Discover How Chronic Care Management Can Increase Your Practice's Revenue

The Background

We had the pleasure of sitting down with ChronicCare IQ on February 21 to discuss chronic care management (CCM) and remote patient monitoring (RPM). The discussion was designed for providers currently caring for chronic care patients or for those who would like to start. We covered the various ways in which reimbursement can be obtained for the important work that providers are already doing. It has become fairly straightforward for every healthcare provider to keep better tabs on their patients with chronic illness, improve care quality scores, decrease hospitalizations, and achieve a potential increase in reimbursement with the aid of simple technology.

Our Goal

Help you better understand the reimbursement opportunities that exist for face-to-face and non face-to-face patient interactions. Every 10-minute increment adds up and you may be leaving hard earned money on the table.

You'll discover how to

1. Leverage your existing systems to keep better tabs on your patients with chronic conditions
2. Automate your time tracking in a few easy steps
3. Tap into detailed accounting of care plans and patient adherence
4. Discover the ins and outs of getting reimbursed for time spent on the phone
5. Improve your care quality scores through stronger patient engagement

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Introduction

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We covered the various ways in which reimbursement can be obtained for the important work many providers are already doing. Most spend an inordinate amount of time managing daily non face-to-face patient interactions—reading emails, responding to texts, and reviewing charts—and are leaving real money on the table.

Background

Justin Barnes, Co-founder, Health Innovation Think Tank, and Matt Ethington, Co-founder and CEO, ChronicCareIQ, both have significant stakes in optimizing healthcare reimbursement.

Justin has formally addressed and/or testified before Congress as well as the last five Presidential Administrations on more than twenty occasions with statements relating to value-based care, chronic care management, virtual care, precision medicine, population health, consumerism, interoperability, and the globalization of healthcare. He is a public speaker on these issues and has appeared in more than 3,000 journals, magazines, and broadcast media outlets.

Matt focused his career in the healthcare IT space after being diagnosed with Type I diabetes in 2001 at the late age of 30.

Today he is a veteran patient and seasoned healthcare IT executive that has worked with providers and patients on two continents. His current company is used by doctors and health systems from coast to coast, in 14 specialties, to maintain status awareness of chronic patients between visits.

2024 Predictions

- 2024 will be the year that chronic care management and remote patient monitoring programs become center-stage with a majority of care providers that treat applicable patients.

- More care providers will be deploying value-based care models to augment FFS reimbursement cuts.

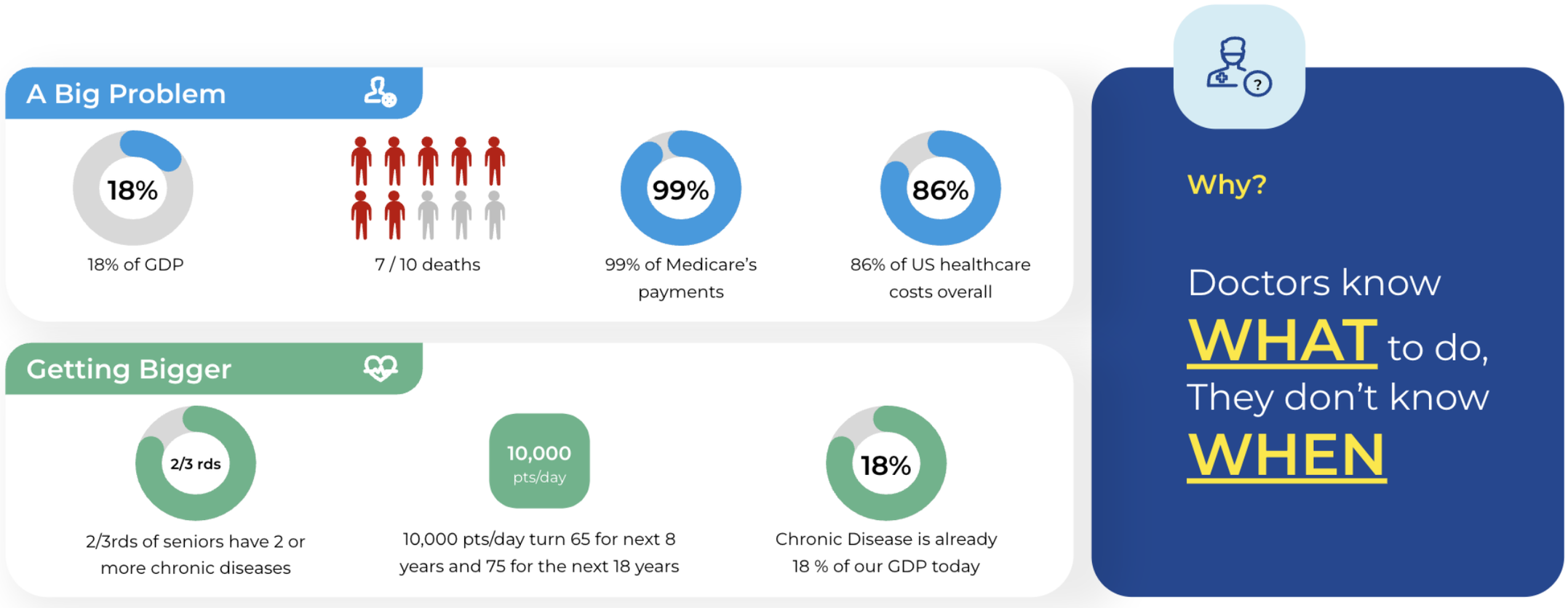
- More patients will be managed by CCM/RPM than ever before.

