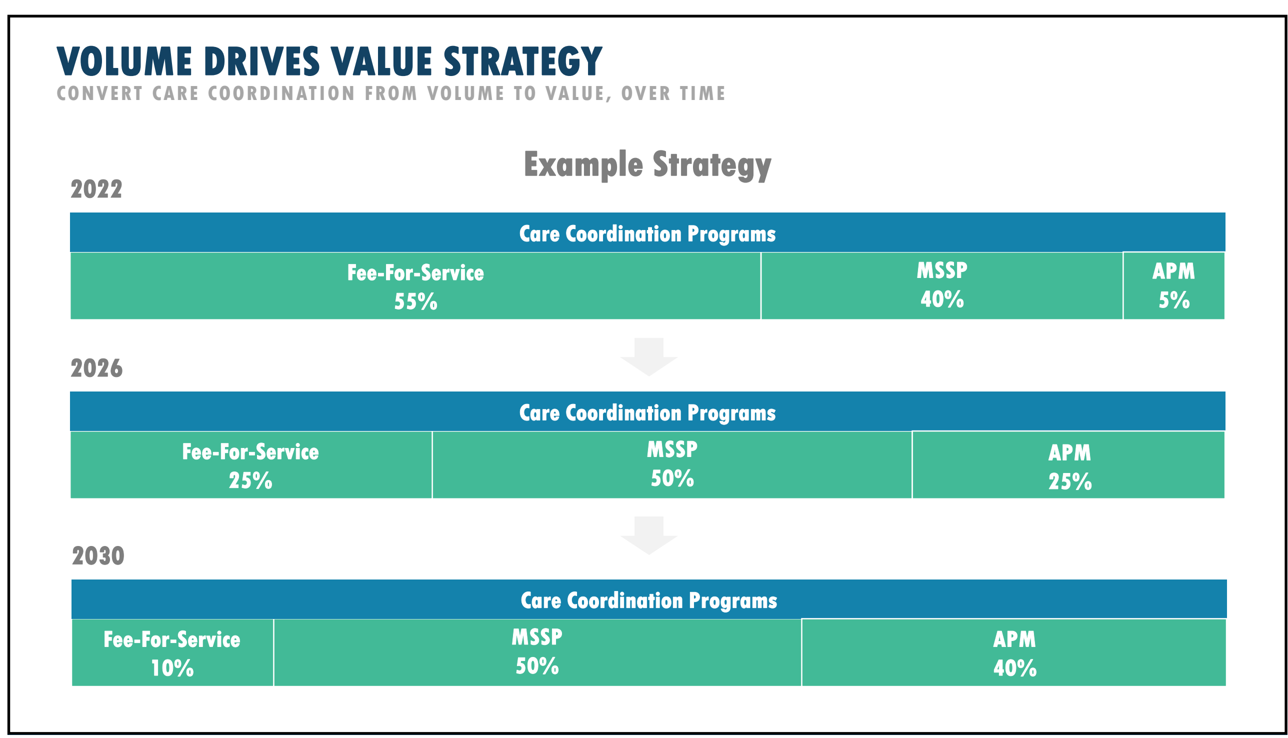
- 2015 Program Launched (99490)
- 2017 Verbal Enrollment Allowed
- 2018 Complex CCM CPTs Codes Introduced
- 2019 Principal Care Management (PCM) Introduced
- 2020 & 2021 Code Families were Expanded
- 2022 RVU Increase Nearly Doubling Reimbursement
- 2024 Proposing Additional Expansion G0511

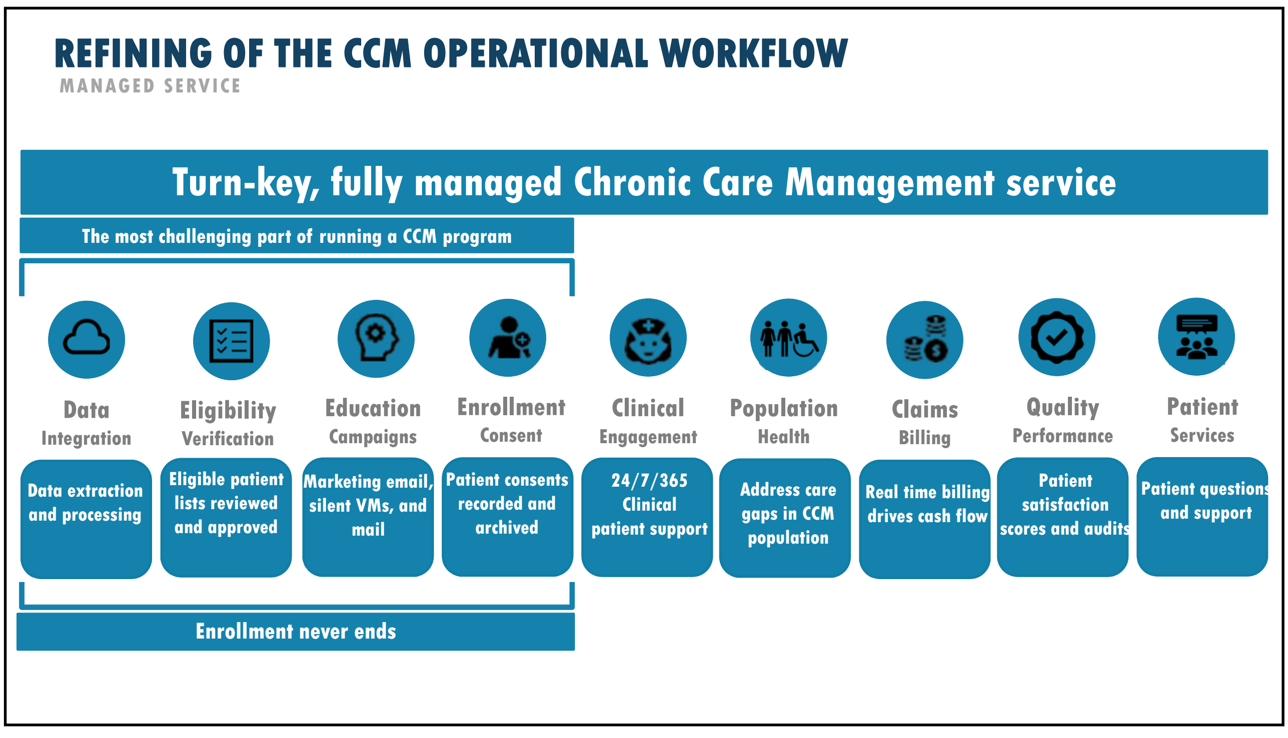



MEDICARE PATIENT COHORT COMPOSITION
CCM IS NOT CASE MANAGEMENT
$ $ $
High Risk | 5-10%
Cost of care increases as illness burden increases
$
High Utilizers
Hight Cost and Intensive Case Management
Chronic Disease Management
ED avoidance, assessments and screenings
Prevention and Wellness
Consistent and proactive engagement


