Chronic Care Management (CCM) and Principal Care Management (PCM)

Netting Higher Outcomes & Increased Financial Incentives

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Speakers

Amy H. Kotch, MHA
Principal Business Consultant

Maria Nikol, MJ
Sr. Business Consultant

Ryan Mackman, MBA, MHA
Business Consultant, User Engagement Lead

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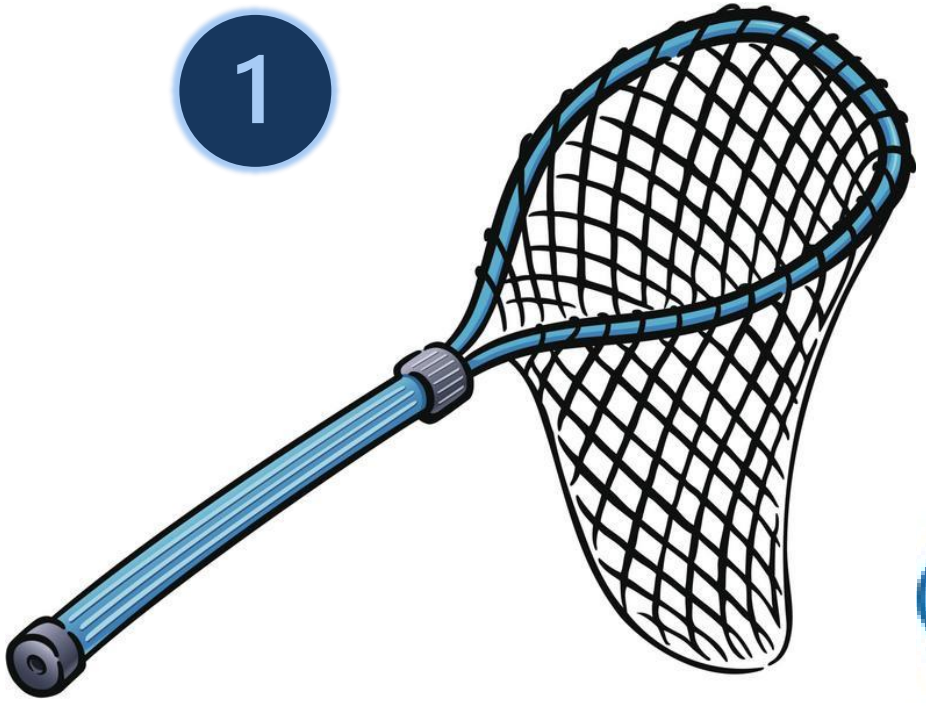
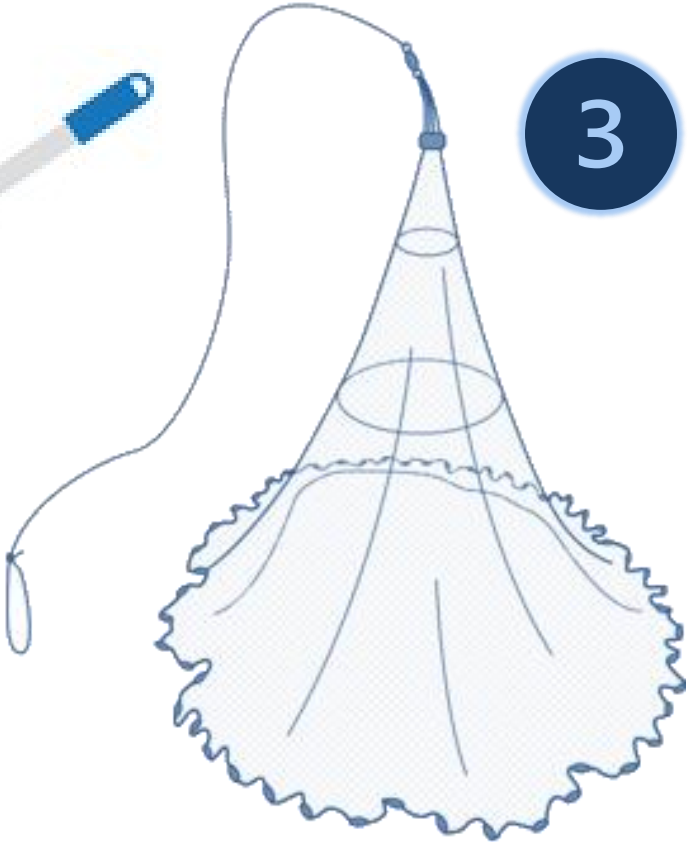
Need the Right Net to Catch the Right Target