- We will collectively experience the “tipping point” for these programs in our nation’s healthcare system.

Justin has been working on improving reimbursement rates on Capitol Hill since 2005. He staved off the reimbursement cuts in the late 2000s all the way through 2021. But with reimbursement cuts for fee for service now well underway, it’s been critical for him to find ways for providers to augment that.

For Justin, it has been an exciting time when we begin to consider the new reimbursement that can come in on a daily basis. He works with practices that receive anywhere from a 5% to 40% increase in reimbursement—significant money! He sees 2024 as the tipping point—there will be more care providers participating in these programs across the board than ever before, more patients being monitored, and better outcomes than we've ever seen as we get better as a country. A recent study that came out of Growth Partners showed that 94% of respondents talked about how remote patient monitoring has improved their outcomes. 73% saw positive ROI from it. From those increases in patient outcomes, the money follows, which is exciting. 94% of chronic care management ROI came from additional revenue. There's not a practice that Justin touches that has not seen a significant increase in reimbursement, a reduction in unnecessary hospital admissions, or readmissions, improved patient outcomes, and significant ROI.

CCM/RPM by the numbers



Matt Ethington, CEO of ChronicCare IQ, began his journey as a patient, and realized it was almost impossible to stay on the same page as his doctor. But what Matt came to realize pretty quickly is that healthcare is communication. The pharmaceuticals and procedures today continue to evolve and get more and more complex, but what does not change is that health care is a trained individual providing care to someone in need. And at the core of that is communication. But we're a little bit behind on that.

The reason Matt knows all this is that at the age of 30, he found himself in the hospital in the emergency room. He was told that he was days, maybe hours away from being in a coma and that he had type I diabetes. He left the hospital with two prescriptions and a pep talk. He had to learn to manage a disease that has to be managed very aggressively. That's when he decided to switch his career specifically to medical technology. He realized that if there were more information about chronically ill patients, something could be done about their situation.

Then in 2015, reimbursements were introduced. It's been said that chronic diseases don't just break the bank, they break the US economy. Currently, 7 out of 10 deaths are due to mostly non-lethal and manageable chronic diseases. They're just not being managed. And the money expended on them is exorbitant. 99% of the checks that Medicare writes are on behalf of chronic patients and represent 93% of the total. If you take the money just spent on chronic disease, it's equivalent to 18% of our gross domestic product. And that's just Medicare. There's also the aging population, the inactive population, and those that continue to eat processed foods. All of that adds up to conditions that will get worse if they're not managed.

