Follow the Money:
Medicare's New Gold Mine is Chronic Care Management Programs

White Paper

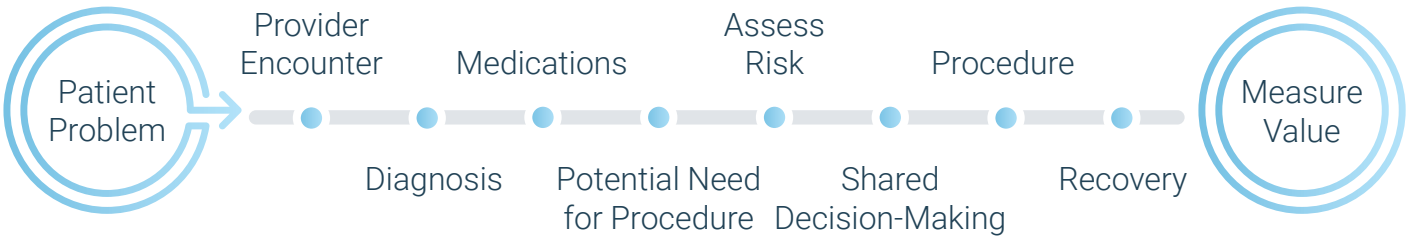
The Problem: Value-Based Care is Stuck

The concept of value-based care was introduced in 2006, so one would think that the change in how we think about, and practice medicine, would have far progressed by now. Over the past fifteen years, however, the premise of value-based care has failed to deliver the promised savings to taxpayers. Healthcare organizations and practices struggle to make well-care a priority because sick-care is consuming all their time and resources. The healthcare system is designed to respond in a reactionary manner versus preventive manner. Patients only visit their provider when they are sick. Many providers and practices are already overwhelmed, so it becomes impossible to fit additional, preventative medical care into their schedules with a revolving door of sick patients.

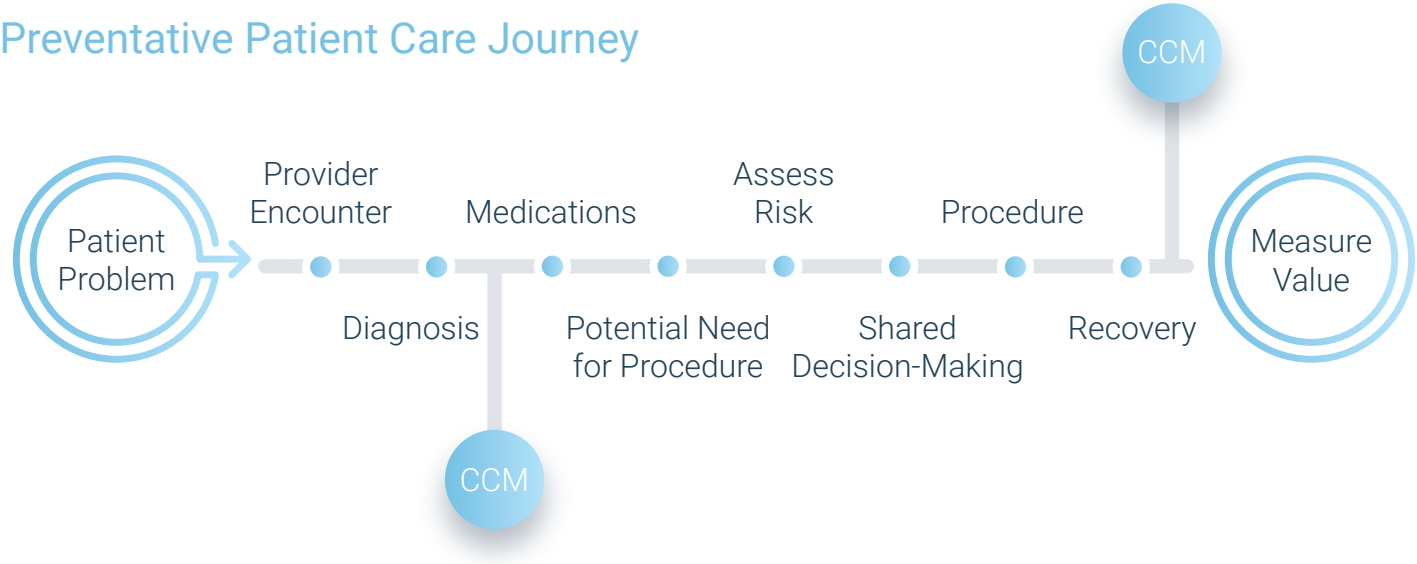
Measuring value-based care is a simple equation. Divide the savings of improved patient outcomes by the cost to deliver those outcomes. Sadly, the claims data shows we've performed miserably. The average taxpayer cost of a Medicare beneficiary has increased every year since 2006. Value-based care is a noble endeavor, but we are failing to achieve success.