Strategic Volume Drives Value


VALUE BASED CARE
MEASURING VALUE
Value
=
Patient Health Outcomes
Cost of Delivering the Outcomes


VOLUME DRIVES VALUE STRATEGY
CONVERT CARE COORDINATION FROM VOLUME TO VALUE, OVER TIME
Example Strategy
2022
Care Coordination Programs
Fee-For-Service 55%
MSSP 40%
APM 5%
2026
Care Coordination Programs
Fee-For-Service 25%
MSSP 50%
APM 25%
2030
Care Coordination Programs
Fee-For-Service 10%
MSSP 50%
APM 40%



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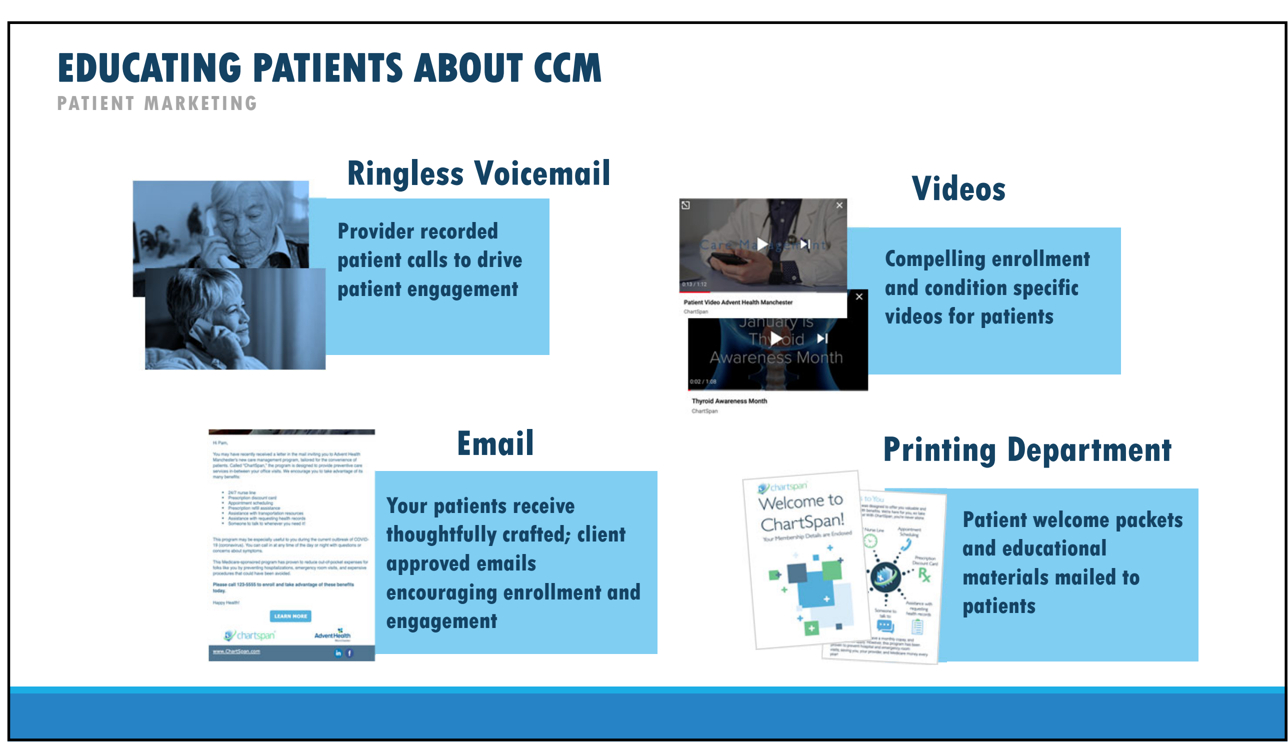
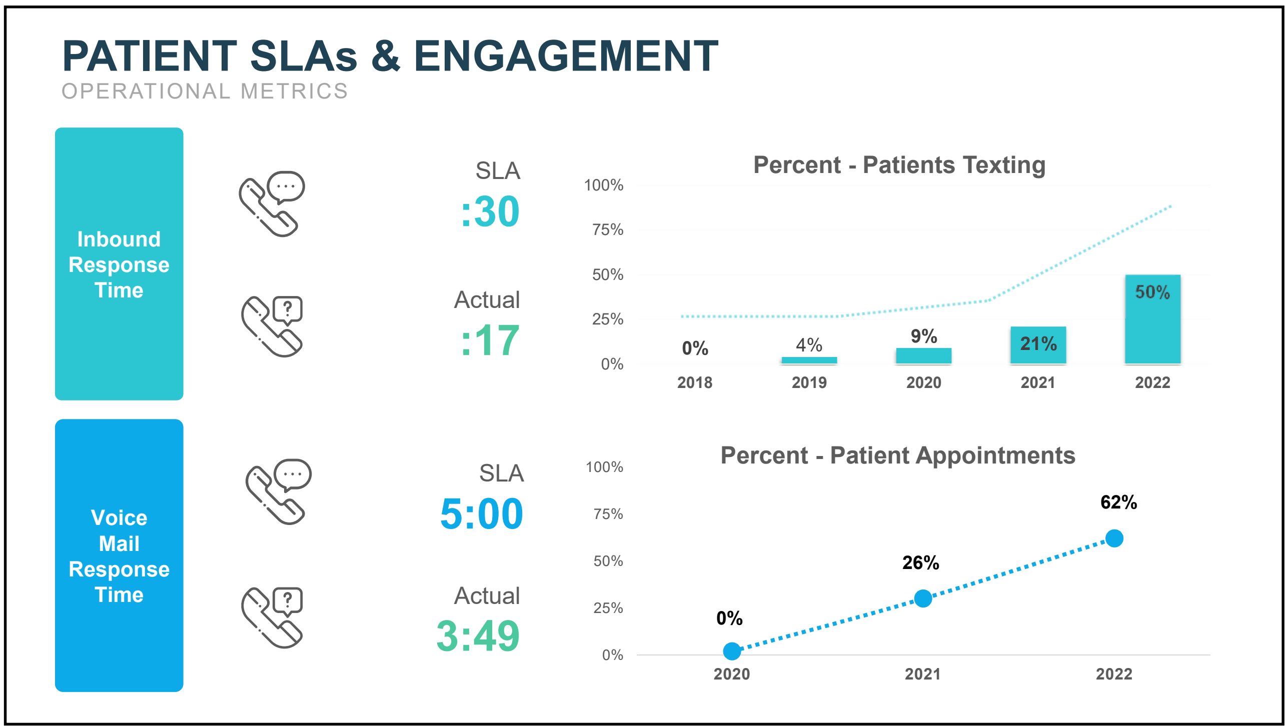
Enrollment


