THE NATIONAL CHRONIC CARE MANAGEMENT

SURVEY 2015

PYA

enli Health Intelligence

INTRODUCTION

For years, physicians have complained – and rightfully so – that they receive no reimbursement for time, effort, and resources spent managing their patients' care outside the four walls of the exam room. Such uncompensated work includes, among other things, care coordination, medication reconciliation, arrangements with social service providers, and telephonic and electronic communication with patients and caregivers. As a result, few providers offer formal care management programs and most patients are left on their own to navigate the complexity of our healthcare system.

That all changed January 1, 2015, when the Centers for Medicare & Medicaid Services (CMS) began reimbursing for chronic care management services (CCM). For the first time, healthcare providers were eligible to receive payment for non-visit-centered care.

CCM payments reimburse a practitioner for providing at least 20 minutes of non-face-to-face care management services per calendar month to a Medicare beneficiary with two or more chronic conditions. In order to bill for CCM, a practitioner must meet several specific practice requirements, which include using a certified electronic health record (EHR) for specified purposes. The current national payment amount for CPT 99490 is $43.12. A detailed explanation of these rules is presented in PYA's white paper, ***Providing and Billing Medicare for Chronic Care Management*** (June 2015).

According to CMS, two-thirds of traditional Medicare beneficiaries – about 25.4 million individuals - have two or more chronic conditions, and thus are eligible to participate in CCM programs. In promulgating its rules for providing and billing Medicare for CCM, CMS emphasized these services are critical to improving outcomes and reducing total costs of care for these individuals.

As reported by *Modern Healthcare* on October 13, 2015, however, CMS officials confirm having received CCM claims for only 100,000 Medicare beneficiaries thus far. That means less than one-half of 1% of eligible beneficiaries are now receiving these critical services.

RESEARCH OBJECTIVES

PYA, a national healthcare consulting firm, and Enli Health Intelligence, a population health management solutions company, jointly developed the *National Chronic Care Management Survey 2015* to inform policy makers, providers, and vendors offering products and services to support providers' CCM programs regarding the following:

- Capture provider attitudes, intent, aspirations, and experience with CCM.
- Identify the types of organizations that are embracing CCM.
- Gain an understanding of the obstacles to CCM adoption.

RESEARCH METHODOLOGY

The National Chronic Care Management Survey 2015 was conducted between August 3 and September 21, 2015. Invitations to participate were sent via email to 7,328 healthcare organizations, including 5,426 members of the Health Information and Management Systems Society (HIMSS) based in the United States.

A total of 356 completed surveys were received, of which 309 were included in the final analysis. The response rate yielded a 95% confidence level, with a +/- 5.5% confidence interval.

Survey respondents represented a wide range of healthcare organizations eligible to provide CCM, including hospital systems, multi-specialty physician groups, and independent practices.

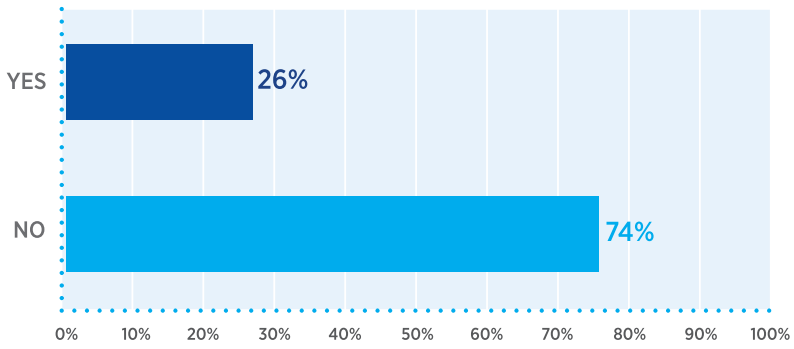
The survey was presented in two parts. The first part was delivered to all respondents, focusing on organization firmographics, respondent demographics, and current and intended participation in CCM. Those respondents who reported their organization had launched a CCM program were asked to complete the second part of the survey regarding their experiences.

All survey respondents were offered a $20 incentive in the form of an electronic coupon, delivered by Starbucks,® to compensate for the time and effort involved in completing the survey. A total of 249 opted-in for the coupon. Respondents were promised a copy of the final survey results as an additional incentive.

