Boosting Revenue with a Chronic Care Management Initiative

By the end of the first full year, CPC saw added revenue of **$32K per month**

As of 2018, **22%** of patients that met the minimum level of criteria to participate were actively managed in CPC's chronic care management program, versus the national average of 2%

CPC experienced minimal impact to workflows, staffing and IT infrastructure when implementing the program

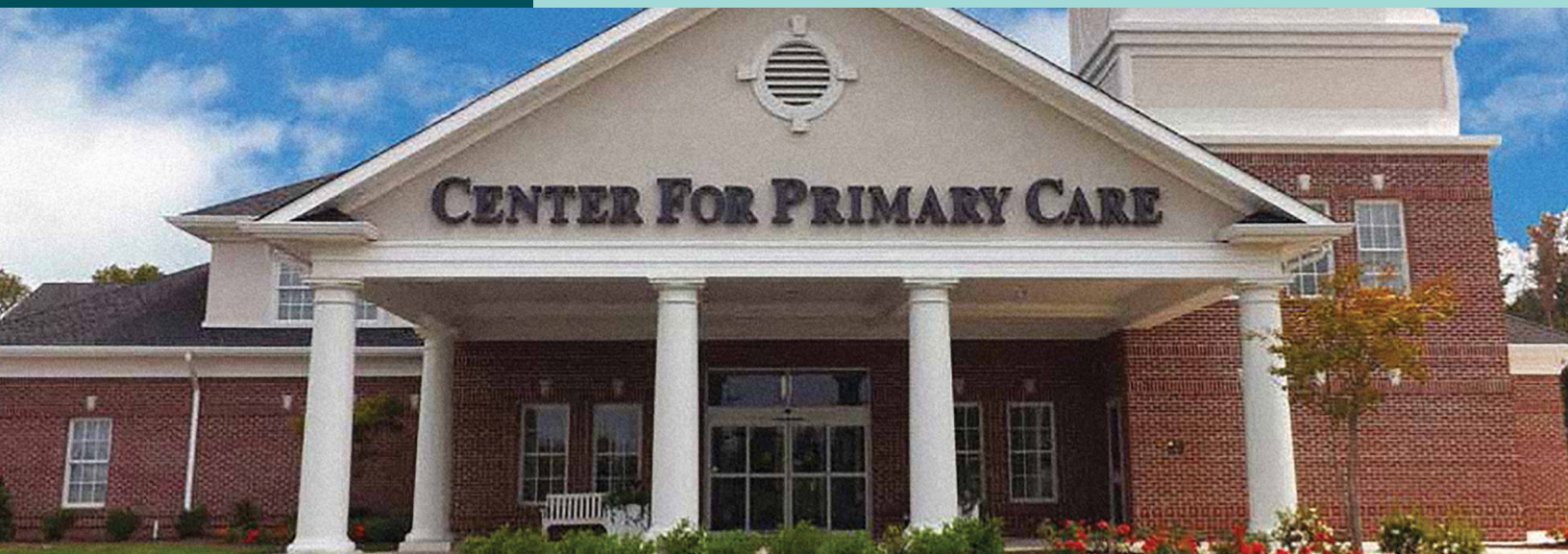
THE CENTER FOR PRIMARY CARE APPLIED POPULATION HEALTH CAPABILITIES TO ADD $400K OF INCREMENTAL REVENUE ANNUALLY

In 2015, the Centers for Medicare and Medicaid Services introduced a non-visit-based payment for chronic care management. CPT code 99490 created a huge opportunity for primary care facilities. Essentially, the change stated that practices caring for patients with two or more chronic conditions that were expected to last at least 12 months and that carried a significant risk of death or decline could receive a monthly fee of approximately $40 per patient if they met applicable requirements.

This case study examines how the CIO of The Center for Primary Care (CPC), a forward-thinking provider organization, helped pioneer the development of an optional chronic care management program for Virence Health's Ambulatory Population Health module. By the end of the first full year of applying these new chronic care management capabilities, CPC was able to add approximately $400,000 of incremental revenue.

CPC IDENTIFIED A LARGE OPPORTUNITY WITH CPT CODE 99490

CPC is a family and internal medicine practice with 42 providers, offering comprehensive healthcare services across Georgia and South Carolina. When the facility learned of the new code, Barry Allison, CIO at CPC, examined the financial opportunity. Allison determined that the facility cared for 24,000 Medicare patients and 78% of these patients had two or more chronic conditions. Also, projections indicated that the facility's Medicare population would grow by 2000 patients per year over the next 10 years. Thus, Allison predicted approximately $80,000 of incremental monthly revenue, roughly $1 million per year, could potentially be attributed to the new code.



CPC believed a Population Health program designed specifically for chronic care management could help efficiently implement the initiative

While many facilities were interested in taking advantage of the new ruling, doing so was somewhat complicated. First, practices were required to use a certified electronic health record (EHR), offer around-the-clock access to staff who have access to the EHR, maintain a designated practitioner for each patient, and coordinate care through transitions to and from the hospital, specialist or other providers. An additional requirement involved collaboration with the patient on creating and maintaining a comprehensive care plan.

In order to implement the initiative, Allison reviewed the reimbursement requirements. It quickly became apparent that CPC needed an easy-to-implement solution that not only met the stringent requirements of the new payment program, but also automated key activities and integrated with its existing IT infrastructure, which was built on Virence Health's EMR.

CPC worked with developers on what is now an integral component of Virence Health's Ambulatory Population Health module to create a pre-configured chronic care management program. Led by Allison, CPC populated the program with eligible patients pulled directly from the system and then leveraged the virtual collaborative workspace for care team members to track, monitor and submit reports for chronic care management services.

Impressive results in program participation and additional revenue

Allison's strategic vision and drive to be at the forefront of value-based care, the tight integration between Virence Health's Ambulatory Population Health module and its EMR, and the ease of executing and coordinating the required chronic care management activities proved to be keys to CPC's exceptional success. By the end of the first full year, CPC saw added revenue of $32,000 per month, nearly $400,000 annually. As of 2018, 22% of patients that met the minimum level of criteria to participate in the program were actively managed in CPC's chronic care management program, versus the national average of 2%.* In addition, CPC also experienced minimal impact to workflows, staffing and IT infrastructure.

Furthermore, the clinical benefits that CPC's patients experienced attracted attention. After CPC achieved a substantial reduction year over year in hospitalization activity for the same sample population, the Atlanta Regional Offices of the Centers for Medicare and Medicaid Services invited Allison to present at their Innovation Day Event in 2017. Allison was the only presenter representing a physician group.

In response to the initiative's success, Allison indicated that he saw additional opportunities to take advantage of the new Population Health capabilities. "We're already beginning to evaluate opportunities to leverage and extend the infrastructure and process for care team coordination to address other value-based programs and initiatives," he said.

*Modern Healthcare, Chronic care management program showing signs of saving money, improving care, February 20, 2018, p. 3.