EDUCATING PATIENTS ABOUT CCM
PATIENT MARKETING
Ringless Voicemail
Provider recorded patient calls to drive patient engagement
Videos
Compelling enrollment and condition specific videos for patients
Email
Your patients receive thoughtfully crafted; client approved emails encouraging enrollment and engagement
Printing Department
Patient welcome packets and educational materials mailed to patients

Patient Behavior

INTEGRATED MULTIMODAL CCM
MULTIPLE PATIENT ENGAGEMENT CHANNELS
Telephonic
SMS
Email
Patient Portal
Direct mail


PATIENT SLAs & ENGAGEMENT
OPERATIONAL METRICS
Inbound Response Time
SLA
:30
Actual
:17
Percent - Patients Texting
100%
75%
50%
25%
0%
0%
4%
9%
21%
50%
2018
2019
2020
2021
2022
Voice Mail Response Time
SLA
5:00
Actual
3:49
Percent - Patient Appointments
100%
75%
50%
25%
0%
0%
26%
62%
2020
2021
2022

Clinical Services

NURSES LED PROGRAM

Employed Nurses Lead the Care

- ✓Each patient's care is supervised by a nurse
- ✓Effective management of chronically ill patients' clinical needs
- ✓Dedicated nurses are assigned to specific practices & patients
- ✓Clinicians and patients matched regionally
- ✓A minimum of two call attempts made to non-engaged patients each month, at no extra cost
- ✓Better patient outcomes, patient retention, and oversight of lower-level clinical staff

ANNUAL CCM CLINICAL STRUCTURE

Technology Enabled, Human Driven

	Inventory Markers | **Assess**	Identify Markers | **Detect**	Intervene Markers | **Action**
Months 1 - 4	✓ Health History Review ✓ Care Continuum Inventory (provider record retrieval.) ✓ Condition Awareness Assessment ✓ Healthy Living Assessment (diet, exercise, etc.) ✓ Establish SMART Care Goals	✓ Provider Access/Health Equity Issues ✓ Condition Management Challenges ✓ Health Education Needs ✓ SMART Care Goal Non-Adherence	✓ Social Partner Connections ✓ Provider and Service Accessibility ✓ Improved Condition Self-Management ✓ SMART Care Goal Adherence
Months 5 - 8	✓ SDOH Screening ✓ Medication Adherence ✓ Fall Risk Screening ✓ Ancillary Service Assessment ✓ SMART Care Goals Management	✓ Social Barrier Discovery ✓ Medication Problem Identification ✓ Fall Risk Indications ✓ Tertiary Service Need Identification ✓ SMART Care Goal Non-Adherence	✓ Provider Awareness ✓ Medication Compliance ✓ Engage Tertiary Service Providers ✓ SMART Care Goal Adherence
Months 9-12	✓ Psychosocial Screening ✓ Cognitive Screening ✓ DME Screening ✓ SMART Care Goals Management	✓ Mental and Social Indicators ✓ Early Impairment Association ✓ Medical Device Suitability ✓ SMART Care Goal Non-Adherence	✓ Mental Health Support ✓ Medical Equipment Needs Filled ✓ SMART Care Goal Adherence
Annually	**6-10** Screenings & Assessments; **12-20** Patient Engagements	**2-3** Clinical Notifications; **1-2** Condition Detections	**2-3** Care Gap Assists; **3-4** Patient Assists