If we step back and look at the entire patient care journey, it's almost entirely reactive. Where does prevention occur? The truth is, since value-based care was implemented, there has not been a concrete effort to add prevention to the patient care journey. To actually progress towards value-based care that improves patient outcomes and reduces costs, we need to insert prevention in the sick-care journey instead of thinking of prevention as a separate initiative.

Reactive Patient Care Journey



Preventative Patient Care Journey



Adding preventative services during the patient care journey sounds easy enough, right? Remember the most basic obstacle to preventative care: providers and practices are overwhelmed and stretched thin. It's difficult for them to find the time and resources needed, especially without a formal plan in place. In 2015, the Centers for Medicare and Medicaid Services (CMS) understood the need for an initiative that addresses preventative care for a particular, growing population of high-risk patients: those with multiple chronic conditions. They created a fee-for-service reimbursable program called Chronic Care Management (CCM) which provides an additional level of preventative care for Medicare beneficiaries with two or more chronic conditions that could also drive savings for taxpayers and Shared Savings Programs. CCM addresses and manages patients' chronic conditions before they worsen, ultimately improving health outcomes and saving costs towards future hospital and ED visits.

Solution: Chronic Care Management

So, what is required of a successful Chronic Care Management program? At its core, CCM is a preventative program, designed by Medicare to offer patient-specific support through 20 minutes or more of non-face-to-face care coordination services each month. Most enrolled patients will have a small, monthly cost-sharing obligation. For this reason, eligible Medicare beneficiaries--those who have two or more chronic conditions and have been seen by their provider in the past year--are invited to join the program and must provide their consent to be enrolled.

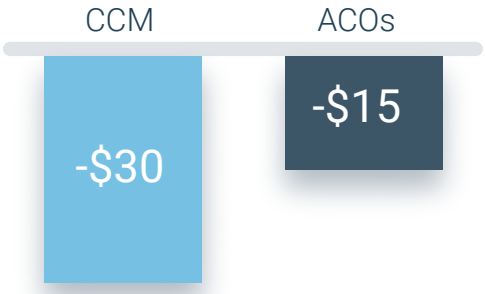
Several types of providers can perform CCM services, widening the opportunity for this crucial step towards value-based care. Provider types can vary and include but are not limited to doctors, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants. Additionally, other clinical staff can perform services under general supervision, meaning the billing practitioner does not have to be physically present to perform the services.

Dual-Stream Approach

When CCM is introduced to the patient care journey, claims data shows the average annual cost of a patient with multiple chronic conditions drop by nearly $900 per year which equates to a staggering 12% reduction in taxpayer spending. By adopting a successful Chronic Care Management program, practices are utilizing a dual-stream revenue approach -- fee for service plus shared savings. CMS conducted a retrospective claims analysis for every patient in the country over a two-year period that was enrolled in a CCM program. The data proved that for every patient enrolled in a CCM program for at least a year, CCM generates an average of $74 in monthly, per patient Medicare gross savings[2].

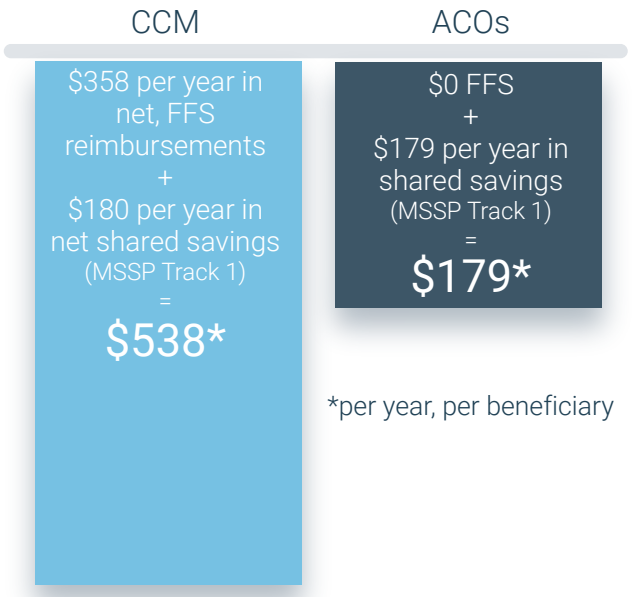
If we look at just net savings, CCM generates $30 in monthly savings, after provider reimbursement, for each patient in the program for at least a year. Contrast that with the average ACO performance in 2020, which only saved taxpayers $15 per patient, per month[3]. CCM represents a chance to generate immediate revenue now through FFS and still dramatically increase shared savings on the back end.