KEY FINDINGS

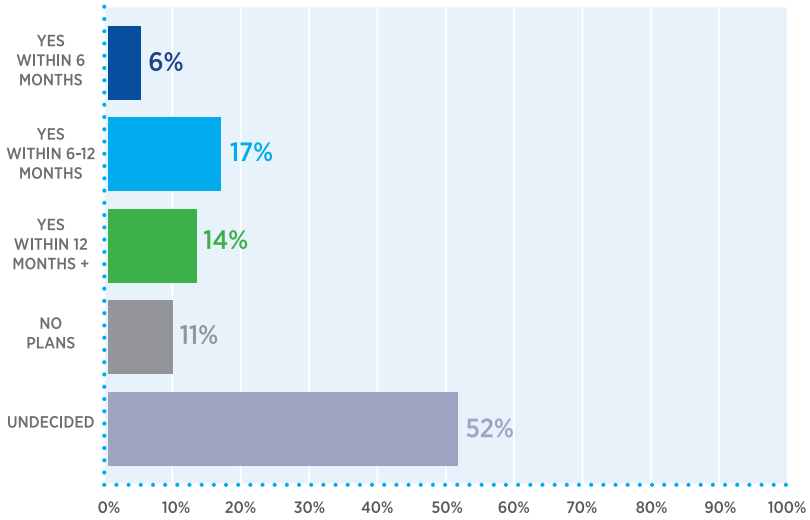
» Only 26% of respondents' organizations have launched a CCM program for their Medicare patients. And just less than half of these (49.2%) early adopters have successfully submitted a claim and received payment from Medicare for CCM.

Has your organization launched a CCM program for Medicare patients?



» The current low adoption rate is not due to a lack of interest in CCM: nearly two-thirds (64.3%) of respondents indicated their organizations had carefully analyzed the opportunity; and, 23% stated their organization intended to launch a program within the next 12 months. Only 11% of respondents stated they did not intend to implement a CCM program in the future.

Does your organization intend to launch a CCM program in the future?



» Respondents identified three key obstacles to implementing CCM:

- **Insufficient reimbursement for the time and effort required. (47%)**
- **Lack of awareness regarding the opportunity. (43%)**
- **Compliance concerns. (39%)**

» More than half of the respondents (60%)—mostly those associated with smaller organizations—are concerned that they would have to hire additional staff to implement a CCM program.

» Identifying ways to improve efficiency in providing CCM is also critical and much room for improvement remains. Of those providers currently furnishing CCM, the median time spent delivering the service is 35 minutes per patient per month, **15 minutes more than the 20-minute minimum requirement**. And, although non-face-to-face services may be furnished by any qualified clinical staff member, half of respondents (50%) are using registered nurses (RNs)—a more expensive resource than other types of clinical staff—to engage patients.

RESPONDENT PROFILE

The survey was made available to HIMSS members with ambulatory care facilities. Because of evidence suggesting the HIMSS database could potentially under-represent independently owned and operated clinics, the Definitive Healthcare database was used to off-set any sampling bias that could be introduced by enterprise-owned clinics.

» Survey responses were received from provider organizations in 45 different states. Providers in 28 states reported having implemented a CCM program, with organizations in 4 additional states indicating a present intention to launch a program in the near future. The greatest number of responses was received from Massachusetts, Minnesota, California, Illinois, and Kentucky.

» Hospital systems of all types and designations (academic medical centers, integrated delivery networks, community hospitals) that own and operate ambulatory facilities accounted for the majority (80%) of total responses. The remainder consisted of independently owned single and multi-specialty clinics, skilled nursing facilities, and federally qualified health centers.