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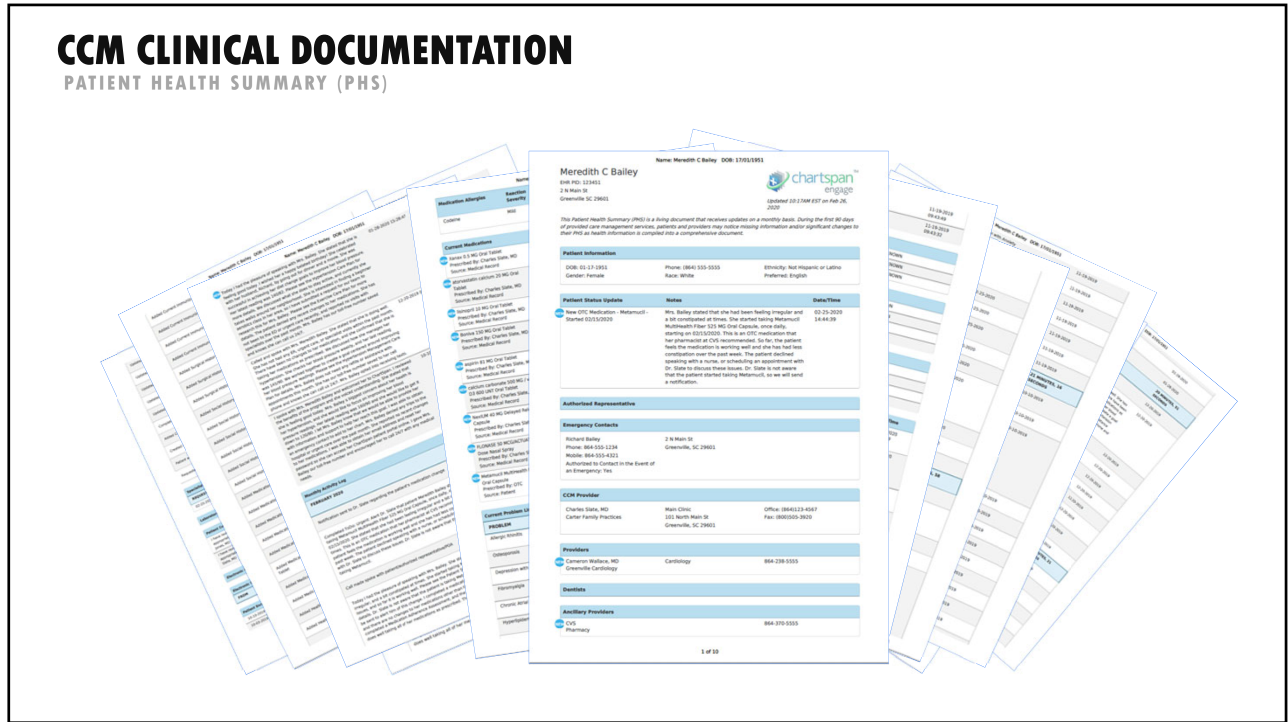
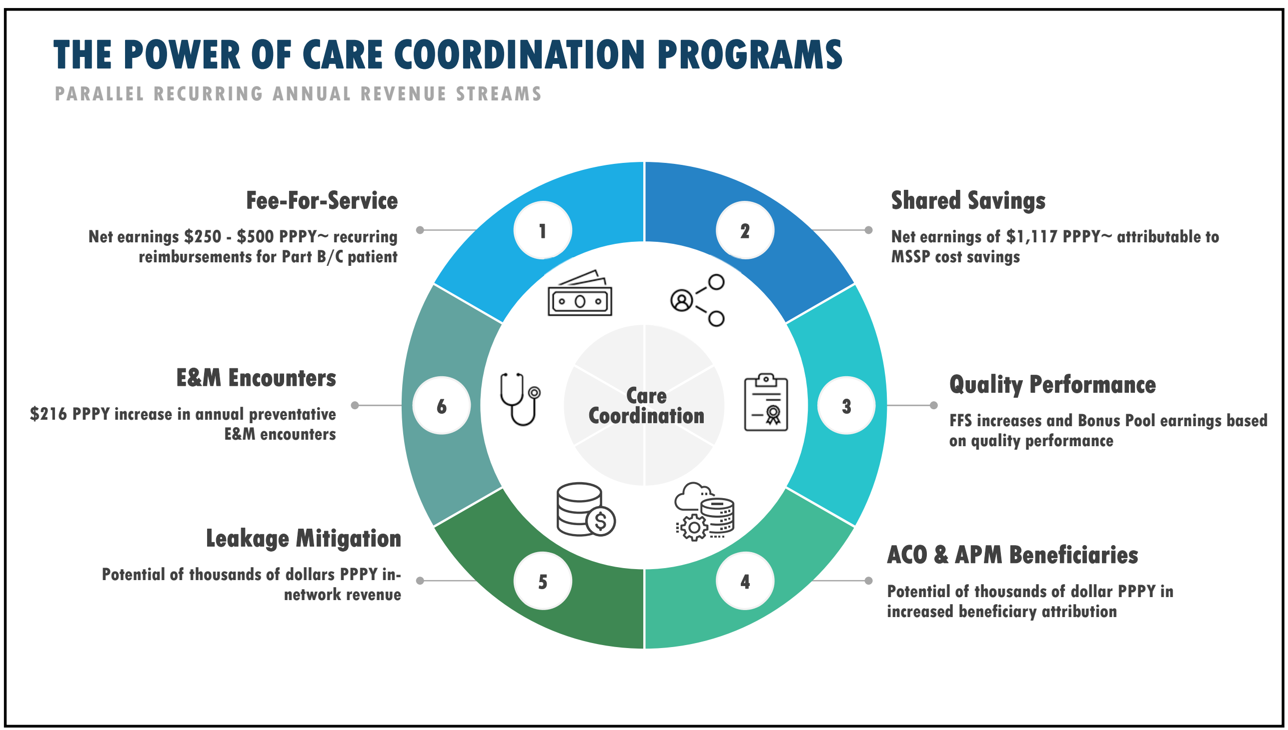
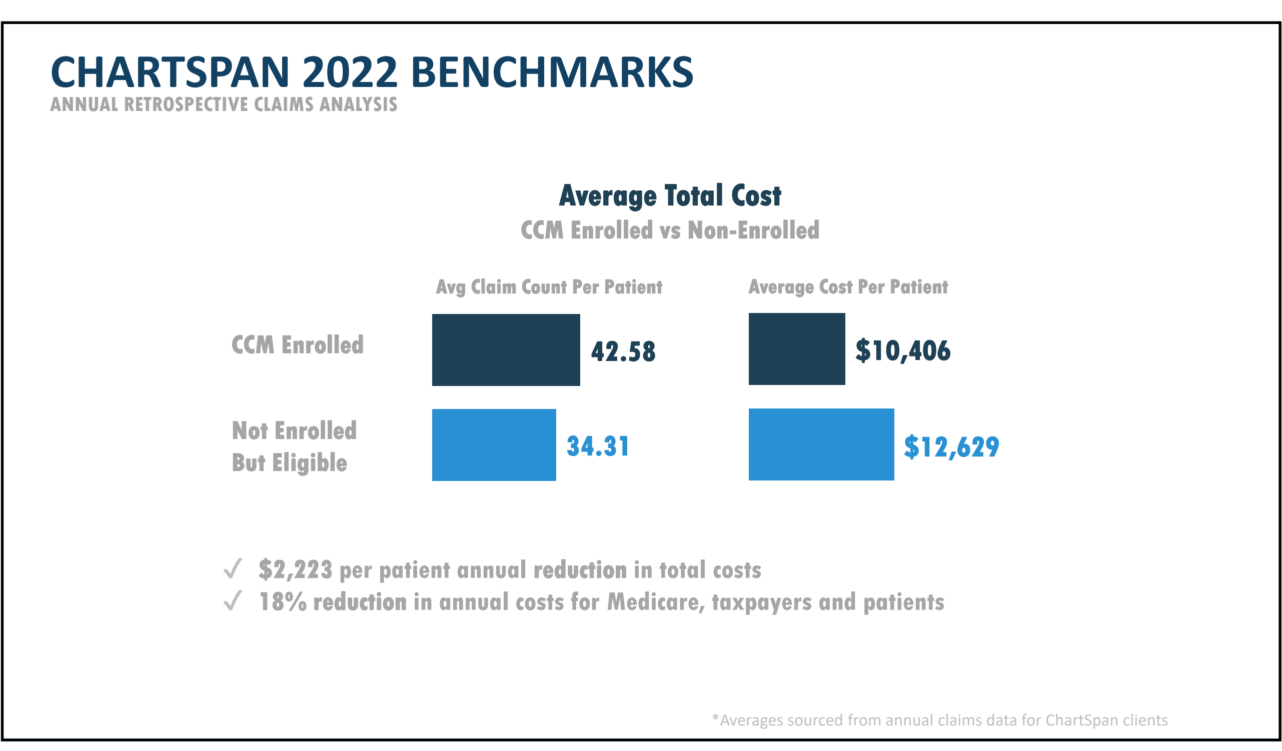