CCM/RPM by the numbers

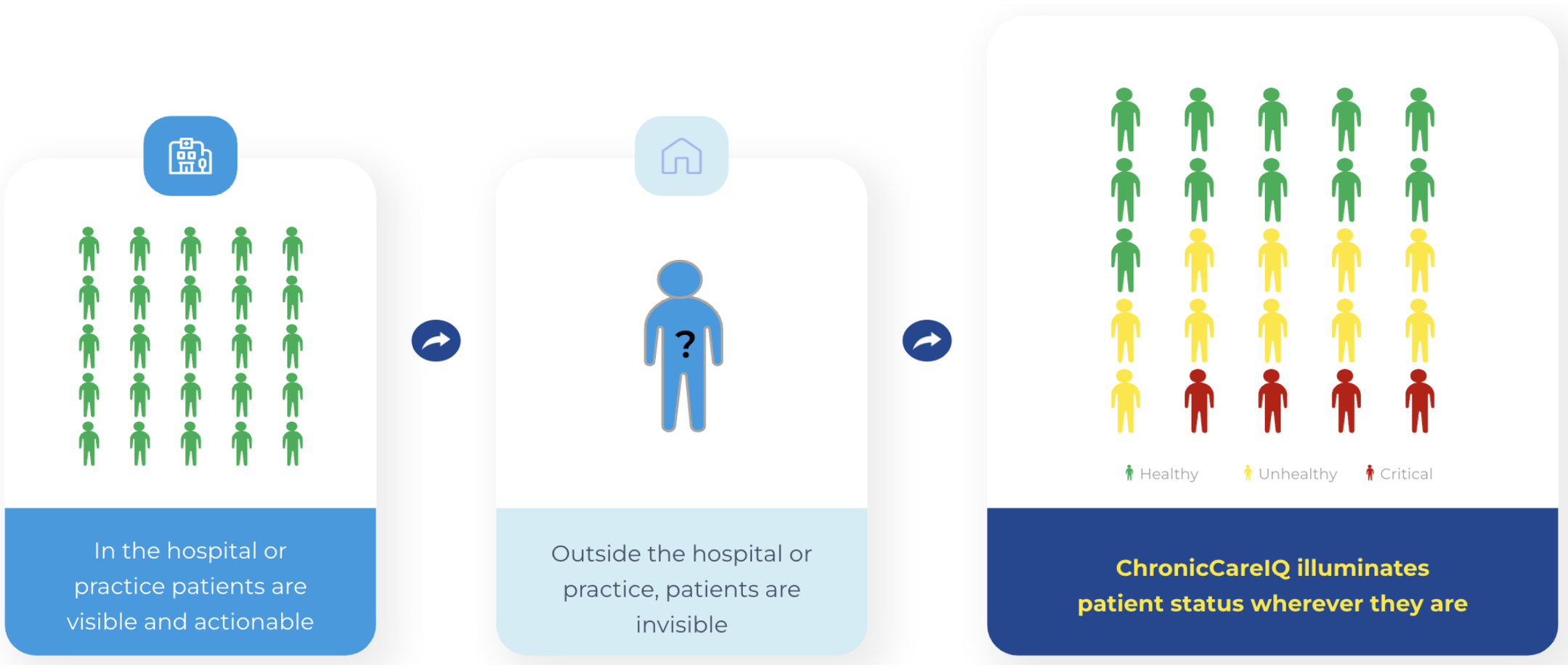
- **In 2015, there were five CPT codes introduced for primaries in chronic care management**
- **In 2017/18, there were four behavioral health codes introduced**
- **In 2019, four codes were introduced for RPM, across any specialty**
- **In 2020, five codes were introduced for specialists and principle care management**
- **In 2021/22, four codes were introduced for remote therapeutic monitoring across specialties**
- **In 2023, two codes were introduced for chronic pain management across specialties**
- **In 2024, FQHC's and RHC's were included in the reimbursements across all services bringing the total care management codes to more than 25**

Studies have shown that if we can keep those chronic diseases managed, they don't need to have a long term effect. They don't have a long term effect on your outcomes or your expenditures. So when we look at chronic care management, Medicare is spending a fortune on CPT codes. At the start of 2015, there was one code for $42. Today, there are 25 codes in eight different categories spanning primary care, specialty care, behavioral health, respiratory care, chronic pain management, and even physical therapy. So there's a lot of reimbursement opportunity!