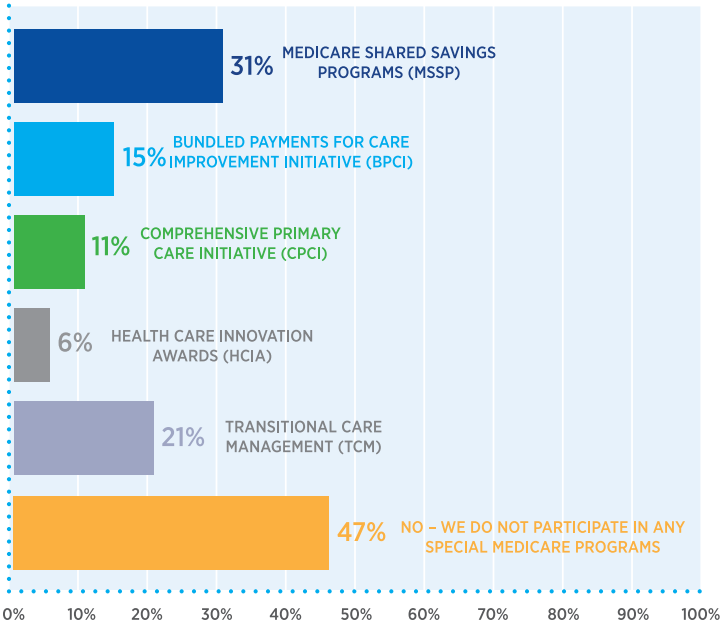
» The key functional areas of the healthcare organization were represented. Clinical staff represented 30% of responses, administrative staff accounted for 60%, and financial staff, 10%.

» Two-thirds of the organizations report having at least ten physicians; one-fourth had more than 100 physicians. Employment of RNs followed a similar pattern.

» Participation in provider networks was also measured. About 40% of respondents reported they are members of an accountable care organization (ACO).

» Participation in alternative payment models (APMs) also was measured. About half of respondents (55%) participate in CMS-sponsored APMs, with 31% participating in the Medicare Shared Savings Program (MSSP). Even more respondents (65%) are engaged in APMs sponsored by commercial payers, with pay-for-performance programs chief among those (42%).

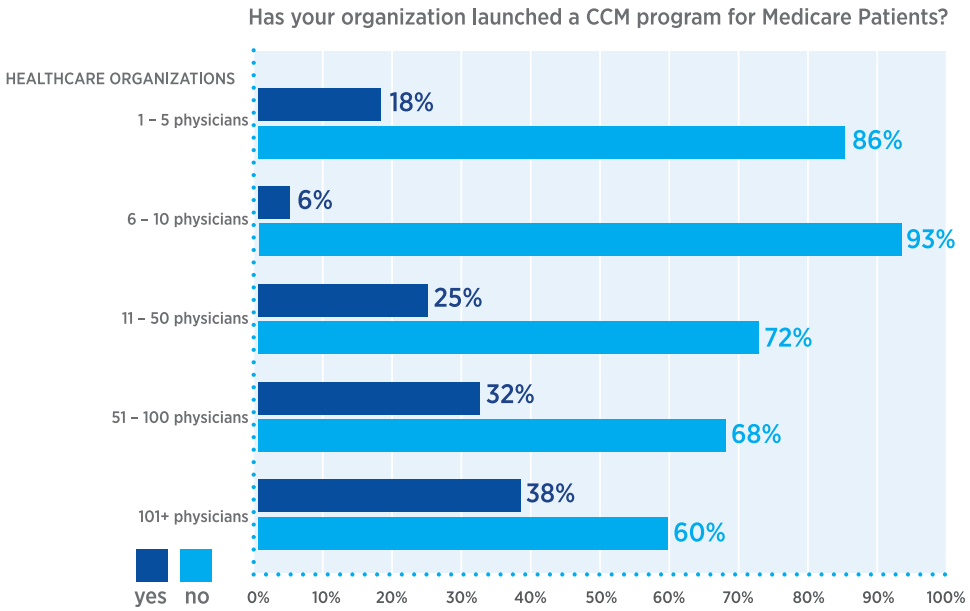
Is your organization participating in any of the following Medicare programs (check all that apply)?



THE CHARACTERISTICS OF EARLY ADOPTERS

The survey results revealed some key differences in organizations' responses to the CCM opportunity based upon their size, with most early adopters being larger organizations.

- Nearly one-third (32.3%) of organizations with more than 10 physicians have launched CCM programs, compared to just over one-quarter of all organizations.
- Organizations with more than 100 physicians had an even higher rate of launching a CCM program, just over 40% of respondents are in that category. The largest organizations also show the highest intent to participate—more than half (51.1%) of respondents with organizations employing 100+ providers plan on launching a program within the next 12-plus months.