CCM CLINICAL DOCUMENTATION
PATIENT HEALTH SUMMARY (PHS)

CCM Effectivity





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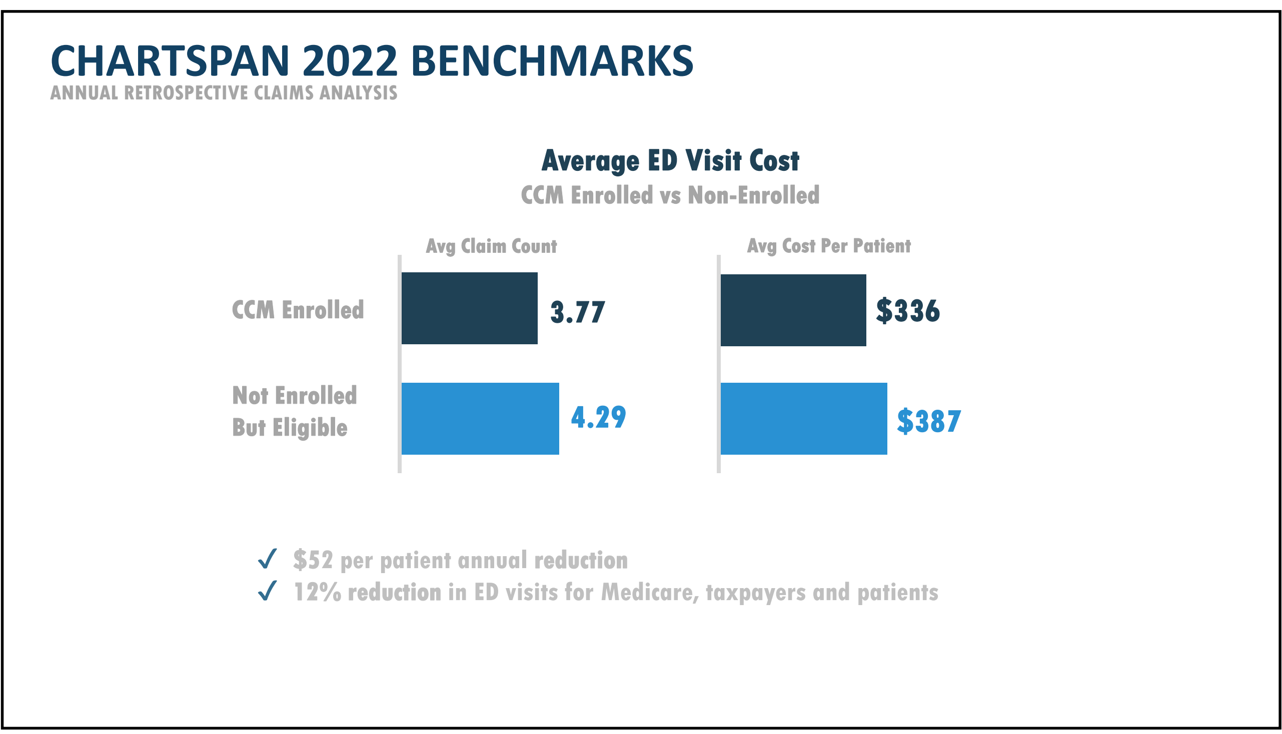
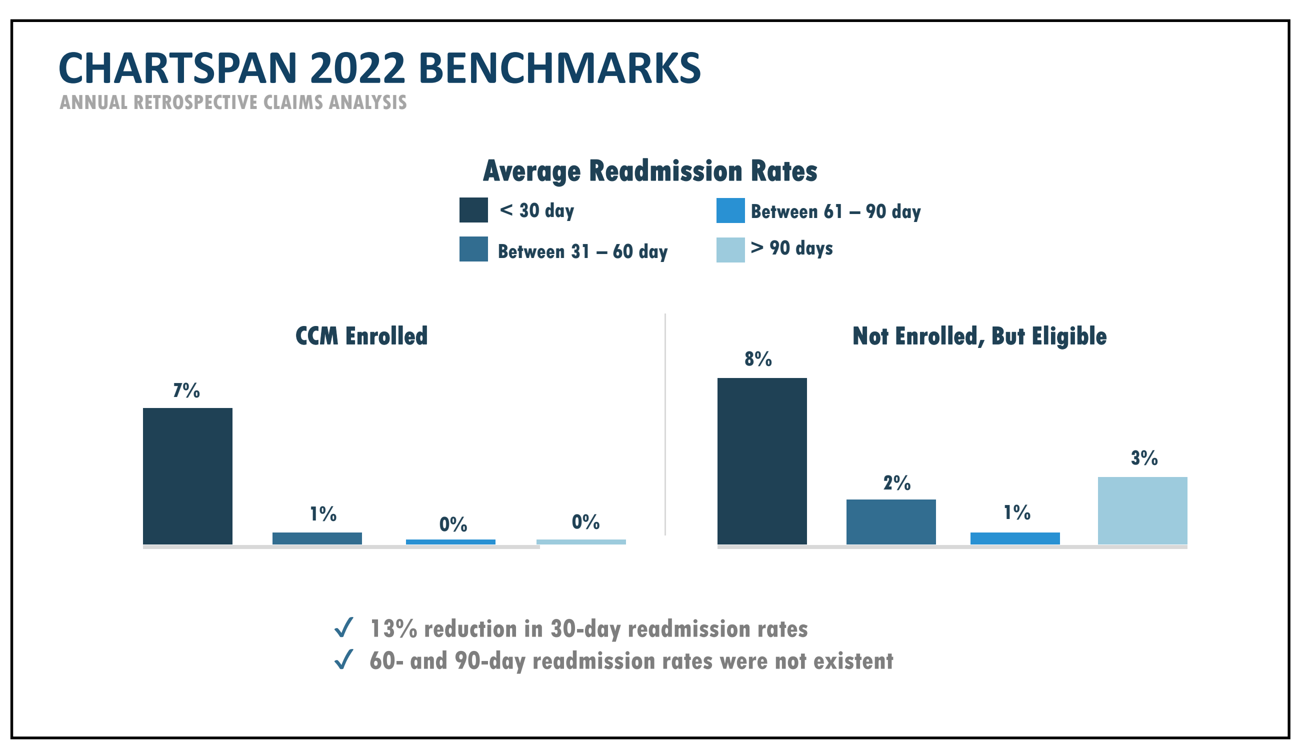
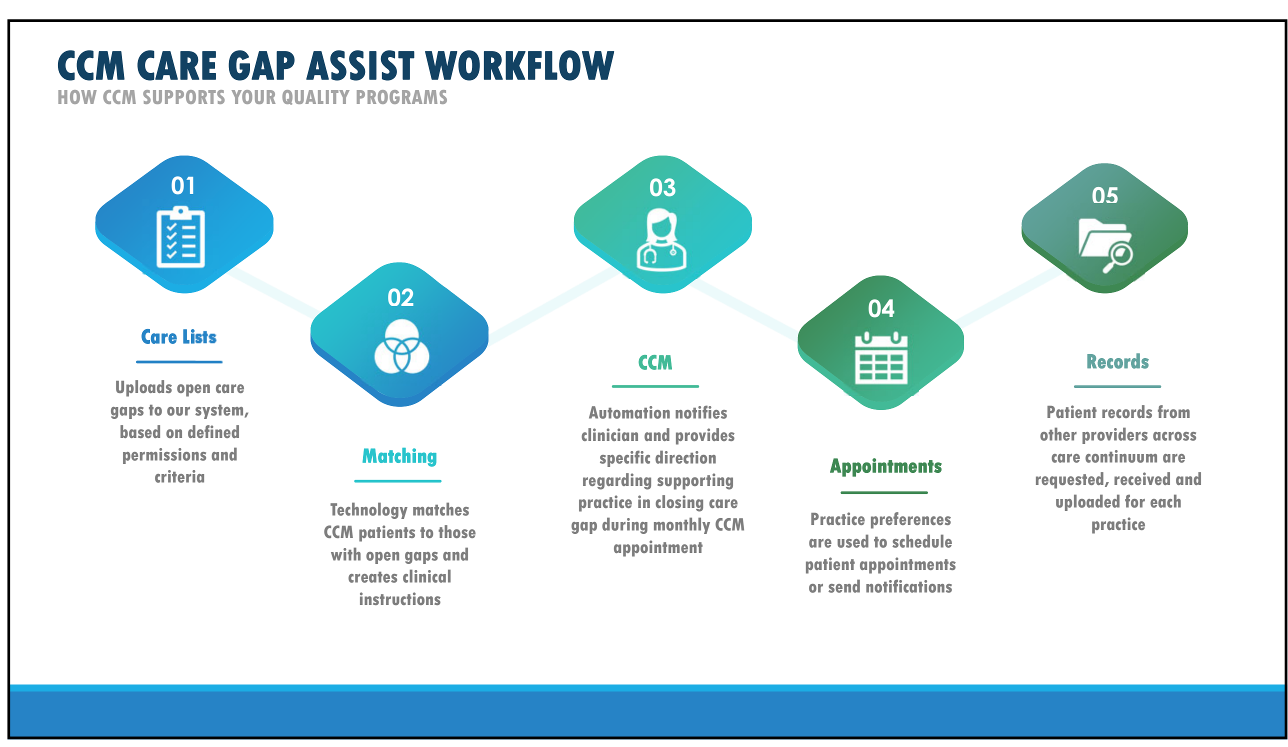
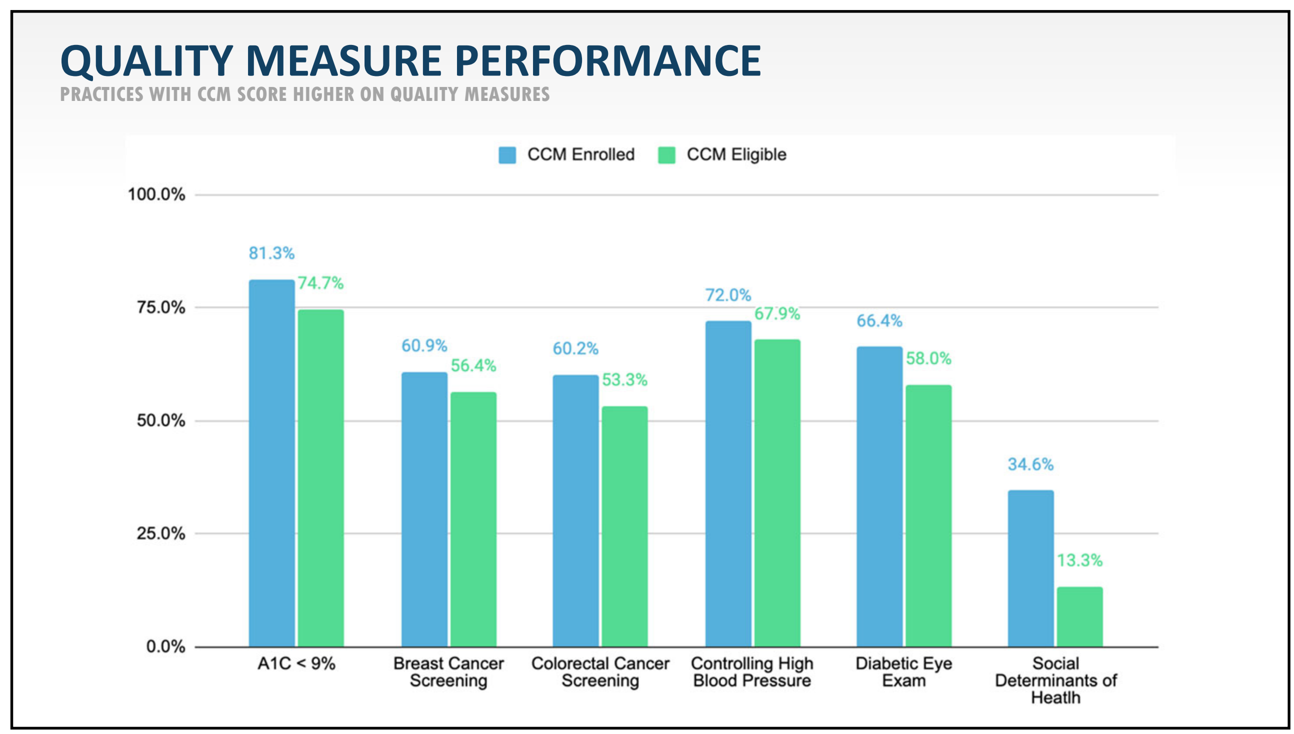