The vast majority of those CPT codes pay for non face-to-face clinical activity that doctors and their staff perform for patients. It's important to engage those patients before the sick get sicker. 10,000 patients a day are turning 65 and entering the Medicare system. Medicare's known this problem was coming and that's why they're throwing so much money at it. It's not that doctors don't know how to manage chronic conditions—they do—but they don't know how to operate outside of a traditional care setup when patients come into a brick-and-mortar office for scheduled visits.

We have smart doorbells that tell us who's at the front door, smart thermostats that adjust to varying temperatures, and check engine lights that alert us to take our car in for a health check. We have all of these things that help us manage complexity in our lives, but our doctors don't have anything that informs them whether or not their patients need help. ChronicCare IQ and Spruce have set out to change that.

Why the sick keep getting sicker

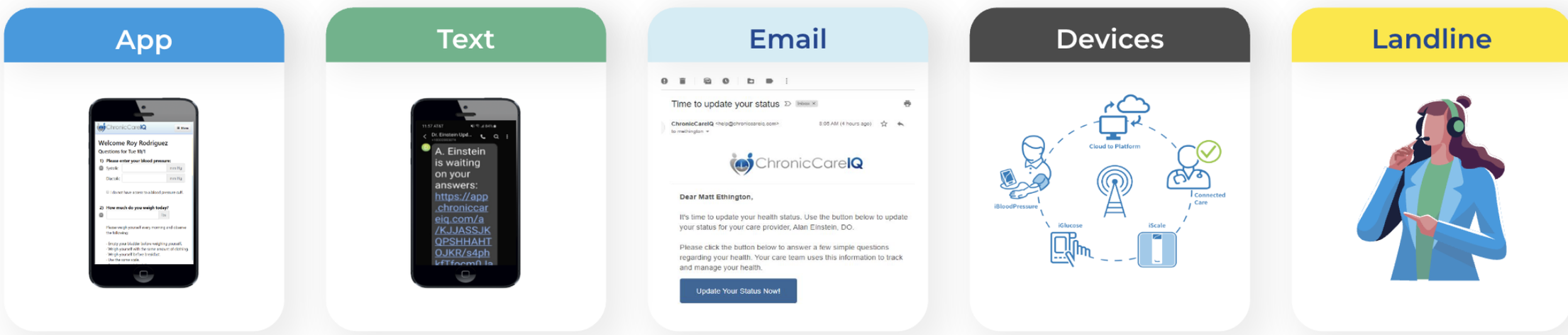


The sick keep getting sicker because they're invisible. Who hasn't left the doctor's office motivated to make changes? We all try to eat healthier, get more exercise, and practice self care but our busy schedules often get in our way and we go back to our unhealthy habits. So it's really hard to know how to manage yourself between doctor visits, if you're not communicating back and forth with your doctor.

You become invisible to your doctors, or to your hospitals, the day that you leave. The challenge is chronic diseases are medical conditions, by definition, that can't be cured. So they have to be controlled. So even if you can mitigate your type two diabetes, to the point that you don't have symptoms, you still have it, you're just non symptomatic. Even when you get your blood pressure under control, it's going to come back if you don't keep managing it. So the idea here is if a doctor knows when a patient is starting to get off course, then they can fix it early on when the patient isn’t so far off course. But if they don't see that patient for six months, and that patient’s blood sugar has been 270 every morning, it's too late. They've already damaged themselves, and they've already had significant disease progression.

ChronicCare IQ talks about how to make patients visible, and that means collecting data. When data is collected, everyone can see the patients that are in need of attention. And, everyone can also see which patients need encouragement to stay on track.