NETS

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CCM: Numbers to Consider

Three in Four Medicare beneficiaries have multiple chronic conditions (*those that last a year or more & require ongoing medical attention, or that limit activities of daily living*).

Among Medicare fee-for-service beneficiaries, people with multiple chronic conditions account for 93% of total Medicare spending.

Improved care coordination can lead to better patient outcomes *and* lower costs.

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https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm

Purpose

The **Care Management Programs (CCM and PCM)** aim to assist patients with **chronic conditions** to optimize their health through **care coordination.**

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Benefits Patients, Practices, and ACOs

PATIENTS

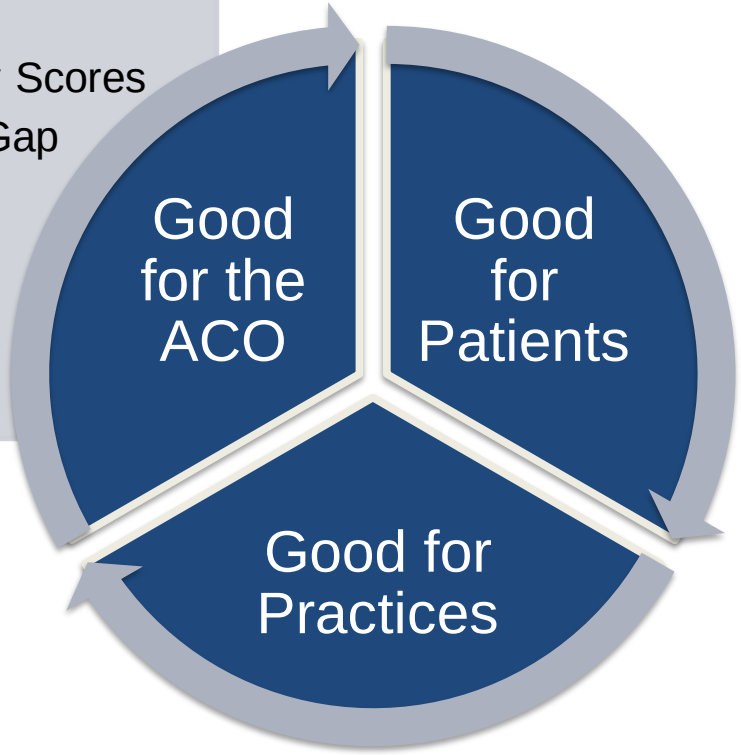
- Promote Independence
- Improve Patient Health
- Enhance Provider/Patient Relationship
- Decrease Unnecessary Acute Care Through Proactive Engagement

PRACTICES

- Strengthen the Provider/Patient Partnership
- Create a Sustainable Revenue Stream for the Practice
- Increased Practice Access
- Promotes Team-Based Care

ACOs

- Decrease Acute Care Utilization & Spend
- Increase Patient Satisfaction
- Improve Quality Scores Through Care Gap Identification



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Chronic Care Management Services

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CCM

CPT CODE	REIMBURSEMENT	TIME SPENT	RENDERED BY
99490	$42	20+ minutes/month	Clinical Staff
99439	$38	Each additional 20 minutes/month, up to 2 times	Clinical Staff
99491	$74	30+ minutes/month	Physician or Other Qualified Health Care Professional