CHARTSPAN 2022 BENCHMARKS
ANNUAL RETROSPECTIVE CLAIMS ANALYSIS
Average ED Visit Cost
CCM Enrolled vs Non-Enrolled
Avg Claim Count
Avg Cost Per Patient
CCM Enrolled
3.77
$336
Not Enrolled But Eligible
4.29
$387
✓ $52 per patient annual reduction
✓ 12% reduction in ED visits for Medicare, taxpayers and patients

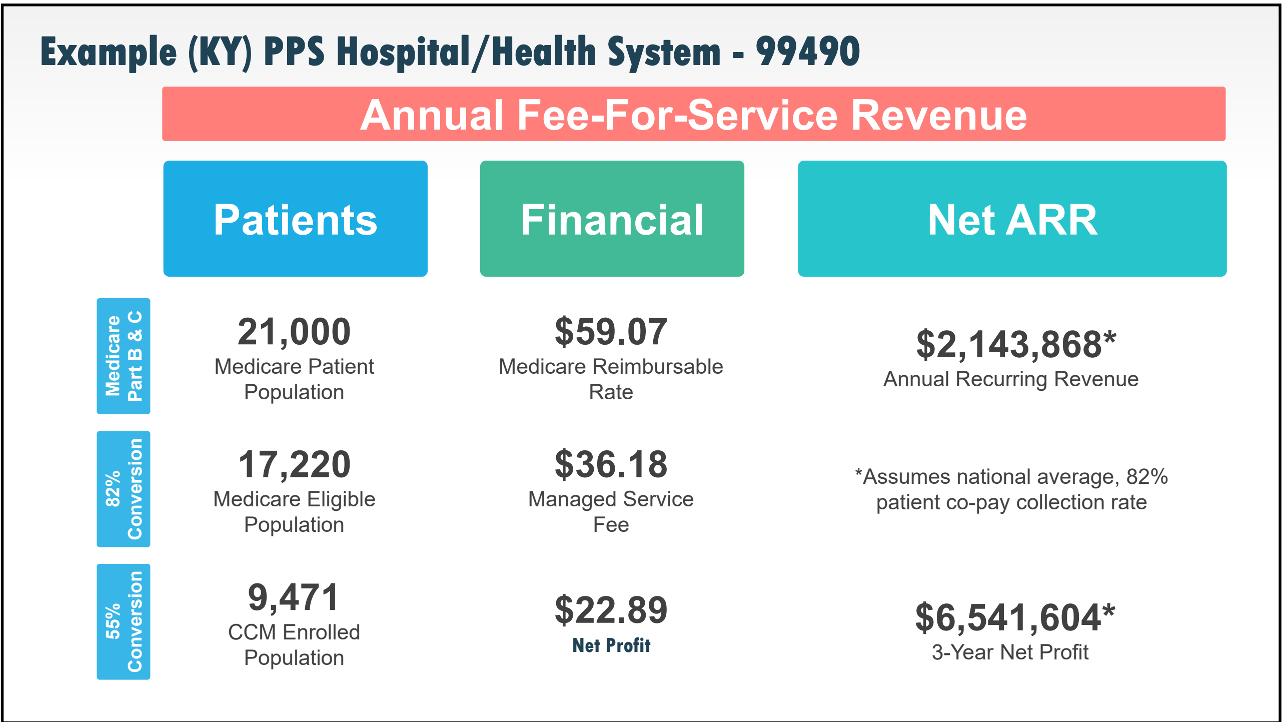

CHARTSPAN 2022 BENCHMARKS
ANNUAL RETROSPECTIVE CLAIMS ANALYSIS
Average Readmission Rates
< 30 day
Between 31 – 60 day
Between 61 – 90 day
> 90 days
CCM Enrolled
7%
1%
0%
0%
Not Enrolled, But Eligible
8%
2%
1%
3%
✓ 13% reduction in 30-day readmission rates
✓ 60- and 90-day readmission rates were not existent