Why visibility is critical



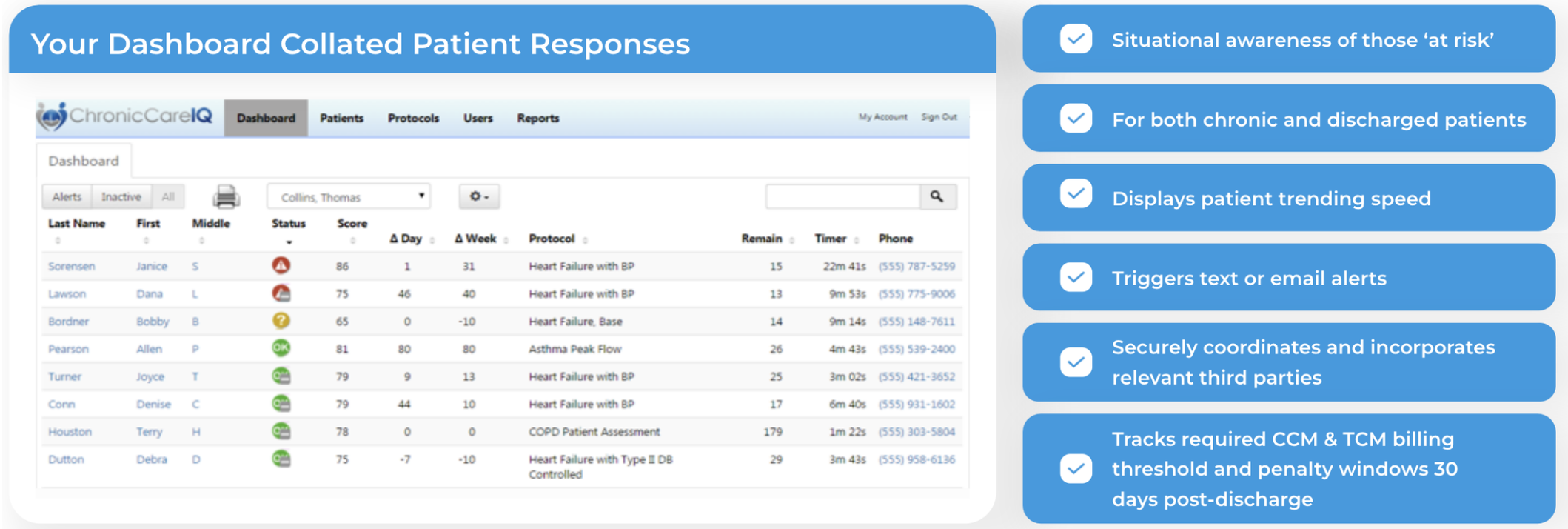
The most important thing you can do is get visibility into your patients. ChronicCare IQ sits on top of the electronic medical record. And the EMR might say something like Mrs. Johnson has stage two heart failure, diabetes, depression, and takes seven or eight medications. Well, we definitely want that blood pressure periodically. We want the glucose or the weight daily since Mrs. Johnson is a heart failure patient, but we don't just want the vitals. We want to know if there's shortness of breath, and if it's better or worse, or about the same as it was the day before. And these questions and answers need to transpire in a way that's really easy for both doctor and patient.

If you're a patient, these are elective programs. Patients may get tired of answering 62 questions every day. And if they stop participating, all of your practice's efforts are for not. So the patient must understand value. And as a provider, it's important to engage with patients personally at a level where they feel like they're getting value.

What technology can do today is it can look at the patient's electronic medical record, and it can ask for symptoms specific to that patient. Have you seen any new doctors or started any new medications? When was the last time you were dizzy when you stood up? If you have patients that have multiple co-morbidities, this is critical. 87% of patients that start answering those questions will still be answering them a year later, because their health is a primary concern for them. But the most important thing is to engage those patients. Why? Because care for patients is communication.

When patient responses come in, you need a system that's going to look at those patients and engage them for you. You'll want a platform that can compare responses to what they were yesterday, or the week/month/year before. Every health system in America has call data about their patients. But how many of them realize they haven't heard from a patient in five months? If suddenly there are four calls in two weeks, that's a rising risk patient. So when you have two platforms that work together, like ChronicCare IQ and Spruce, you can start to see when something's happening.