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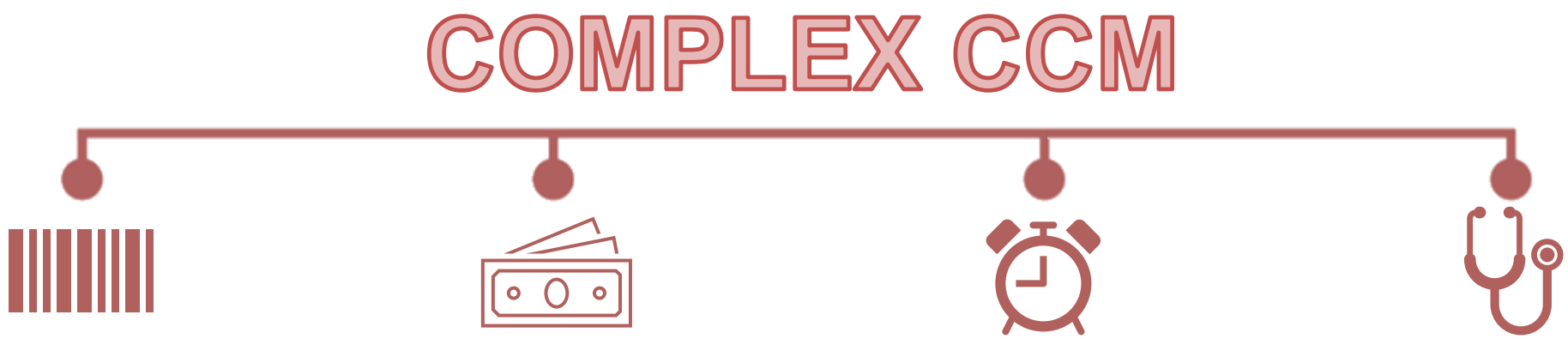
https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99091&M=5
2020 Physician Fee Schedule; CMS; Non-facility Price Average

Complex CCM



CPT CODE	REIMBURSEMENT	TIME SPENT	RENDERED BY
99487	$93	60+ minutes/month	Clinical Staff
99489	$45	Each additional 30+ minutes/month	Clinical Staff

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https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99091&M=5
2020 Physician Fee Schedule; CMS; Non-facility Price Average

Behavioral Health

CPT CODE	REIMBURSEMENT	TIME SPENT	RENDERED BY
99484	$45	20+ minutes/month	Clinical Staff

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https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99091&M=5
2020 Physician Fee Schedule; CMS; Non-facility Price Average

Which Providers Can Bill for CCM?

Physicians & the Following Non-Physician Practitioners

- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

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Which Patients are Eligible for CCM?

Patients with **multiple (two or more)** chronic conditions expected to last **at least 12 months [or until the death of the patient**, and that places the patient at **significant risk of death, acute exacerbation / decompensation, or functional decline]** are eligible for CCM services.

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https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Care Plan Components

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CCM Sample Workflow: Team-Based Approach

Patient Identification	• RN/PCP: Identify Patients with 2+ Chronic Conditions • Chronic Conditions are Expected to Last at Least 12 months or Until Death; and Place the Patient at Significant Risk of Death, Acute Exacerbation/Decompensation, or Functional Decline
Patient Engagement / Initiation	• Complete Patient Outreach & Scheduling
Patient Consent / Comprehensive Care Plan	• Explain Program & Obtain Consent • Complete Comprehensive Assessment • Provide Care Plan to Patient
Complete Care Management	• Document Phone Calls, E-mails, & any Care Coordination Activities • Coordinate Patient Care with Other Providers (Specialists, Community Resources, Caregivers) • Bill for CCM Services Monthly
Graduation from the Program	• PCP Reviews Patient Progress & Determines Patient Readiness

Implementation Best Practices

- Full Time Job, Embedded in the Practice
- Signing up During AWV
- Picking the Right Patients, Consider Behavioral Health / SDOH
- Fee-for-Service vs. Shared Savings (RN vs. Pharmacist vs. Someone Else)
- Full Office Buy-In & Reiterated with Every Staff Member
- Weekly Touch with the Patient
- Best Coverage Practices and Getting to at Least 20 Minutes
- Providers Need to be Involved and Reviewing
- Promoting Graduation from the Program
- A Solution to Track Compliance, ROI, Patient ID

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Principal Care Management Services

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Why Was PCM Developed?

The Final Rule States That Qualifying Conditions:

- Will typically be expected to last between 3 months & 1 year, or until the death of the patient
- May have led to a recent hospitalization and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Is of such complexity that it cannot be managed effectively by primary care, and requires management by another, more specialized practitioner

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Which Patients are Eligible for PCM?