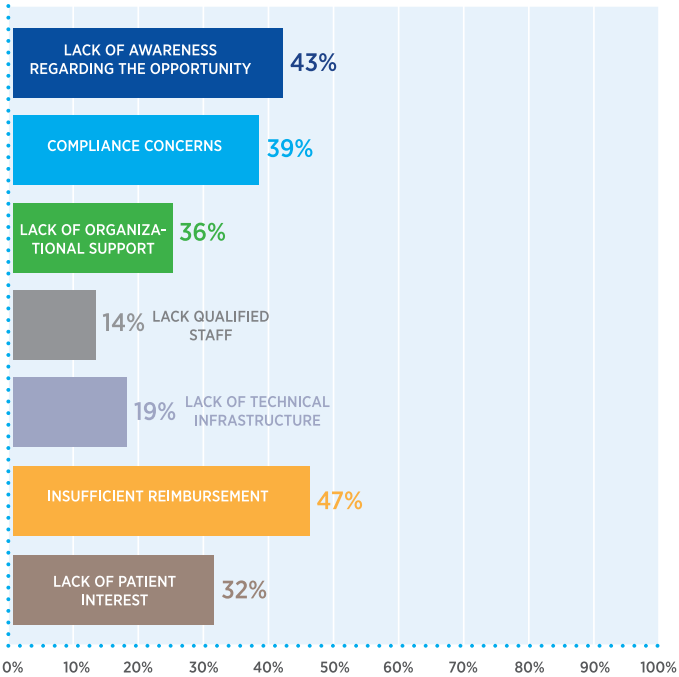


- Organizations with fewer physicians are struggling with issues related to organizational support and infrastructure, as well as knowledge about the CCM program. These are the two primary reasons why small organizations (1-5 physicians) are choosing not to offer CCM to eligible patients.
- It is noteworthy that small organizations that have initiated a CCM program report a greater rate of physician engagement, as well as less patient resistance to CCM relative to organizations with more than 50 physicians.
- Another key factor correlated with CCM implementation relates to whether an organization has prior experience participating in an APM, such as the MSSP and bundled payment initiatives: 42% of respondent organizations participating in an APM have launched a CCM program, while only 14% of organizations not participating in an APM have done so.
- APM-participating organizations that do not currently provide CCM are nearly twice as likely (49%) as non-participants (26%) to have definite plans to launch a CCM program in the near future.
- Interestingly, non-participating organizations (37%) are far more likely than APM-participating organizations (17%) to cite insufficient reimbursement as an obstacle to providing CCM.

ORGANIZATIONAL READINESS FOR CCM

- More than 65% of respondents reported having conducted an analysis to determine the requirements and cost benefits of pursuing CCM in the near term. The depth of analysis varies, but those who have launched a CCM program report having done moderate to extensive due diligence prior to implementation.
- Having done the research, and with experience, just 40% believe they can profitably pursue CCM. About 40% are unsure, and 23% believe they cannot.
- Provider organizations cite four primary reasons they are not presently pursuing CCM:
  - **Insufficient reimbursement – 47%**
  - **Lack of awareness about Medicare payments for CCM – 43%**
  - **Compliance concerns – 39%**
  - **Lack of organizational support and infrastructure – 36%**
- Respondents' concerns regarding insufficient reimbursement extend to their ability to pursue CCM with existing staff. Only 40% of respondents believe they can profitably pursue a CCM program with current staff.
- Limitations associated with the electronic health record represent another set of significant obstacles to CCM adoption. While EHRs certified by the Office of the National Coordinator for Health Information Technology (ONC) are capable of hosting the care plan, the following percentages of respondents indicated their current EHR had the necessary capabilities required for front and back office efficiency:
  - **Electronic patient consent – 59%**
  - **Patient cohort identification – 54%**
  - **Data-level integration – 54%**
  - **Patient-centric time aggregation – 25%**
  - **Role-based clinical and administrative process – 24%**

What do you believe are the primary obstacles to providing CCM (check all that apply)?



EARLY RESULTS WITH CCM

Based upon both quantitative and qualitative survey responses, many organizations believe that CCM appropriately aligns delivery with the principles of Medicare payment reform. At the same time, they generally also believe that the program will require some fine tuning. This supports emerging evidence that providers are taking a "wait-and-see" approach toward CCM as a service offering for their patients.