Total Monthly, per Patient Medicare Net Savings



The average practice will earn $358 per patient per year in CCM reimbursements and approximately $180 per year in net shared savings (assuming MSSP track 1).That sums to $538 per year, per Medicare beneficiary enrolled in your CCM program.

Dual Stream Provider Earnings



*per year, per beneficiary

A Cut Above the Rest

There are several companies out there who provide Chronic Care Management services. You'll find everything from CCM software in your EHR to a team of CCM-devoted nurses who provide a turn-key service. ChartSpan became the largest provider of CCM services in the industry, based on the notion that a CCM program needed to be turn-key and not interrupt the workflow of a practice or provider. ChartSpan provides CCM "as a service" delivering everything from start to finish so that providers can focus on what they do best: practicing medicine in-office. They operate on the notion that successful value-based care programs occur when providers are relieved from the burdens of value-based care administration, like data reconciliation and patient enrollment, and can focus on the patient care portion of value-based care.

ChartSpan partners with practices to deliver operational support services in a simple six step process to improve patient outcomes and practice profitability. Through this process, they have documented successes like no other CCM company in the industry, including the only CCM service provider to achieve positive Net Patient Churn.

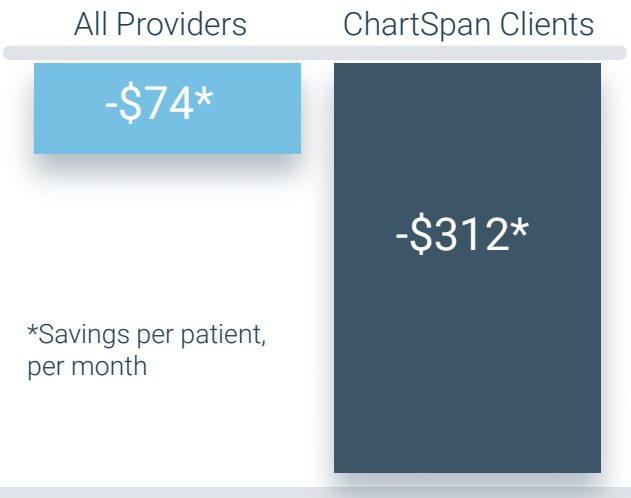
The ChartSpan Process

- Data Management
- Patient Education
- Patient Enrollment & Eligibility
- Clinical Support Services
- Billing Automation
- Quality Assurance

The Power of ChartSpan CCM

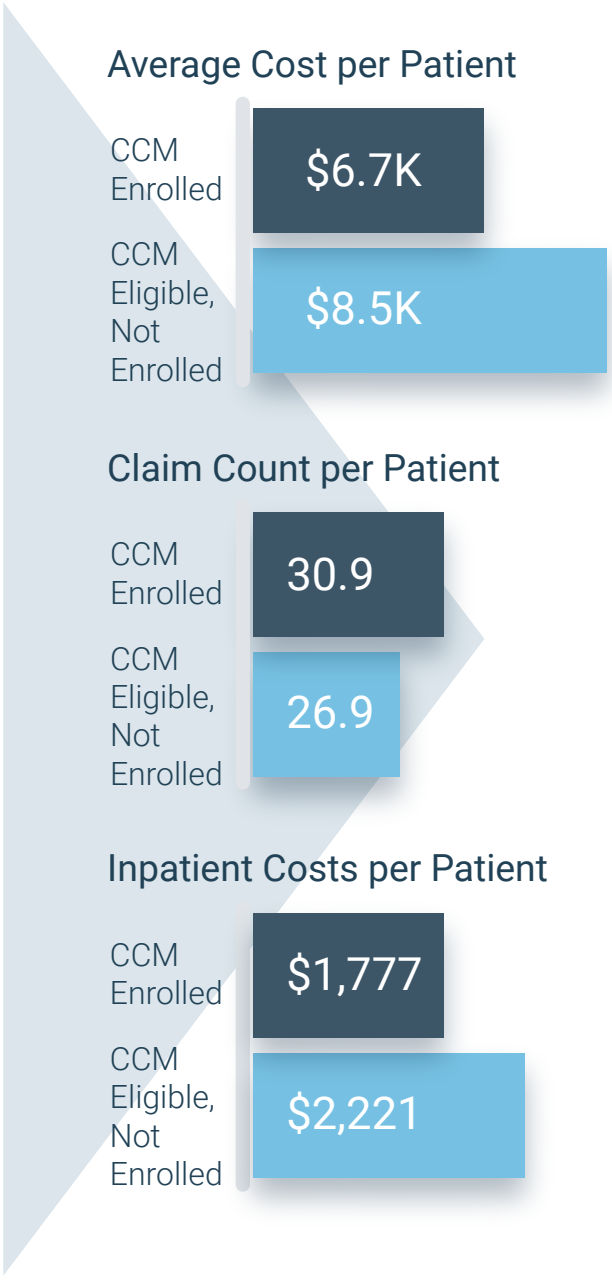
Medicare claims analysis shows that ChartSpan customers dramatically outperform their CCM peers and the rest of the industry. A blended average of savings across all ChartSpan customers showed savings of $312 per patient per month, a shocking 322% higher than the industry average.

