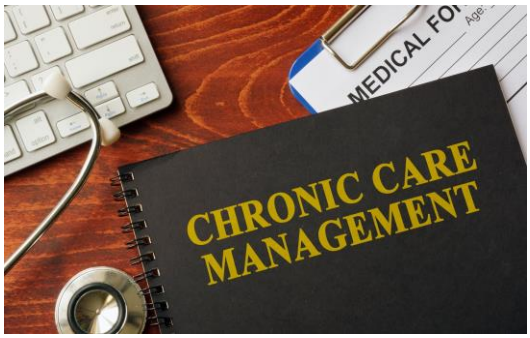
Chronic Care Management (CCM) services: win-win for patients, providers, and payors!



What is CCM?

Chronic Care Management (CCM) is a Medicare Part B benefit delivered under the general supervision of a physician (a non-physician provider can also provide services under the physician's general supervision).

This benefit allows eligible providers to offer services outside the office to help those patients with two or more chronic care conditions to practice preventative care, follow a medical care plan, and effectively manage their health.

Why is CCM becoming so important?

The statistics speak for themselves...

- **50%** of the U.S. population has at least one chronic condition.
- **25%** of the U.S. population has two or more chronic conditions. *(BMC Health Service Research 2018)*
- Approximately **93%** of total Medicare dollars are spent on patients with two or more conditions.
- Usually highest hospitalization rate, (re)admission rate, utilizers of home health are among patients with 2+ chronic conditions.

The CCM Model

In the past, multiple providers worked separately (face-to-face) with a patient to treat individual conditions, generally with no over-arching care plan.

Over the past few years, the CCM model has evolved, and now focuses on a patient's overall wellness. The patient is looked after by a care team who develops a holistic care plan, and uses multiple interaction methods such as telephone, secure internet, face-to-face, and secured messaging, to coordinate patient care.

FACT SHEET

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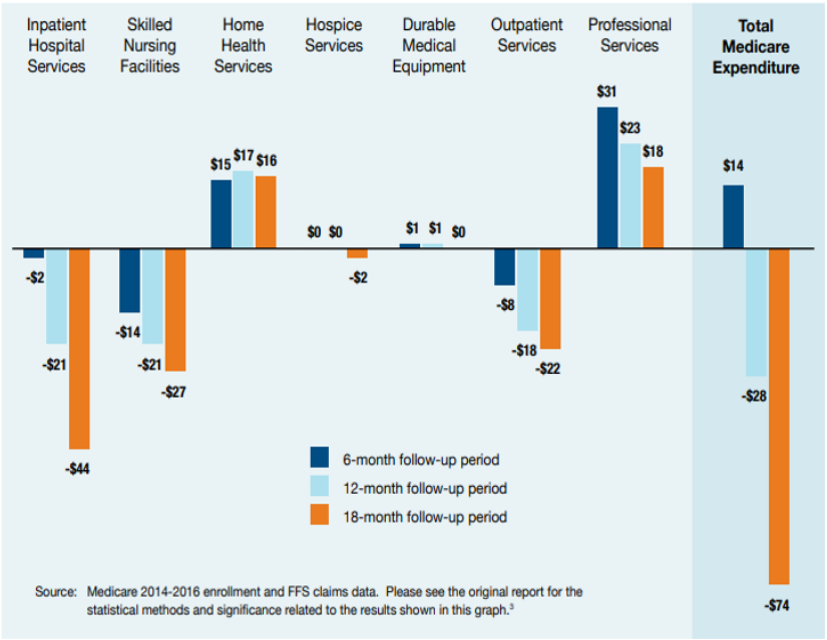
Chronic Care Management (CCM) services

Estimated PBPM impact of CCM on total expenditures and by expenditure category: follow-up periods of 6,12, and 18 months



Source: Medicare 2014-2016 enrollment and FFS claims data. Please see the original report for the statistical methods and significance related to the results shown in this graph.[3]

CCM positive impact on Medicare spend

A recent Mathematica Policy Research report "Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report" analyzed the outcomes of CCM services in primary care from 2014-2016.

Among other findings, they discovered that the per-beneficiary-per-month (PBPM) cost *decreased* for CCM beneficiaries after 18 months (most of these savings were realized in in-patient and post-acute care), while Medicare payments to physicians *increased*.

CCM Benefits

1**) For patients:** Program is designed to keep patient out of hospital, and offers increased access to health care team when (and how) the patient needs or wants. May also be less costly in many cases.

2) **For providers:** Ensures better and more comprehensive care for patient (more "eyes" on patient), which reduces frustration for provider and enables focus on more acute patients.

3) **For payors**: Promotes wellness, reduces ER/facility (re)admissions, and decreases overall chronic care costs.

Not sure how to implement CCM services to benefit you and your patients? Contact us to find out more.

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