» Slightly more than one quarter of respondents (26%) have launched a CCM program. More than 60% are undecided or have no present plans to launch a CCM program in the near future.

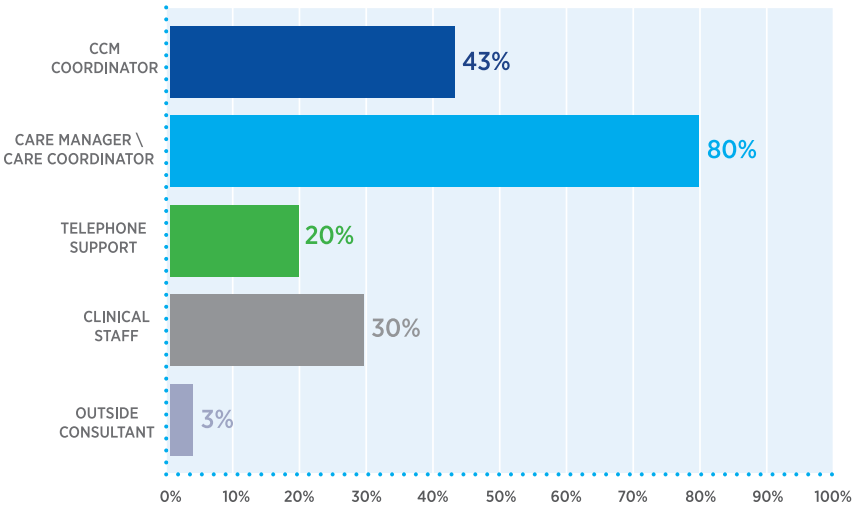
» Early adopters have developed their CCM programs internally. Less than 10% of respondents have considered outsourcing CCM to a third-party vendor, such as a care management company.

» Although CMS permits any qualified clinical staff member to provide non-face-to-face services, half of all early adopters use RNs to pursue their CCM initiatives. Medical assistants and nursing assistants are used by 19% and 11% of respondents, respectively.

» Nearly half of the early adopters (47%) report they have hired additional staff dedicated to their CCM programs. The job titles they have hired for include:

- **CCM Coordinator – 43%**
- **Care Manager / Care Coordinator – 80%**
- **Outside Consultants – 3%**
- **Telephone Support – 20%**
- **Clinical Staff – 30%**

Please specify the roles for which you have hired (check all that apply).



BARRIERS TO ADOPTION

Early adopters still are struggling to make their programs efficient and to provide the services to a greater percentage of eligible patients. Physician engagement, care team efficiency, and patient engagement are cited as three key challenges.

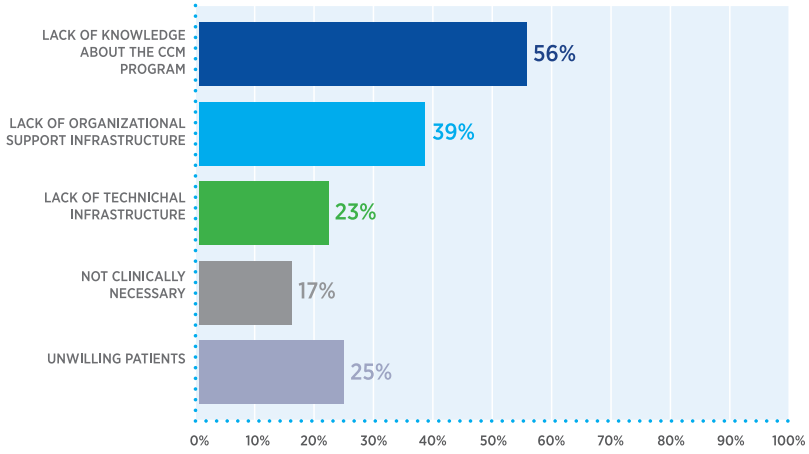
Provider Engagement

- Provider engagement is the first hurdle to a successful CCM introduction. Among the 26% of respondent organizations that have deployed CCM services, the typical respondent reports engaging just 13% of their Medicare physicians with the initiative.
- Small organizations, though adopting CCM at a slower rate, achieve broader physician engagement than do larger organizations. For example, organizations with 11-50 physicians report that nearly half (47%) of their doctors are now providing CCM services, while their enterprise counterparts (100 doctors or more) report they have engaged just 22% of their qualifying physicians.
- When participating organizations were asked to gauge the main reasons why their physicians are reluctant to engage with CCM, they cited the following:
  - **Lack of knowledge about the CCM program – 56%**
  - **Lack of organizational support/infrastructure – 39%**
  - **Lack of technical infrastructure – 23%**
  - **Not clinically necessary – 17%**
  - **Unwilling patients – 25%**

