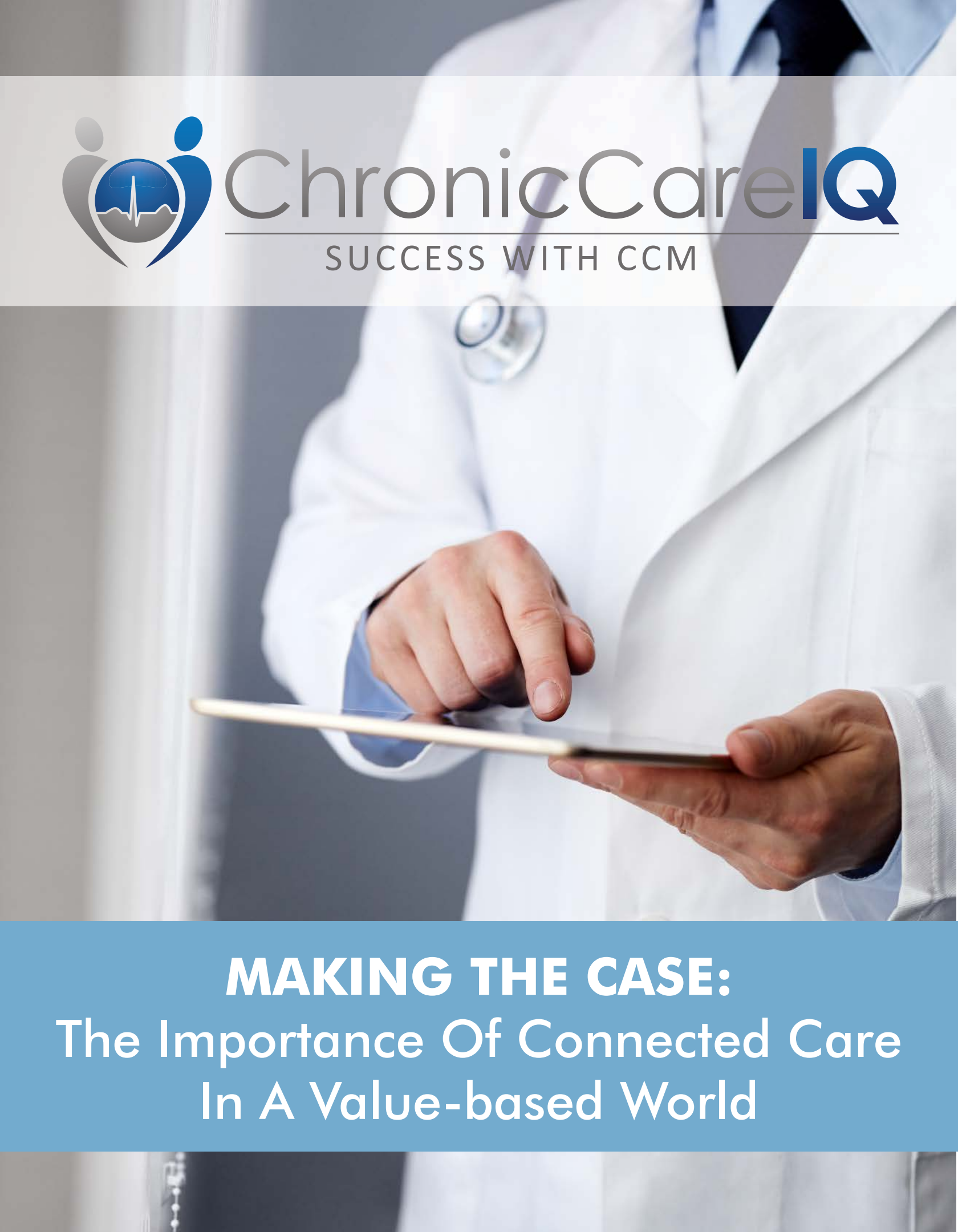

ChronicCareIQ

SUCCESS WITH CCM

MAKING THE CASE:
The Importance Of Connected Care In A Value-based World

The Problem: Episodic Care Leaves Patients Invisible

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CMS began with 'Connected Care' as its new terminology surrounding Chronic Care Management (CCM) in 2015 when it released a new code to recognize non-face to face time spent managing Medicare Beneficiaries. On January 1, 2015, the Medicare Physician Fee Schedule (PFS) began to reimburse qualified providers for Chronic Care Management (CCM) services for beneficiaries with two or more chronic health conditions. The development of 'Connected Care' has been prolific and is relevant to new models of healthcare reimbursement focused on maintaining wellness and improving outcomes. The 2020 Final Rule grouped these codes into the Care Management section of the final rule (link to the Federal Registrar's Final Rule publication here).

The expansion of the Care Management approach is a focus on value. Over the recent years, payment models have begun to compel providers to perform on outcomes as well as generate savings to healthcare payers and consumers. This is the essence of what is being called 'value-based care'. It's a move from a focus on patient volumes as a driver of the healthcare economy to the achievement of value through quality and cost outcomes. The 'Connected Care' or newly minted Care Management codes defined in the 2020 Final Rule resemble a value-based care agenda by the Centers for Medicare and Medicaid Services (CMS). The value-based care philosophy has found expression in the form of these new CPT codes. They are a recognition of the interactions and transactions which lead to value in healthcare. Such things as more frequent access to a medical team, frequent contact and exchange of data points brings forth a 'concierge' level of care.

