The Savings and Health Benefits of Implementing Chronic Care Management

By Travis Bond, Founder and CEO of CareSync

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When CareSync shifted from a B2C to B2B model for CCM, we hypothesized that the outcomes would drive down costs for emergency department visits, inpatient services, and duplicate procedures and labs. Our belief, in the absence of data, was that if patients and their caregivers were more informed and had between-visit care coordination, it would result in an all-win scenario.

We also believed that managing the patient would direct them back to primary care more often, where the provider could continue to reinforce the treatment plan. We even went so far as to say that CCM would be a central mechanism for managing risk in a value-based model.

In February 2018, the Centers for Medicare and Medicaid Services (CMS) published the results of a study it commissioned from Mathematica Policy Research: "Evaluation of the Diffusion and Impact of Chronic Care Management (CCM) Services: Final Report." Using data from 2015 to 2016, researchers identified significant positive changes that took place in just the first two years of the CCM program alone.

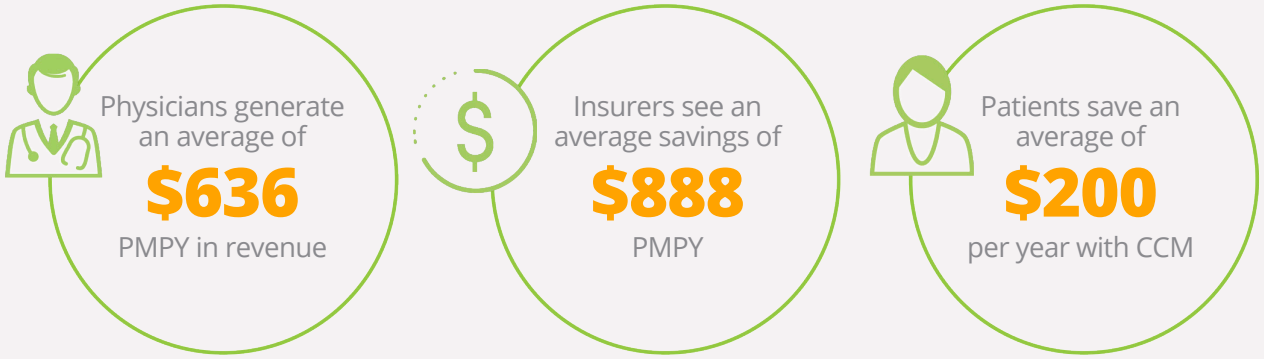
I'm happy to say the results support our hypotheses and our strongly held beliefs that care coordination would have a significant impact on controlling healthcare costs and improving the lives of individuals who battle chronic disease.

Excerpts and several key takeaways from this important assessment of the Medicare CCM program follow.

CCM Benefits Providers, Payers, and Patients

Our review of the data suggests that with CCM, providers generate an additional $636 per member per year (PMPY) on average in revenue, payers see an average savings of $888 PMPY, and patients save approximately $200 per year.

CCM By the Numbers



Generates New Revenue | **Reduces Costs for Payers** | **Saves Patients Money**

CCM Is Looked On Favorably By Participants

Researchers interviewed beneficiaries who were enrolled in CCM to gauge their views on the program and its value. They found many or most beneficiaries who participated in the interviews:

- Learned about CCM services from their primary care physician or another member of their primary care team
- Had a good first impression of CCM services and discussing them
- Felt being contacted about CCM services reflected their provider's commitment to their well-being
- Said they had a growing concern about the state of their health and could benefit from more regular communication
- Reported CCM services improved coordination across their care team
- Appreciated having a point of contact who could communicate with the physician or get them an appointment faster than they could on their own
- Generally appreciated monthly check-ins, saying they were "reassuring" and "a good reminder"

Some beneficiaries indicated an understanding of their CCM provider's role, saying it was to serve as "quarterback," "a gatekeeper," or a "first line of defense"

Some beneficiaries indicated:

- They were glad their doctor was getting paid for communicating with them outside of regular office hours
- They liked the idea that they could share concerns without having to wait until their next office visit
- An understanding of their CCM provider's role, saying it was to serve as "quarterback," "a gatekeeper," or a "first line of defense"
- Their perceptions of their provider improved after discussing CCM services (as one caregiver of a beneficiary explained, "It shows me that he cares about his patients")

CCM May Need Better Positioning

A few beneficiaries said that being asked about CCM services made them question if they were in worse health than they thought. As the authors of the report noted, and we agree, this suggests:

- "It may be important for providers to emphasize that patients do not need to be severely ill to experience benefits of participating."
- "Some patients do not recognize the seriousness of their chronic conditions, particularly conditions which may be asymptomatic, such as hypertension, hyperlipidemia, and early stage diabetes."
- "Some beneficiaries may need to have someone from the CCM practice explain some of the ways they can engage more fully with the services, and derive more benefits into the future."