Patient Engagement

- Physicians and their organizations target CCM patients in various ways. The most common strategies include targeting patients with specific chronic conditions (61%), targeting patients with high-risk chronic conditions (54%), and targeting high-frequency patients (37%).
- Despite their targeting priorities, the median patient engagement rate is just 10% amongst early adopter organizations.
- Some clinics have done better—the highest reported engagement rate was 70%. Overall, however, most respondents (80%) have enrolled 20% or fewer patients, despite the fact that two-thirds of these same patients are eligible for the service.
- There is a clear need for patient education regarding CCM. According to early adopters, the reasons patients have given for not electing to receive CCM include beliefs that:
  - **Care management services are unnecessary (58%)**
  - **CCM services are already covered under Medicare services (51%)**
  - **The required co-payment is too costly (48%)**

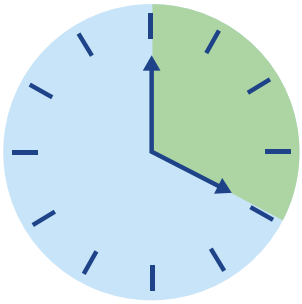
What are the main reasons physicians in your organization would choose not to offer CCM services to eligible Medicare patients(check all that apply)?



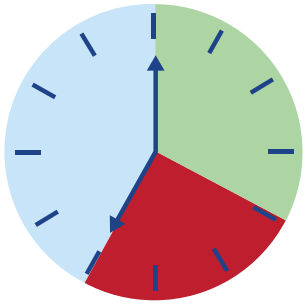
Efficiency

- Although CMS requires a minimum of 20 minutes of non-face-to-face care management services each calendar month to bill for CCM, early adopters are spending significantly more time providing these services. The median time spent delivering this service to patients each month was 35 minutes, almost twice the amount required by CMS.

Required minimum: 20 minutes



Median time actually spent: 35 minutes



- Importantly, CMS calculated the reimbursement for CCM based upon only 20 minutes of service provision, primarily done by clinical support staff. The current inability to perform CCM services in that time frame may be one reason providers believe reimbursement is inadequate.
- About half (49%) of early adopters report having successfully billed and received payment for CCM services furnished to eligible Medicare beneficiaries. Slightly more (55%) report having submitted claims and received payment for CCM from a Medicare Advantage plan.
- Early adopters do not believe Medicare patients will qualify for CCM services consistently —just less than three-quarters (73.5%) of respondents believe that patients will qualify for these services for 6 months or less in a calendar year. Only 11% of respondents believed that the typical Medicare patient would be eligible for CCM billing 12 months out of the year.

INSIGHTS & GUIDANCE

The National Chronic Care Management Survey 2015 offers key insights for providers and policy makers, as well as vendors offering products and services to support providers' CCM programs:

1. *The key to increasing the availability of CCM is CMS reducing the associated administrative burden.* Nearly all of the reasons cited by respondents for not having fully implemented CCM programs relate to the complexity of the Medicare billing rules.

   In its 2016 Medicare Physician Fee Schedule proposed rule, CMS invited comment regarding how to simplify the CCM rules and whether current reimbursement levels are sufficient. Based on its experience working with providers on CCM programs, PYA submitted extensive responses to CMS addressing these concerns. A copy of these comments is available upon request.

2. *More and better beneficiary education and engagement is needed*. Beneficiary objections to CCM reflect a lack of understanding regarding the service and its benefits. Once beneficiaries become aware of the benefits of the service, there will be greater consumer pressure on providers to implement CCM.

3. *Smaller organizations need a clear path forward to implement CCM programs*. There is an enormous opportunity for smaller organizations to work together, directly or through third parties, to leverage resources to provide CCM.

4. *Better technology solutions are needed*. Survey respondents reported many shortcomings in their existing technology with respect to CCM. Also, technology is needed to resolve the inefficiency many providers are facing in providing CCM.