- One complex chronic condition lasting at least 3 months, which is the focus of the care plan

- Severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization

- Development or revision of disease-specific care plan

- Frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

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https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Which Providers Can Bill for PCM?

FEDERAL REGISTER
The Daily Journal of the United States Government

> "Although we did not propose any restrictions on the specialties that could bill for PCM, we expect that most of these services will be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management."

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https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

PCM

CPT CODE	REIMBURSEMENT	TIME SPENT	RENDERED BY
G2064	$94.03	30+ minutes/month	Physician or Other Qualified Health Care Professional
G2065	$40.56	30+ minutes/month	Clinical Staff

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https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99091&M=5
2020 Physician Fee Schedule; CMS; Non-facility Price Average

Care Plan Components and Workflow

Follow Similar Steps to CCM Workflows

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Live Demo!

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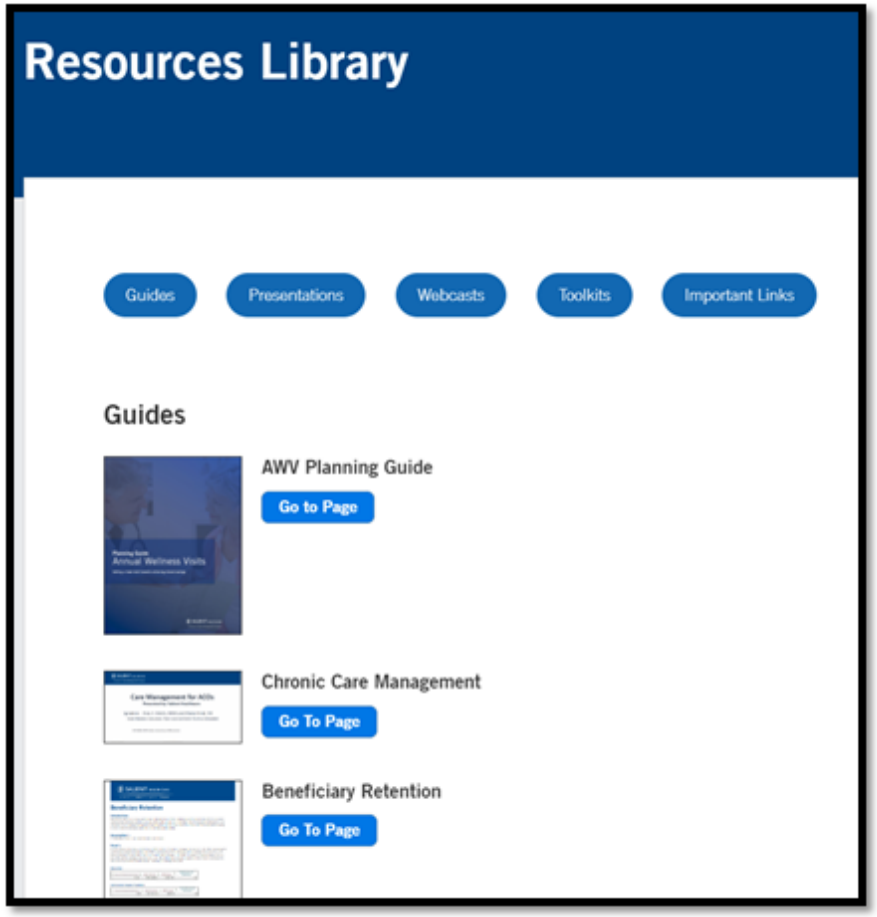
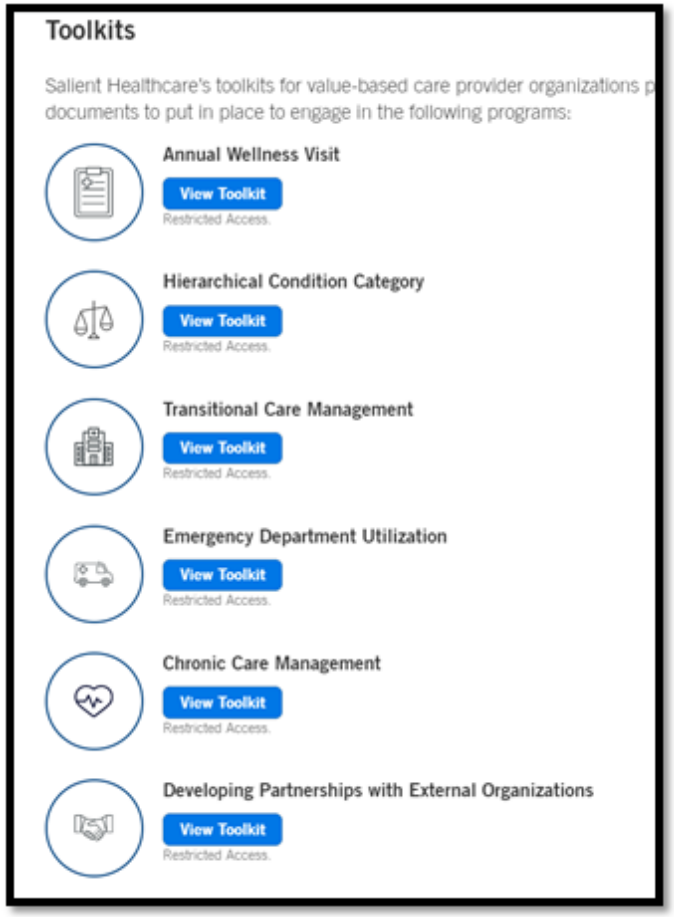
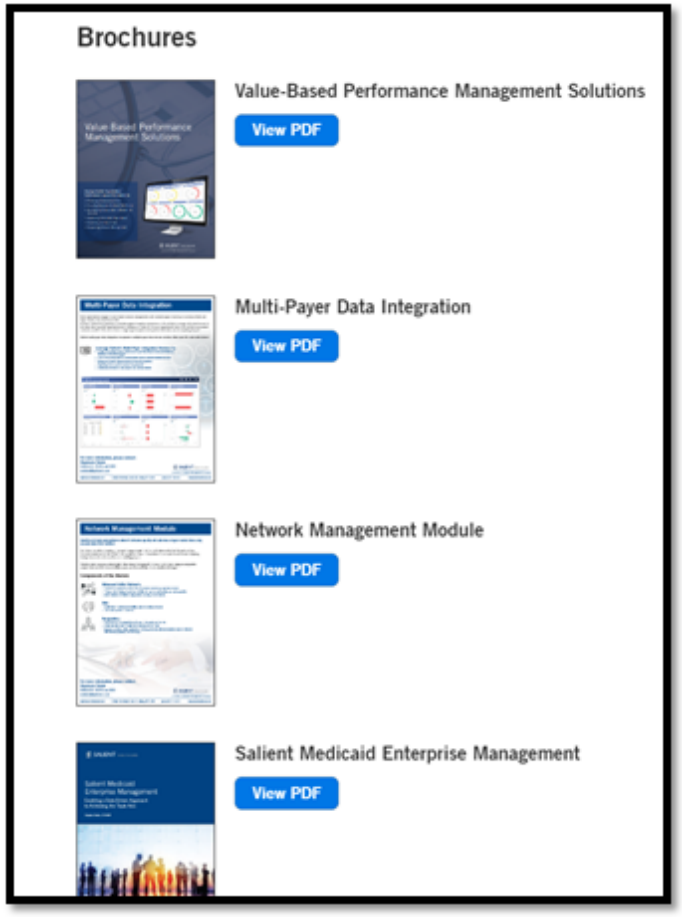
Salient Resource Library