A recent research report from Mathematica Policy Research suggests that CMS's CCM program is moving the cost and quality needle in the right direction. Because of CMS's invested time and continued expansion of CCM, it appears this program will continue to progress and help contain spending and improve the quality of life for millions of Medicare Beneficiaries. As new codes are released such as 'Principal Care Management' which was part of the new 2020 Final Rule for the 2020 Physician Fee Schedule (PFS), we are reminded as to why we should care: more than 130 Million adults suffer from 1 or more chronic diseases; 66% of adults suffer from 2 or more chronic diseases. These diseases are the fulcrum of population health care models which attempt to quell the utilization of Medicare resources dedicated to these diseases. 'Connected Care' is about the practice, physician and patient care teams working together to improve outcomes and satisfaction on that patient's disease state. The direct result of that is lower utilization. Medicare has seen that by promoting a connection with patients in a non-face to face manner and reimbursing providers for time spent managing a patient who is not right in front of them that the patient incurs fewer costs to Medicare. Even the earliest data on the CCM program shows significant trends towards reduced costs

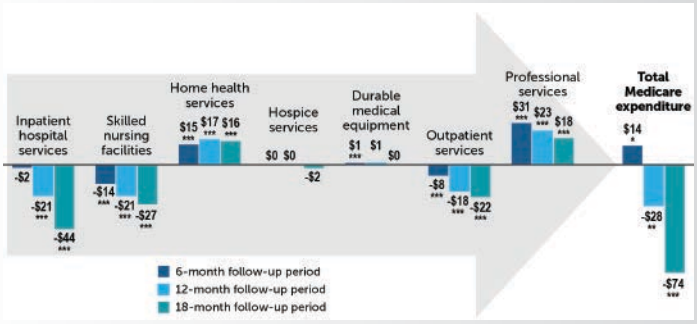


Table 1.0 Estimated PBPM impact of CCM on total expenditures and by expenditure category: 6-, 12-, and 18-month follow-up periods. (2014-2016 claims data).

The Mathematica report referenced above and here describes some of the benefits and challenges of developing a CCM program. Specifically, it was reported that 75% of practices which initially decided to outsource the time requirements to call center vendors retracted that plan and brought it all in-house for consistency and continuity of care reasons. Also, they simply cited that they did not want strangers calling their most fragile and complex patient base (page 34, of the report cited above). The initial results from the earliest adopters of CCM is overwhelmingly positive. The overall decline in total Medicare expenditures is telling; it shows that patients use costly acute services less.