5. *As more providers move into alternative payment models, CCM adoption likely will increase*. As more payers move to value-based reimbursement, providers will seek strategies to improve quality and enhance efficiency. A well-constructed CCM program provides a bridge from volume-based to value-based reimbursement, as it generates fee-for-service payments to support the development of organizational infrastructure and staff competencies to effectively manage risk-based contracts.

THE RESEARCH TEAM

For PYA

Lori Foley, *Principal*

Lori specializes in providing physician practices with operational improvements, strategic planning, and other advisory services. Lori is well versed in the development of chronic care management initiatives across provider organizations. She assists organizations in developing strategic plans to maximize quality initiatives. Prior to joining the consulting arena, Lori was responsible for the fiscal and operational management of ten hospital-owned primary care and specialty practices.

Martie Ross, *Principal*

Following a successful two-decade career as a healthcare transactional and regulatory attorney, Martie now serves as a trusted advisor to providers navigating the ever-expanding maze of healthcare regulations. Her deep and wide understanding of new payment and delivery systems and public payer initiatives is an invaluable resource for providers seeking to strategically position their organizations for the future. Martie has an uncanny ability to synthesize complex regulatory schemes and explain in practical terms their impact on providers.

Aaron Elias, *Staff Consultant*

Aaron provides consulting services in support of provider organizations to help them evolve within a changing healthcare market. Aaron focuses on the market transition to value-based payments and assists healthcare organizations with this shift in payment methodology. His successes include assisting clients with value-based initiatives and implementing programs like chronic care management. Aaron performs analytics of physician productivity and compensation, strategic value-based payment modifier positioning, and payer reimbursement.

For ENLI HEALTH INTELLIGENCE

David Rowe, *Senior Vice President of Marketing and Business Development*

David leads strategic planning, integrated marketing, brand management and business development at Enli Health Intelligence. He has 15 years of experience in healthcare IT, with a focus on improving patient-provider interaction using information technologies. Prior to joining Enli, David was head of global product marketing at for GE Healthcare's Centricity patient portals. He joined the founding team at Caradigm - GE Healthcare's joint venture with Microsoft – to drive the company's patient engagement and health information exchange strategies. Before joining GE Healthcare, David was a vice president at WebMD Health Services, the population health management division of WebMD.

Erik Simshauser, *Vice President of Marketing*

Erik focuses on the strategic development, and tactical execution, of Enli's marketing plan and integrated programs. This includes public relations and corporate communications, advertising and promotion, sales enablement and support, as well as market intelligence. Prior to Enli, Erik served as the Vice President of Marketing at WebMD Health Services, an $80M division of WebMD. He is a past member of the Healthcare Information and Management Systems Society (HIMSS) Patient Generated Health Data Task Force, is certified in the Pragmatic Marketing Framework, and an active member of the American Marketing Association.

ABOUT PYA

For over three decades, Pershing Yoakley & Associates (PYA), a national healthcare consulting firm, has helped clients navigate and derive value amid complex challenges related to regulatory compliance, mergers and acquisitions, governance, business valuations and fair market value assessments, multi-unit business and clinical integrations, best practices, tax and assurance, business analysis, and operations optimization.

PYA's steadfast commitment to an unwavering client-centric culture has served the firm's clients well. PYA is now ranked by Modern Healthcare as the nation's 9th largest privately-owned healthcare consulting firm. PYA affiliate companies offer clients world-class data analytics, professional real estate development and advisory resources for healthcare providers, self-insured employer health insurance claims audits for Fortune 500 companies, wealth management and retirement plan administration, and business transitions consulting.

For more information, please visit http://www.pyapc.com.

ABOUT ENLI

Enli Health Intelligence™ is the market leader in population health management technology. Enli enables care teams to perform to their full potential by integrating healthcare data with evidence-based guidelines embedded in provider workflows across the population and at the point of care.

Enli's suite of value-based programs help provider organizations coordinate the care of high risk patients, including those eligible for chronic care management. By consistently applying care management protocols to defined populations, continuously informing the care team of progress toward plan objectives, and optimizing program resources, Enli programs standardize best practices, improve administrative and clinical efficiency, and increase practice revenue.

For more information, please visit http://www.enli.net.