Monitoring patients



Consider calling your patients and getting them enrolled in a monitoring program. CCIQ has 600 different clinical monitoring protocols that attach themselves to patients if there's a concern. You take those responses and you collate them on a color coded dashboard. You will quickly be able to identify those patients that need some attention. The first step is getting dialed into your patients to help them see enough value to encourage them to stay involved, because if they don't stay involved, then there's no such thing as a chronic care management program. If they do stay involved, you can deliver the care that you are trained to provide. So having that situational awareness is important. It improves outcomes. It's why patients do it.

Checking that dashboard generates 30 seconds a day, and on a 20-day month, that's 10 minutes. Remember, care management reimbursements are based on time. The first increment of reimbursement starts at 20 minutes, and it pays $64. So do that math in your head. $192 an hour is if you can monetize 20 minute increments perfectly. $192 an hour is what Medicare and some commercial insurers are willing to pay you to keep patients out of the hospital. It's an extravagant reimbursement. The trouble is, it's death by 1000 cuts if you don't have the right type of system in place.

So patient engagement comes first. Next is ascertaining where your team spends their non face-to-face time. If you’re not in a room with the patient, you’re on the phone with them, or you’re in their chart, or texting them back. If you're using Spruce, and it took three minutes to review a message and six minutes to craft a response, that's nine minutes. If you've monitored that patient through the dashboard, and you've spent nine minutes answering a question from that patient, you're getting care back to them faster, you're improving their outcomes and now you're only one minute away from $64.

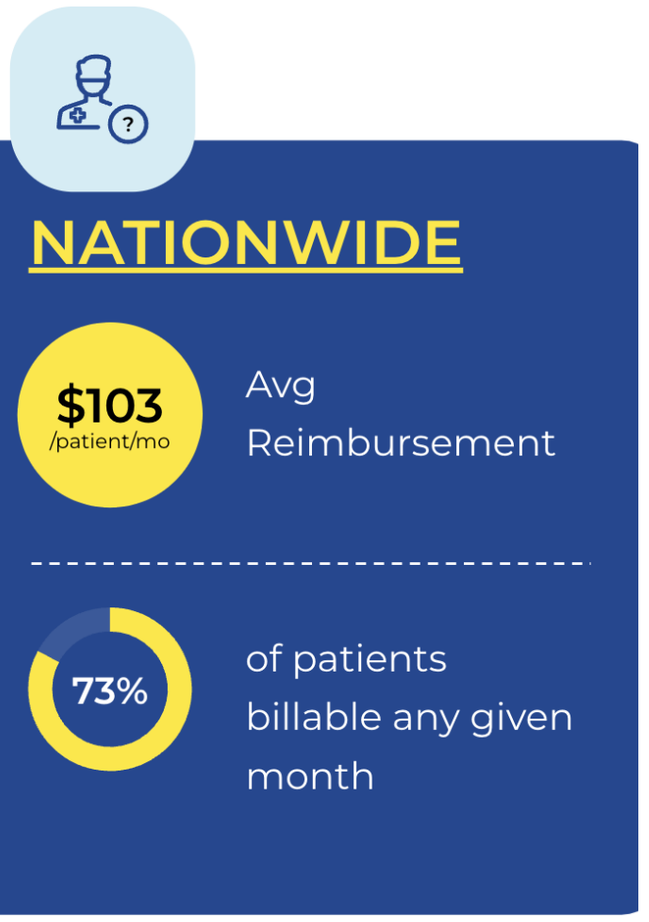
Meaningful reimbursements

ChronicCareIQ

Thursday January 4th, 2024 12:05 PM

Total Projected Billing

Month	Active Patients	Billable Patients	Precentage Billable	Projected Billing Amount
Jan-23	242	233	96%	$33,893
Feb-23	241	215	89%	$28,058
Mar-23	243	227	93%	$30,834
Apr-23	244	225	92%	$27,543
May-23	245	230	94%	$30,814
Jun-23	246	219	89%	$28,141
Jul-23	240	224	93%	$31,246
Aug-23	230	217	94%	$31,677
Sep-23	227	199	88%	$22,945
Oct-23	225	200	89%	$27,703
Nov-23	227	177	78%	$24,637
Dec23	230	208	90%	$29,011



Now think about how many times a day your staff takes a patient call, answers a text, or crafts a thoughtful email. You have to be able to add up the time for all non face-to-face work, across your staff! That said, it’s got to be easy for you and your staff to make sense of it all. When you have a system that looks at call duration and frequency, you’re empowered and can see what’s going on. Tracking all the systems that we already use every day to give us time to add on top of the monitoring makes a very revenue-productive, cashflow-positive organization.

