MEDICAL SYSTEMS

A Guide to Understanding Chronic Care Management (CCM) Programs

Overview

The need is evident for better care coordination and management of patients as they transition from an inpatient to an outpatient setting, and to help them better manage their chronic conditions. With the TCM and CCM programs, CMS has provided clear financial incentives for providers to collaborate in improving patient outcomes and reducing overall healthcare costs.

CMS: Fostering Better Care, Healthier People, Smarter Spending

The Centers for Medicare and Medicaid Services (CMS) was established in 1977 to oversee public health programs including Medicare and Medicaid. Its vision is to create a high quality healthcare system that ensures better access to coverage and improved health for all citizens.

CMS' primary goals are to:

- Strengthen and modernize the healthcare system
- Provide quality care at lower costs
- Provide oversight and foster innovation and collaboration

1 in 3

Americans are currently enrolled in CMS programs

To accomplish the above goals, CMS has introduced a number of programs that incorporate new payment models and incentives for healthcare providers. Two of these programs are Transition of Care Management (TCM) and Chronic Care Management (CCM).

With both programs as well as HRRP, CMS desires to transform the health care system into one that keeps patients healthier and reduces preventable hospitalizations and medical costs through more effective care planning, coordination and patient engagement. These programs are intended to reward providers for performing care coordination services - most of which were previously uncompensated.

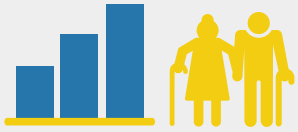
Hospital Readmissions Reduction Program (HRRP)

HRRP authorizes CMS to penalize hospitals with higher-than-expected 30-day readmission rates.

- Hospitals may be penalized up to 3% of their Medicare payments
- Over 500 billion in penalties projected over the next year
- Over 50% of hospitals penalized
- NOTE: TCM & CCM programs help reduce HRRP penalties

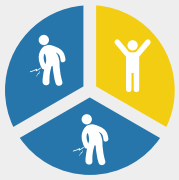
CCM Program Overview

55 Million



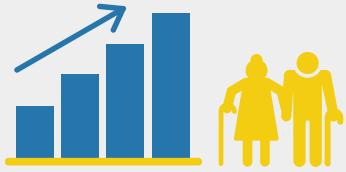
number of people covered by Medicare in 2015

⅔ of Medicare Patients



have 2 or more chronic conditions and account for **75%** of Medicare spending

80 Million



projected number of Medicare beneficiaries by 2030

CMS introduced the Chronic Care Management program in January of 2015, and began paying providers $42 per month for non-face-to-face care for patients with two or more chronic diseases. The goal of this program is to improve care and outcomes for patients with chronic conditions, reduce the overall costs associated with the care of these patients, and reduce avoidable hospital admissions. The CCM program gives providers financial incentives to develop care teams that can effectively deliver chronic disease management services.

Key Program Requirements:

- Patient has 2 or more chronic conditions expected to last at least 12 months or place patient at risk of death, exacerbation or functional decline
- Provide a comprehensive physical exam or wellness visit to initiate the CCM service
- 20 minutes of non-face-to-face clinical staff time per month, delivered under direction of a qualified provider
- An electronic care plan which must be available to the patient and other care providers
- Patient signed consent for CCM services
- Ensure 24/7 access to care management services
- Only 1 provider per patient can bill CCM

Revenue Opportunity:

The estimated population that qualifies for CCM services is 35 million. The average individual primary care physician would have approximately 200 patients who qualify. At $42 per patient per month, this equates to $100,800 in annual revenue. The additional revenue opportunity is significant, and pays for activities that their staff is already doing to some extent.

Individual Physician:

200 Patients | $42 | 12 Months | approximate annual revenue

While CMS views primary care as an ideal provider for this program, many physicians lack the staff and time needed to implement and manage it. This creates an opportunity for CCM service providers to offer outsourced services to primary care and specialty physician practices. In fact, CMS specifically states,"Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare PFS "incident to" rules and regulations and all other applicable Medicare rules".

Conclusion

Better care coordination is key to improving patient outcome and helping to manage their chronic conditions. The Medicare CCM programs provide the framework and financial incentive for providers to offer these services. Multiple types of care providers can potentially benefit from providing CCM services, including physicians, home healthcare agencies and other care service providers. As awareness of these programs increase, new care coordination and chronic care management businesses will continue to emerge. New technology solutions can help these emerging businesses succeed in optimizing patient outcomes, provider productivity and revenues through automation of their care coordination processes.

About Saaytech

We are a fast-growing company focused on providing care coordination services to patients, serving small to mid-size independent physician practices. Our care coordinators are experts in helping patients and caregivers navigate the healthcare system and better manage patients' chronic illnesses. We partner with primary care physicians to help support their patients and generate immediate revenues for the physicians practice.

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