VALUE-BASED CARE MANAGEMENT SERVICES

With MACRA, most clinicians will be measured against their peers in their ability to improve overall health outcomes and reduce claims for wasteful and unnecessary services, with contracted payments hinging on the results.

The Centers for Medicare and Medicaid Services in 2015 began to reimburse physicians for providing chronic care management services to Medicare patients who have more than two chronic conditions under the Medicare Physician Fee Schedule (PFS).

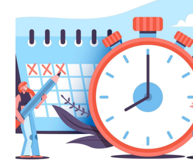
CCM Workflow

1. Identify eligible PCM, CCM patients

2. Obtain consent to enroll them

3. Create care plan & integrate EHR

4. Provide monthly care management


5. Track time spent in contact

6. Provide documentation for billing

For Patients

- Improved self-management skills of chronic conditions
- Improved quality of care and patient satisfaction of services
- Personalized coaching on care management and preventative care from a care manager
- Opportunity for collaborative decision making and engagement in their own care
- 24/7 emergency access to **ChronicCare** clinicians
- Creation of a customized, comprehensive care plan
- Access to personalized disease library
- Coordination of care between specialists, pharmacy, testing centers, etc.

For Practices

- Compliance with MIPS/MACRA reporting requirements
- Earn new stream, recurring reimbursable revenue to sustain and grow your practice
- Entry/preparation for value-based care and risk-based contracting
- Acquire and retain new patients
- Promotes patient loyalty and connection to practices
- Increased volume of patients, i.e., not losing patients to ER Department visits hospitalization and reduce admission
- No setup charges and no upfront and ongoing charges to practices

Chronic Care Management

Monthly continuous support and coordination of medical services for patients with **multiple chronic conditions**.

Principal Care Management

Monthly continuous support emphasizing prevention for patients with **one chronic condition** for improved health outcomes.

Transitional Care Management

Facilitates the transition of patients from **one healthcare setting to another**, ensuring continuity and coordination of care to reduce hospital readmissions.

Remote Patient Monitoring

Tracking patients' health data outside healthcare settings to manage and **monitor their conditions remotely** for better care.

Estimated CCM Revenue Calculator	
Number of staff overseeing CCM program	2
Estimate the number of patients each clinician will oversee in this program	250
Total number of potential participating patients	500
Estimate the number of months each patient will spend in the program	12
Per-patient, per month CCM revenue	$61.56
Total monthly CCM revenue	$30,780
Total annual CCM revenue	$369,360

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