The Medicare CCM Program is Smart, Safe & Vital

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- Mid-levels assign their billing rights to the organization and work under their NPI & insurance.
- Mid-levels work under the direction of a physician and conduct proactive monthly telehealth outreach.
- Specific care plans for each patient are agreed upon between the care manager (NP) and physician.
- Includes five sets of reimbursement codes which are reported monthly on a timed basis, each set with a base code of 20-to-60-minutes and an add-on code for each additional 30 minutes.
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ACO Feasibility Analysis FAQ

M-CCM is the missing piece of your reimbursement puzzle.

FEASIBILITY ANALYSIS FAQ

Why do our member clinics need a Feasibility Analysis?

Without a deep analysis, program success is nearly impossible. This is why both vendors and ACOs have failed to generate adequate program adoption and enrollments.

The program is a complex initiative. It is very much like a new business venture. Therefore, it is prudent and desirable to first test assumptions, define strategies, evaluate data, and develop plans that would enable results that meet the goals and needs of your member clinics and their providers.

The analysis will complete all preliminary work necessary for program success (i.e. establishing clinical policy, providing physician education, conducting patient identification, developing the patient engagement / onboarding strategy, and more). This combined with a full-service support system, SaaS technology, and a team experienced in big initiatives – they can double or even triple average cadence results.

The starting point was their CMS Data Set Snapshot and Detailed Spreadsheet, which clearly showed the additional reimbursement potential justifies the Feasibility Analysis.

How long will the analysis take to complete?

Project duration will vary depending on the size of their organization (i.e. number of providers and eligible patients). The following is our basic rule of thumb to go by. Organizations with:

- 100 to 249 *eligible patients – up to 15 business days.
- 250 to 499 *eligible patients – 15-30 business days.
- 500 to 999 *eligible patients – 30-60 business days.
- 1,000 to 9,999 *eligible patients – 60-90 business days.
- 10,000 to 19,999 *eligible patients – 90-120 business days.
- Greater than 20,000 *eligible patients – 120-180 business days.

Your member clinics acceptance will be for the Feasibility Analysis only. The decision to proceed with a pilot program and/or execute a full or hybrid service, or SaaS only contract, will depend on the results of the Feasibility Analysis.

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M-CCM PROGRAM FAQ

How will the program benefit our member clinics patients?

The program empowers Medicare beneficiaries with chronic conditions take control of their health; offering education, guidance, and resources that foster a better understanding of their conditions. Through consistent monitoring and interventions, the program helps reduce complications, ER visits, and hospitalizations.

We think our member clinics are already doing M-CCM. How do we verify that we are?

Most organizations are doing some sort of CCM & telehealth outreach. However, according to CMS, more than 97% are not billing the programs specific CPT codes. This means additional reimbursement, that can easily be captured, is being left behind. Your members participation can easily be verified by asking their billing department to check the frequency of their CPT 99490 and 99487 billing. If they are submitting these codes, their monthly billing cadence should be no less than 20% of their eligible Medicare patients.

What is the difference between the program and their current CCM & telehealth outreach activities?

M-CCM is monthly telehealth interactions by mid-level nurse practitioner's (NP's) – physician-based CCM & telehealth is staff centric. Patients must explicitly 'opt-in' to the program. Their physicians, a nurse on their staff, a care manager or nurse or NP on your ACO staff, or an outsourced certified mid-level NP - on the physicians behalf (who assign their billing rights to the physicians organization and work under their NPI and insurance) are the only authorized people that can discuss the program with a patient (this can be done in-person or on the phone). Then the patient must schedule an 'initiating visit', which can be any face-to-face evaluation, management visit, annual wellness visit, or initial preventive physical exam. This creates indirect benefits in terms of generating more engagement and thus more in-office visits and more billable events for the member clinic and provider.

We do our own version of case management for chronic diseases that has been successful. So why do we need this?

Your ACO, member clinics, and providers are NOT paid in probabilities; you are paid in dollars. Accordingly, capturing additional reimbursement, maximizing financial performance, and helping eligible patients should be the only consideration. The program creates monthly billable events for each enrolled patient.