Chronic Care Management Outcomes

- Improves patient satisfaction
- Helps ensure adherence to recommended therapies
- Improves clinician efficiency
- Decreases hospitalizations and emergency department visits
- Provides patients and caregivers with enhanced access to the practice during between visit-care
- Allows more medication monitoring and reconciliation
- Helps connect patients to home and community-based services
- Identifies patients' formerly unmet needs
- Reduces acute care utilization
- Facilitates advance care planning

As I've seen over the years, even when someone is diagnosed with multiple chronic conditions, they don't always identify as being "sick." It's similar to when someone says, "I don't have high blood pressure," but they are taking two medications for blood pressure. They are confusing having a condition "under control" with not having the condition at all. Or perhaps they're so accustomed to seeking out healthcare when something goes wrong, they have a hard time leveraging it to ensure things go right.

Sadly, someone's definition of what is sick can be one of their biggest roadblocks to achieving optimum health and letting their doctor and care team help them do it.

At CareSync, we work hard to overcome this obstacle on a daily basis. We find these approaches help:

- Care coordination is as much about maintaining good health as it is about preventing poor health.
- Having your care coordinated helps others involved in your care. It gives your doctor valuable information about your health and progress between office visits, and peace of mind knowing you aren't going without something important that you need, like a medication refill or an appointment with a specialist. Additionally, any family members or caregivers who support your care can rest easier knowing there is someone helping to look out for your health interests 24/7.
- If you have multiple chronic conditions, it's reason enough to have your care coordinated. Medicare created this program because they believe coordinating the care of individuals with two or more chronic conditions all of the time - not just when they're in the doctor's office - is critical to improving patient health and decreasing healthcare spending.
- Having support that helps you stay on track with your doctor's care plan is good for anyone to have, but it can be especially important when you have chronic conditions that require continuous monitoring and management, such as diabetes, high blood pressure, COPD, arthritis, asthma, and heart disease.

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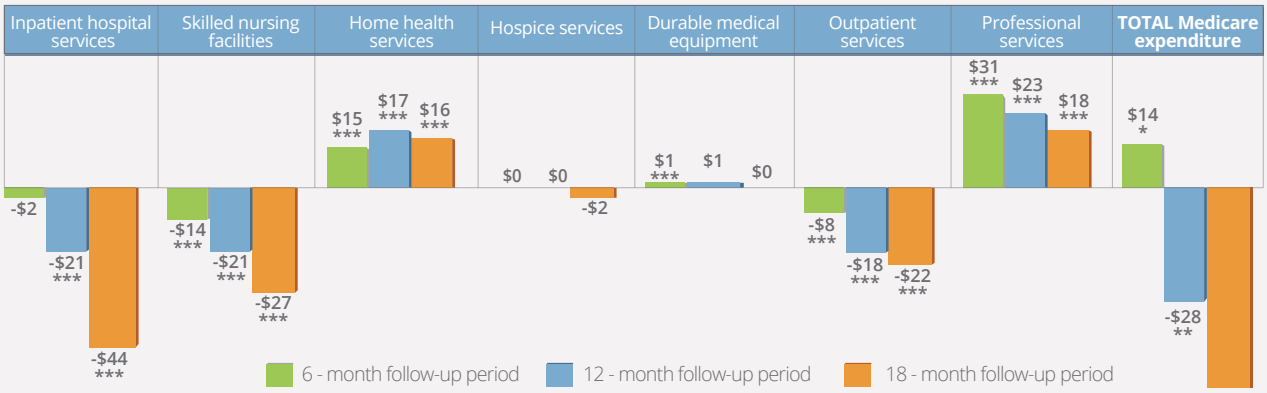
CCM is Proven to Reduce Healthcare Spending

CCM resulted in slower rates of growth in total Medicare expenditures, ranging from $28 to $74 per beneficiary per month (PBPM), after removing the average monthly CCM fee. CCM services also reduced healthcare utilization and the likelihood of hospital admissions for CCM recipients.

In particular, those with CCM had lower inpatient hospital, emergency department, and skilled nursing facility costs. They also experienced care that reduced the likelihood of hospital admissions related to diabetes, congestive heart failure, urinary tract infections, and pneumonia, relative to the comparison beneficiaries.

Based on the research, the gross savings associated with CCM for the Medicare program over one 12-month period was $88 million.[2] During that same time, CMS paid roughly $52 million in CCM fees, generating net savings to the program of $36 million.[3]

CMS Savings (Net of CMS' Payment of the CCM Code)[1]



[1] Source: Medicare 2015–2016 enrollment and FFS claims data. *Significantly different from zero at the .10 level, two-tailed test. **Significantly different from zero at the .05 level, two-tailed test. ***Significantly different from zero at the .01 level, two-tailed test.
[2] Gross savings to the Medicare program associated with CCM over a 12-month period following first receipt of CCM services.
[3] Mathematica Policy Research, Evaluation of the Diffusion and Impact of Chronic Care Management (CCM) Services: Final Report, 2018, Page 72.