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Q&A

QUESTIONS

Q&A

ANSWERS

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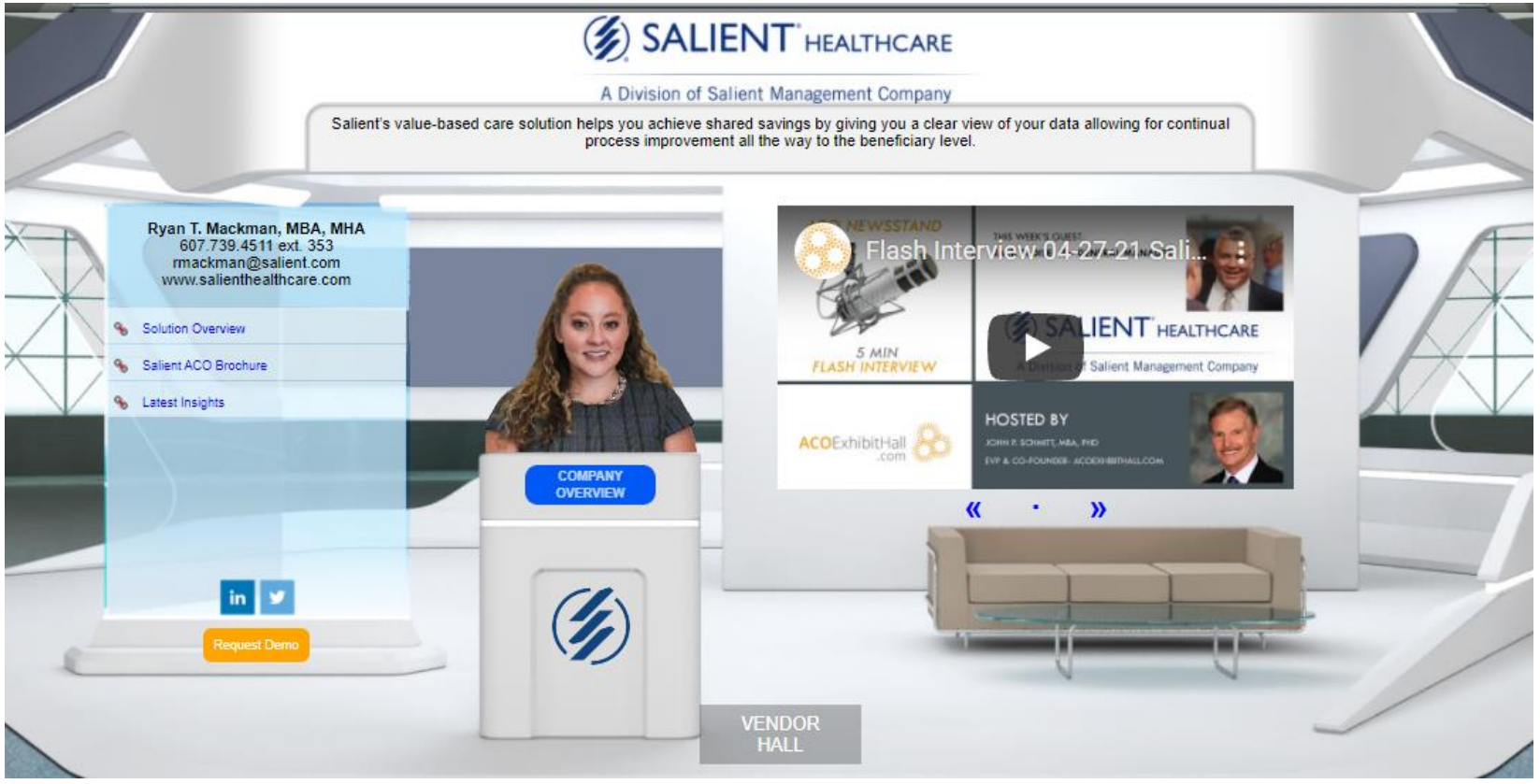
Stop By Our ACO Exhibit Hall Virtual Booth



https://www.acoexhibithall.com/vendor-booth/salient-healthcare/population-health-ii-software-tools-data-analytics/117/

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Thank You

Amy Holm Kotch, MHA | Prin. Business Consultant
- **Mobile:** 914.275.6531
- **E-Mail:** akotch@salient.com

Maria Nikol, MJ | Sr. Business Consultant
- **Mobile:** 410.812.7156
- **E-Mail:** mnikol@salient.com

Ryan Mackman, MBA, MHA | Business Consultant
- **Mobile:** 954.270.0692
- **E-mail:** rmackman@salient.com

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