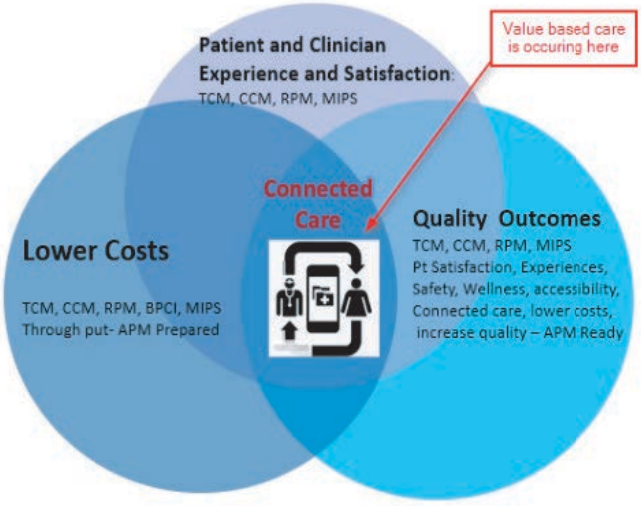
Brief Background - Why the Focus on Connected Care?

Looking in the rear-view mirror just slightly is a reminder that use of EMR through Meaningful Use, measures management through PQRS and previously the Value-based Modifier which provided differential payments based on utilization, all have culminated in refined models for 'value-based care' we now call the Quality Payment Program (QPP). Innovation is present. It's right to look toward technology as a focus of how to increase access to care and improve outcomes on cost and

quality. Efforts to do this have been persistent so let's level-set on why 'Connected Care' is so important right now.

'Connected Care' is important because the data is near real-time and patient reported. This is the world we live in now.

Breakthroughs in business intelligence and cost modelling have certainly helped with understanding where costs can be cut. Lengthy data aggregation projects, interfaces and data warehousing all have tried to offer insight into trends. But what about just asking the patient how they are doing or finding out some physiological data points?



This is needed because nothing in our system of healthcare thus far has been able to tell us 'when' a Medicare patient has deteriorated or begun a trend of more complex care and higher utilization until now. Nearly all Americans have internet in their homes and a computer in their pocket wherever they go. The Senior Living website (https://www.senior-living.org/tech/ is chock full of information on the likelihood of seniors using technology.

A featured study included The Pew Research Center report indicating that only 14 percent of seniors had internet in their homes in 2000. As of 2017, that number increased to 67 percent for adults over age 65. In addition, 51 percent have high-speed internet. Eighty-two percent of seniors aged 65 to 69 have internet, while 44 percent of those over age 80 have internet in their home. For seniors who do use the internet, 71 percent are going online daily.

Families and loved ones connect seamlessly using the internet and their smart phones. Physicians and Medicare Beneficiaries are destined for this level of connectivity. The current analysis by CMS has shown CCM to produce an effect on utilization which is too strong to ignore. 'Connected Care' and the new Care Management codes released and updated in the Final Rule for 2020 can subsequently have the effect of being a significant propeller of performance in the new government Medicare programs.

There are pressures which are building within the Medicare payment models to reduce costs of Medicare Beneficiaries, take on risk and then move to more advanced levels of participation. Let's not forget why.

In the spring of 2015, when Congress repealed the Sustainable Growth Rate formula (SGR), an Executive signature with a Republican Congress and Democratic President together ratified the future of value-based care. Upon the advent of The Medicare Access and CHIP Re-authorization Act (MACRA) and the Quality Payment Program (QPP) a hyper sensitivity to healthcare cost and quality has emerged from the Centers for Medicare and Medicaid Services (CMS). Payment models which attempt to guide physicians to low cost and high quality are under development and refinement by CMS and its innovation center CMMI. The Advanced/ Alternative Payment Model (APM) one track of the QPP is innovating and refining faster and with plurality more so than its counterpart The Merit Based Incentive Payment System (MIPS), the other track of the QPP. MIPS has really been evolving as a 'catch all' for physicians that do not participate in APMs and is in a 're-thinking' phase right now.