CCM Drives Patients Back To Primary Care

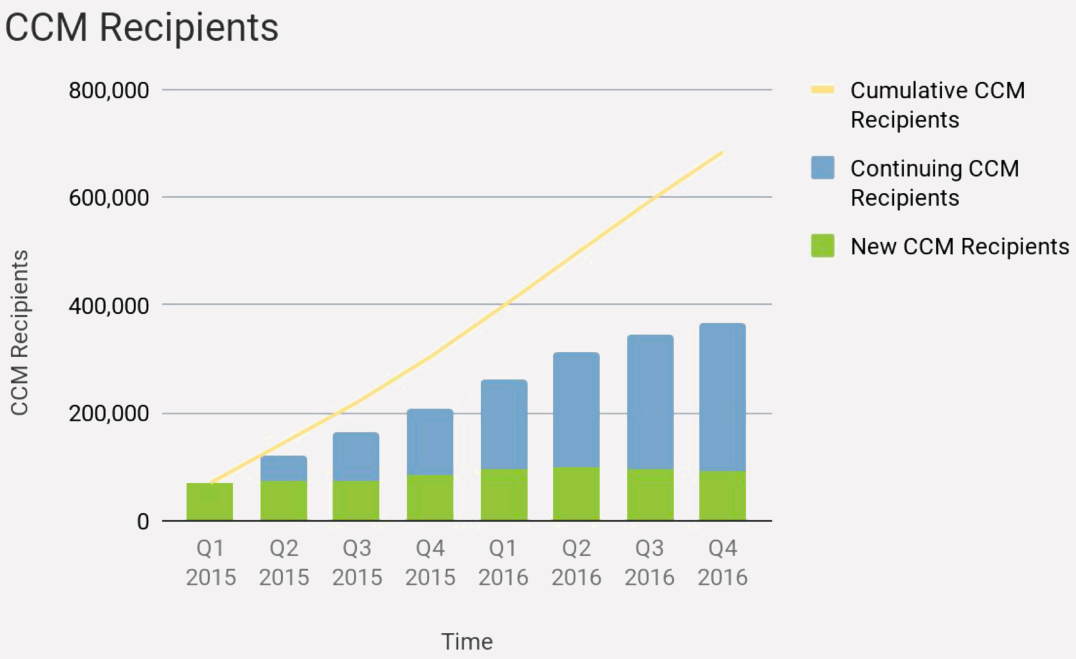
There were higher rates of growth in expenditures for professional services, reflecting a higher rate of primary care visits after initiation of CCM services.

Additionally, there was evidence that suggested patients in the CCM program took greater advantage of the healthcare benefits available to them, such as advance care planning, and that participating in CCM led to better management of end-of-life care.

CCM Gets More Effective Over Time

Providers offering CCM in 2015 and 2016 were true early adopters and tested the proof of concept of between-visit care. With every quarter, CCM participation grew and so did evidence of its value.

CCM Participation Is Increasing



CCM in 2016 outperformed CCM in 2015. The authors of the report noted that baseline total Medicare expenditures, which are an indicator of overall health status and care needs, decreased over time.

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In the first six months of 2015, the PBPM expenditures for those who received CCM services was $1,395. Compare that to the $1,192 PBPM for those who received CCM services in the first six months of 2016, and you can see that CCM is getting more effective in driving down costs.

In 2017, CMS added complex CCM and other codes, as well as remote enrollment options that directed more resources to care coordination activities. We are certain these baseline years (2105 and 2016) are only the beginning of a maturing awareness of CCM and the effectiveness of care coordination.

Our Perspective at CareSync

At CareSync, we believe the data from the report supports our long-standing value propositions: Save the payer/patient money, increase revenue for the provider, and improve the quality of life for patients. We also believe it demonstrates that CCM is an important, proven care delivery model that will be critical in helping the healthcare industry move deeper and more effectively into value-based care.

One can speculate that with the overall improvements made to the CCM program in 2017, and with the new general care management codes implemented in 2018 for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), we can expect increased implementation of CCM and a greater number of patients experiencing the benefits of CCM moving forward. We believe this means the numbers reflected in the report have no place to go but up.

Learn more about the savings and health benefits of CCM.

Download our free CCM White Paper or our free RHC and FQHC CCM White Paper today. Or call 800-501-2984.

Disclaimer: At the time this white paper was published or uploaded to the web, the information included was current. This report was written to provide you with a general summary of CCM health outcomes and savings based on the 2018 study commissioned by CMS and our experiences at CareSync. It is not intended to take the place of written laws or specific statutes as they evolve. CareSync encourages you to visit CareSync.com and CMS.gov for updates regarding the Medicare CCM program.

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