As mentioned earlier in this document, there was one lonely CPT code for $42 back in 2015. Today, there are 25+ codes that pay you for your time. This is the foundation for where the future of healthcare is going, certainly from a federal government standpoint. They're going to continue to invest in these programs. Unfortunately, we do see more and more fee-for-service cuts, that's been kind of hard coded in there, and we don't see any big changes to that. So this is where you augment that 3% or 4% cut—you’re going to have a 5% to 15% increase, and these care management codes can make you a lot more money.

The fact is, the average Medicare hospitalization today is between $14,000 - $15,000. Medicare is happy to pay you $64 to avoid that. In CCIQ’s case, the average is $103 a month, and Medicare can pay you to manage that patient for a decade just by preventing one hospitalization. The mission is to put care back into the doctors’ hands, instead of waiting for the sick to get sicker. The analogy in medicine today is we change the engine instead of changing the oil. Let's get health care back to the doctors outside of the hospital instead of waiting for them to show up at the hospital with massive disease progression.

ChronicCare IQ + Spruce makes the difference

18.8%	Medicare Reimbursement Increase
6-8%	Monthly Increase in Patient CCM Enrollment
90%	Patient Billability
4,000%	CCIQ Platform Return-on-Investment

To summarize, you need data from patients to manage them. The CCIQ platform asks questions that are specific to those patients, it looks at the answers, alerts the clinician if there is something troubling, all so that the provider can get involved early if necessary. The reimbursements are based on the amount of time you spend with each patient—either face-to-face or non face-to-face. The integration with Spruce provides a tremendous amount of data to make it easy to calculate that time spent.

Leveraging Spruce enables CCIQ to not only quantify the time spent, but also qualify who spent that time and assign the right reimbursement to the patient. Maybe they're a Blue Cross patient that is mostly covered for remote patient monitoring. Or they have a Medicare plan that covers chronic care management. The system analyzes each case uniquely so that you get the optimal reimbursement and the optimal combinations of reimbursement, instead of either over-billing or under-billing.

Now, when it comes to behavioral health, there's a huge reimbursement in place—it's called BHI or behavioral health integration. There's a BHI and a complex BHI, and behavioral health integration pays for 30 minutes of time, which includes counseling. When a psychiatrist is involved, there's something called collaborative care management. It is a constant endeavor to be available to a patient when they need care. The hardest part about being sick is not knowing when you're going to be well.

CCIQ is fully integrated with Spruce and mutual customers have recognized an almost 19% Medicare reimbursement increase—one of the leading payers for chronic care and RPM reimbursement. But every month, these mutual customers are also increasing their CCM enrollment by 6% to 8% of their patients. So that's a great success story in itself. 90% of these patients are going through the program, but they also have chronic conditions. And so if you are able to bill them, it brings significant ROI.

Conclusion & resources

If you can engage your patients in a way that's meaningful to them, they will stick with you, and they will feed you the data that you need to be able to keep them well. You're already doing all the work necessary to drive reimbursement, you just can't capture it. So plug into the places where things are happening, plug into the patient so that you know when they need you, keep them engaged, and then plug into the systems to make it easy for the patients to communicate. When you plug into those systems, you can quantify and qualify the time you spend, automatically.

Learn more about ChronicCare IQ and the integration with Spruce Health.

Learn more about Spruce Health and find out how your colleagues are successfully leveraging Spruce to optimize their practice.

If you're new to Spruce, get to know us better with a free 14-day trial of Spruce. Learn how to use Spruce in a HIPAA-compliant way in this succinct white paper.

Take 15% off your first year with Spruce using code CCIQ24, start your trial here.

Note: the information in this document is not legal or financial advice, and not all views necessarily reflect the views or positions of Spruce Health.