A Focus on Cost Outcomes has led to a recent CMS announcement on July 29th, 2019 which proposed changes to the QPP over the next 2-5 years. See the detailed facts from CMS here in the proposed changs fact sheet. The strong emphasis on 'Connected Care' is gleaned through the cost measures and managing the numerator and denominator of the Total Per Capita Costs (TPCC) and Medicare Spending Per Beneficiary (MSPB) cost measures. For 2019, MIPS uses cost measures that assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during 8 episodes of care (CMS.gov). The Medicare Spending Per Beneficiary (MSPB) measure evaluates solo practitioners and groups on their spending efficiency and is risk-adjusted to account for patients' risk profiles. The Total Per Capita Costs (TPCC) measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall efficiency of care (https://qpp.cms.gov/mips/cost).

Measure achievement points are determined by comparing performance on a measure to a benchmark. Cost measure benchmarks are created using performance data from the performance period, rather than historical benchmarks. It's

important to achieve in this area and lead in the 'bell curve' in this class. Cost impacts on MIPS scores will prove significant as the categories weighting recalibrates. Sustained performance on reducing utilization is paramount to success in value-based care, i.e. the QPP. The message is that submitting a measure or two via claims or doing a few improvement activities in MIPS no longer avoids a penalty of up to 9% on Medicare allowable charges starting in the 2022 performance year.

There is significant pressure on the program and especially MIPS where the math just has not panned out for cost reduction to Medicare so far. The MACRA law stipulates that in the 6th year of MACRA there must be a level of cost reduction and quality achieved specifically CMS stated: "Our goal is to continue incrementally increasing the performance threshold to meet the requirements established by Congress that beginning with the sixth year of the program (2022 Performance Year) the performance threshold needs to be set at the mean or median of the final scores for all MIPS eligible clinicians for a prior period. These increases are also a response to the strong performance of clinicians during the 2017 and 2018 Performance Years."

Here is the Layout of Proposed Changes to MIPS:

• Reduce the Quality performance category weight to 40 percent in 2020, 35 percent in 2021, and 30 percent in 2022

• Increase the Cost performance category weight to 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022

Interoperability and improvement activities really have marginal proposed changes all found in the full proposal fact sheet report in the link above.

Unforeseen high participation rates of eligible clinicians (ECs) have created a tough scenario for CMS and physicians. The big squeeze is on as CMS will recoup the money it promised to Congress through rebalancing of categories and emergence of cost measures to influence an expected tighter performance threshold. Avoiding the penalty requires 45 points in 2020 and 60 points in 2021. CMS is proposing to increase the additional performance threshold for exceptional performance to 80 points in 2020 and to 85 points in 2021. Cost measures and performance on outcomes measures which are specialty specific will drive the proposed program called MIPS Value Pathways.

The question is: has healthcare transformed enough yet for physicians to succeed in these value-based payment models?

The MIPS and APM tracks have laid the ground work for a freight train of transformational models to help physicians move from a volume focused healthcare economy to a more balanced value-based one. This has been a deliberate step away from incentivizing physicians for simply having an EMR, a portal, or a registry to straight-up paying for activities which reduce costs to CMS.

REMOTE PHYSIOLOGIC MONITORING	CHRONIC CARE MANAGEMENT
99453 - $21 99454 - $69 99457 - $54 99458 - $26	G0506 - $64 99490 - $42 99491 - $74 99487 - $94 99489 - $47 G2058 - NEW
PRINCIPAL CARE MANAGEMENT	**TRANSITIONAL CARE MANAGEMENT**
G2064 - NEW G2065 - NEW	99495 - $165 99496 - $234

Chart 1.0 *(Reimbursements may vary by state,above are mean whole amounts).*

CMS's value-based care agenda is further realized through the new reimbursements for non-face to face time spent with patients.