Patient Savings



In a retrospective Medicare claims analysis of a mid-sized health system and ChartSpan customer, located in Ohio, the data showed a $1,800 per patient annual reduction in total costs for each patient enrolled in CCM. It equated to a 21% reduction in total annual costs for Medicare, taxpayers, and patients when a patient is enrolled in a CCM program. Additionally, inpatient costs showed a $444 per patient reduction in costs.

Case Study: Ohio Health System

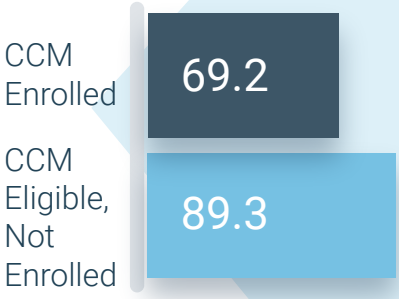


A primary care clinic, and ChartSpan customer located in Louisiana, showed even more remarkable results. This practice showed an $18,500 per patient annual reduction in total costs for patients enrolled in CCM and a 64% reduction in annual costs for Medicare, taxpayers and patients. Similarly, the cost of ED visits dropped by $211 per patient for those enrolled in CCM.

Case Study: LA Primary Practice

Average Cost per Patient

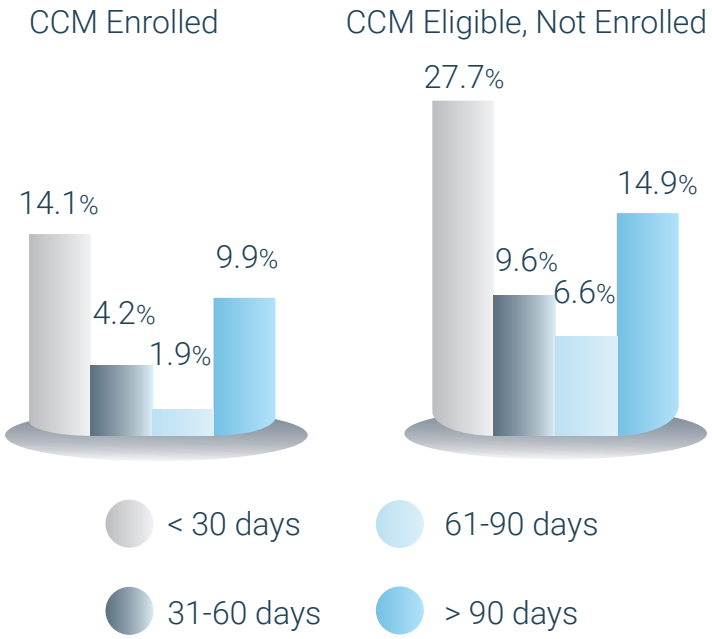
Claim Count per Patient



ED Visit Cost per Patient

Notably, ChartSpan customers have also proven a reduction in readmission rates. For example, at the same Louisiana practice, patients who were eligible, but not enrolled in a ChartSpan CCM program were readmitted within 30 days, 96% more often than those enrolled in CCM.

Readmission Rates



In summary, Medicare created its own gold mine, Chronic Care Management. The data proves it is working. CCM checks every box in terms of improving outcomes, generating revenue, and lowering overall healthcare spending. And with organizations like ChartSpan available that have mastered the operational complexities and require nothing up front to get started, there is simply no excuse not to have a CCM program available for your patients.

Sources

[1] S.L. Hayes, et al, High-Need, High-Cost Patients: The Commonwealth Fund.

[2] Evaluation of the Diffusion and Impact of Chronic Care Management (CCM): Final Report. 59% of savings was paid in reimbursements. $74 represents saving for patient in program for at least 12 months. Source: S.L. Hayes, et al, High-Need, High-Cost Patients: The Commonwealth Fund.

[3] IPW News: Chelsea Cirruzzo. ACOs Saved $1.19B In 2019, CMS Says, Touting Revamped Program. Per beneficiary savings was concluded by splitting.