Why have ACO's not b'seen effective at handling the program?

It is the mission of ACO's to reduce Total Cost of Care, and the program was developed to help you accomplish this. So, indeed all ACO's can and should manage the program for their member clinics and providers. However, most cannot because of the complexities of the program and the way they are paid by CMS (shared savings). This means most lack the funding, technology, and staff to properly conduct the required preliminary work.

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ACO's are better suited for conducting program care management and patient outreach after a feasibility analysis is completed. Or after member clinics have opted-in 20% or more of your eligible patients. And we can help make this happen. Unless your ACO is owned and operated by the medical organization, most do not move on anything unless its demanded by the member clinics and providers.

All ACO's fail to provide a feasibility analysis and/or possess the required tech. But these organizational problems do not mean your member clinics and providers must take a pass on capturing the additional reimbursement and improved patient care. The ROI from the Feasibility Analysis is well worth the investment.

We have contracted with a vendor on a fully-outsourced contract (staffing and all other services), which had initial enthusiasm with eligible patients and physicians, but has fallen off. Why?

To promote the program, most vendors have utilized a highly flawed business model called 'service-now-pay-later.' This has never and will never work, and has caused most to fail in onboarding a sufficient number of eligible patients. Onboarding success requires many man-hours of preliminary work. In addition, it requires a great deal of trust from member clinics, which is never earned (when a service has no fee - data is the goal). Our service provider partner is certified by CMS and is a professional consulting firm that provides a real service. They know what works and what does not.

Fall off in enthusiasm is also from not having done the proper preliminary work and setting a proper level of expectations among physician staff, and performance metrics beyond basic billing data. These include:

- No feasibility analysis.
- No indication of how many patients are currently enrolled.
- No indication of what percentage of eligible patients are enrolled.
- No software tools that report on staff efficiency.
- No easy access to reporting on CPT 99490 and 99487 billing.

Is there a penalty for not participating in the program?

No, not directly. But CMS will penalize your member clinics and providers with a lower Cost Category Weight Score, which could affect their MIPS score and payment adjustments under MACRA and the QPP.

Patients do not like the co-payment. And this hurts our patient satisfaction score. How does the program overcome this?

All Medicare services require co-payments/coinsurance. This is normal. But your member clinbics and their providers can selectively choose not to pursue patients for co-payment if they think it will help with patient relationships. That is their decision to make. The reimbursement the program can capture, without added staffing pressure or additional workload - more than justifies participation.

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Will the program affect our member clinics workflow?

It does not have to. Outsourcing the program management to a third-party specialist result in lower costs and administrative burdens and allows your member clinics and providers to focus on their core services.

What is the average eligible patient opt-in rate?

We can generate a **20-30%** opt-in rate, while most opt-in rates from clinic staff, ACO, or a vendor is often in the low to mid-single digit percentage.

Why does the SaaS technology platform need to integrate with our member clinics EHR?

The SaaS technology platform is utilized during all phases because some deliverables will be generated using the platform. For example, executive dashboards as draft of executive reporting, and onboarding call management steps and processes.

There are several other reasons for use during a pilot program and contract phase; First, the program requires the mid-level NP's to interact with patients as a qualified medical provider. This means they need to have access to current patient records. Second, the NPs make notes on each call, which needs to be integrated into the patients EMR, so physicians remain up to date on all clinical patient interactions. And finally, to assist with opting patients in the program, the NP's need to be aware of any relevant diagnosis and physician activity to verify eligibility.

What data security protocols does the SaaS technology platform provide?

The platform is securely hosted on Amazon HIPAA-certified servers.

What is the bottom line on why our member clinics need the program?

Participating in the program can deliver a direct margin and profitability flow (after expenses). And with our full-service option - no additional staffing requirements and very limited additional workload. But with any service option you choose, the result will be capturing additional CMS reimbursement, maximizing financial performance, simplified care processes, improved patient outcomes and satisfaction, and more.