The effect may actually be the roadmap to the quadruple aim. Clearly the value-based care agenda of CMS is inclusive of the physician experience, patient experience and outcomes on cost and quality. The Final Rule for 2020 introduced Principle Care Management (PCM) as a way for specialty specific chronic care needs to be addressed and is for 30 minutes of time for patients with just one chronic

disease. It pays $42 per Medicare patient per month. The Remote Physiological Monitoring Category is growing since its unbundling in 2018. RPM code (99457) for example is $54 dollars per month per patient for interactive communication; CMS is paying physicians through interactive patient engagement. CMS unbundled this code from the original RPM code which was 99091 and is now superseded by 3 sets of codes for Remote Patient Monitoring (RPM). The set-up of patients on an RPM protocol may include use of a smart phone or a device and are now reimbursed through the 99453 and 99454 codes. The Final Rule for 2020 added an additional code for each additional 20 minutes of RPM time and that is new (code 99458).

This is different from CCM which is inclusive of 2 chronic diseases and includes work done like medication refills, and care coordination including phone time with the patient, whereas RPM code 99457 requires asynchronous communication which generally infers phone, text and email or using technology platforms to interact with a patient. A provider can bill both RPM 99457 and CCM 99490 in the same month. This is allowed because CMS recognizes the kind of analysis involved in furnishing RPM services is complementary to CCM. The proliferation of new codes for non-face to face interaction further illustrates the move away from the stymied innovation of the past. There is a shift towards patient engagement and population health strategies which are interactive. There is a move away from regulated technologies seen in the EMR adoption and Meaningful Use programs.

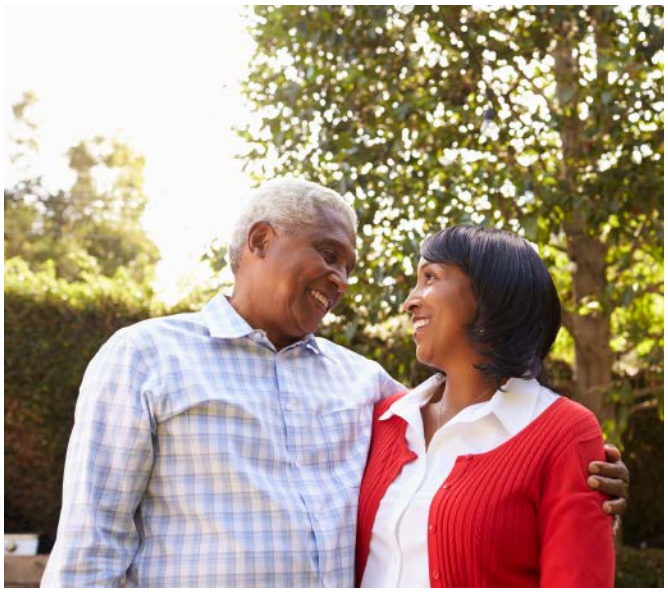
It's an interesting evolution seemingly aligned to the client server world versus the Software as a service (SaaS) world. The hand held device and internet-ready patient is a game changer for value-based approaches which rely on patient engagement and their outcomes as well as satisfaction to be part of the equation. This internet-ready connection can materialize as protocol based on disease state which aligns with reimbursement requirements. For example having interactive communication for RPM code 99457 could be facilitated through phone, text or email check-ins which update the practice and further care collaboration with the patient. It is billable when 20 minutes of interaction is accumulated. Example: a 70 year old submits answers to questions, data points and goes back and forth with the practice for 20 minutes in a month regarding a chronic condition; this time is billable for 3 codes totaling 144 dollars for that patient. Technology which facilitates this for the practice enables full or partial automation of these interactions and satisfies the billing requirements while helping patients avoid trips to the hospital. RPM 99454 which requires 16 data points in a month feeds the time requirements for the aforementioned code 99457. What's great is that the patient is getting attention to details like oximetry, weight, blood pressure, sleep, and other subjective data and providers are offered awareness of their at-risk population.