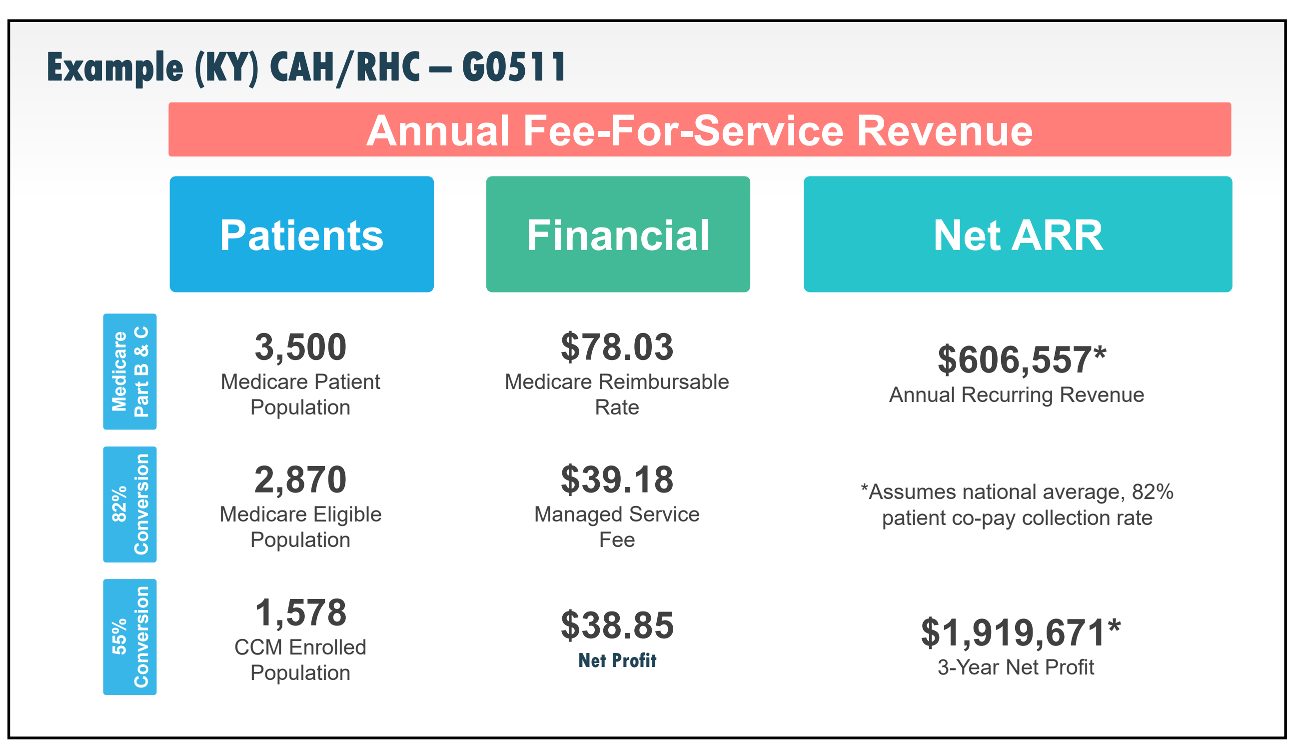
Pop Health/Quality Program


CCM CARE GAP ASSIST WORKFLOW
HOW CCM SUPPORTS YOUR QUALITY PROGRAMS
01
Care Lists
Uploads open care gaps to our system, based on defined permissions and criteria
02
Matching
Technology matches CCM patients to those with open gaps and creates clinical instructions
03
CCM
Automation notifies clinician and provides specific direction regarding supporting practice in closing care gap during monthly CCM appointment
04
Appointments
Practice preferences are used to schedule patient appointments or send notifications
05
Records
Patient records from other providers across care continuum are requested, received and uploaded for each practice


QUALITY MEASURE PERFORMANCE
PRACTICES WITH CCM SCORE HIGHER ON QUALITY MEASURES
CCM Enrolled
CCM Eligible
100.0%
75.0%
50.0%
25.0%
0.0%
81.3%
74.7%
60.9%
56.4%
60.2%
53.3%
72.0%
67.9%
66.4%
58.0%
34.6%
13.3%
A1C < 9%
Breast Cancer Screening
Colorectal Cancer Screening
Controlling High Blood Pressure
Diabetic Eye Exam
Social Determinants of Heatlh

CCM FFS Revenue Projections


Example (KY) PPS Hospital/Health System - 99490
Annual Fee-For-Service Revenue
Patients
Financial
Net ARR
Medicare Part B & C
21,000
Medicare Patient Population
$59.07
Medicare Reimbursable Rate
$2,143,868*
Annual Recurring Revenue
82% Conversion
17,220
Medicare Eligible Population
$36.18
Managed Service Fee
*Assumes national average, 82% patient co-pay collection rate
55% Conversion
9,471
CCM Enrolled Population
$22.89
Net Profit
$6,541,604*
3-Year Net Profit


Example (KY) CAH/RHC – G0511
Annual Fee-For-Service Revenue
Patients
Financial
Net ARR
Medicare Part B & C
3,500
Medicare Patient Population
$78.03
Medicare Reimbursable Rate
$606,557*
Annual Recurring Revenue
82% Conversion
2,870
Medicare Eligible Population
$39.18
Managed Service Fee
*Assumes national average, 82% patient co-pay collection rate
55% Conversion
1,578
CCM Enrolled Population
$38.85
Net Profit
$1,919,671*
3-Year Net Profit

KEY CCM TAKEAWAYS

- ✓ CCM is Here to Stay
- ✓ Medicare Population is Growing
- ✓ Patient Adoption has Accelerated
- ✓ Patients are Utilizing Technology
- ✓ More Deployment Options
- ✓ Federal Dollars Allocated to You
- ✓ CCM can Assist Care Gap Closures
- ✓ Improve MSSP Performance
- ✓ Increase Beneficiary Attribution

QUESTIONS?

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