New codes like RPM and CCM connect the patient to the physician and practice staff with reimbursements for deploying a 'Connected Care' strategy. Such a strategy using these codes or their cadence of 'Connected Care' can embolden the expected returns of care management strategies to include success in shared savings arrangements or APMs. The attribution of any model can be managed with 'Connected Care' strategies regardless of the fact reimbursements in such places like Comprehensive Primary Care Model (CPC Plus) and End Stage Renal Disease (ESRD) APMs are seen by CMS as duplicative to their existing care management fees and payments.

Three sets of codes: CCM, the new PCM, RPM as well as Transitional Care Management (TCM) are key to optimizing what CMS has promoted as Care Management. The emergence of new Care Management codes includes Behavioral Health Integration (BHI) models as well known as the Behavioral Health Psychiatric Collaborative Care Management Services, Collaborative Care Model (CoCM). As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period. This model is promoting integrated connectivity with a behavioral health care team. Please see link to CMS fact sheet here

The American Psychiatric Association reports that the majority of mental health care is provided in primary care settings. Evidence shows that care and outcomes improve when psychiatric expertise is made available to primary care providers through an evidence-based psychiatric Collaborative Care Model (APA 2019). While this model has been well-studied, there was no consistent reimbursement mecha-

nism in place to cover the cost of providing services until now (American Psychiatric Association 2019). This is the integration of primary care and behavioral health services into the primary care setting and reimbursement for remote communication and collaboration with a behavioral health care team. Physicians will be reimbursed for 70 minutes of behavioral health care manager time the first month and 60 minutes for subsequent months. An add-on code for 30 additional minutes any month is in place as well. Since the introduction of BHI, Medicare has continued to update the billing codes and expand the reimbursement opportunities for providers aiding the millions of Americans living with a mental health disorder. The model consists of behavioral services that are categorized into general BHI and the psychiatric collaborative care model (CoCM) See source info here.



Conclusion:

'Connected Care' models have continued to grow and evolve since the 2015 creation of CCM and the passing of MACRA. The 2020 Final Rule has expanded Care Management with multiple new Care Management codes to reimburse physicians for coordinated and 'Connected Care'. The importance is not just about payment models and billable codes or pressures from MACRA; it's about a mindset that waiting for a decompensated patient to show up at the Emergency Room or be re-admitted to a hospital is a non-sustainable cycle for improving cost and quality. Patient satisfaction and the wellness of families who care for seniors living with chronic physical and mental conditions is improved through 'Connected Care' by aligning a strategy for wellness and chronic care with reimbursement. The expected effect, which is shown by the Mathematica data on CCM, is lower utilization of acute services.

Seven in ten deaths, 99% of Medicare's payments, and 86% of US healthcare costs overall are due to poorly controlled non-lethal chronic diseases. 1 in 5 seniors are readmitted in 30 days.

This is preventable. 'Connected Care' strategies are growing as CMS takes the lead in offering payment models which compel providers to perform in low cost and high-quality outcomes. Offering reimbursement for the actions of caring for patients through non-face to face methods of communication is a significant step by CMS to further its value-based care agenda and perhaps even attainment of the quadruple aim.

Physician practices, Independent Physician Associations (IPAs), Accountable Care Organizations and APM participants in CPC+ or Bundled Payments for Care Improvement (BPCI) stand to benefit from the paradigm of 'Connected Care'. These care strategies are transformational in that they lead practices to greater scope of opportunities in the QPP and commercial value-based care programs. Implementing a strategy which is tied to reimbursements facilitates new revenue while offering patients greater access to care teams and a path to lower utilization. This is good, because most patients want to stay out of the hospital and home with their loved ones if they can.

Mr. Brendan McAuley has 20 years of healthcare experience including most recently being part of the CMS Transforming Clinical Practice Initiative (TCPI) and was instrumental in the creation of a Clinically Integrated Network (CIN) and Commercial Accountable Care Organization. His experiences are vast including EMR, Cost Accounting, Quality Improvement methods and lean six sigma. He is a content expert in the Quality Payment Program as well as strategist for Connected Care which focuses on increased practice revenue and performance in value-based healthcare delivery systems.

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