



## MAKING THE CASE:

*The Importance Of Connected  
Care In A Value-based World*

## THE PROBLEM: EPISODIC CARE LEAVES PATIENTS INVISIBLE

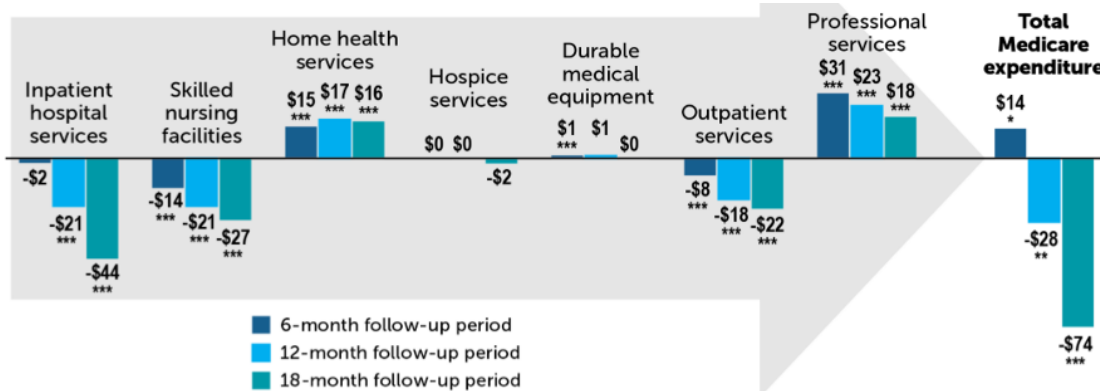
**The Centers for Medicare and Medicaid Services (CMS) began with 'Connected Care' as its new terminology surrounding Chronic Care Management (CCM) in 2015 when it released a new code to recognize non-face to face time spent managing Medicare Beneficiaries. On January 1, 2015, the Medicare Physician Fee Schedule (PFS) began to reimburse qualified providers for Chronic Care Management (CCM) services for beneficiaries with two or more chronic health conditions. The development of Connected Care strategies has been aligned with technology adoption and Care Management CPT codes, as defined in the previous and recent 2020 and 2021 Final Rules. Connected Care has recently evolved to be a colloquialism to intimate technology used to connect patients and providers. Care Management is so relevant now to new models of healthcare reimbursement focused on maintaining wellness and improving outcomes on cost and quality that a Connected Care strategy is a must have. [The 2021 Final Rule grouped these codes into Article E which is the Care Management section of the Final Rule.](#)**

The expansion of the Care Management approach is a focus on value. Over the recent years, models of payment have begun to compel providers to perform on outcomes as well as generate savings to healthcare payers and consumers. This is the essence of what is being called 'value-based care'. It's a move from a focus on patient volumes as a driver of the healthcare economy to the achievement of value through quality and cost outcomes. The value-based care philosophy has found expression in the form of these new CPT codes. For CMS, transformation has always been about technology (see Meaningful use or Pay for Reporting, MIPS) but now includes codified CPT reimbursement for deliberate time-based activities associated with care of chronic patients. The message is simple: help Medicare prevent readmissions and reduce overall costs of care and receive new revenue for it. This is good because transformation of healthcare to a value-based system will rely on physicians seeing monetary reward for their hard work in managing chronic diseases.

A [research report](#) from Mathematica Policy Research suggests that CMS's CCM program is moving the cost and quality needle in the right direction. Because of CMS's invested time and continued expansion of CCM, it appears this program will continue to progress and help contain spending and improve the quality of life for millions of Medicare Beneficiaries. As new codes are released such as 'Principal Care Management' which was a new addition in the 2020 Physician Fee Schedule (PFS), we are reminded as to why we should care: more than [117 Million adults](#) suffer from 1 or more chronic diseases; 66% of adults suffer from 2 or more chronic diseases. These diseases are the fulcrum of population health care models which attempt to quell the utilization of Medicare resources dedicated to these diseases. Care Management reimbursement is the reward for a Connected Care philosophy and is about the physician and patient care teams working together to improve outcomes and patient satisfaction using technology as a core focal point for engagement. The direct result of that is lowered use of resources such as Skilled Nursing Facility (SNF), inpatient care and outpatient services. Medicare



has seen that by promoting a connection with patients in a non-face to face manner and reimbursing providers for time spent managing a patient who is not right in front of them that the patient incurs fewer costs to Medicare. Even the earliest data on the CCM program shows significant trends towards reduced costs.



**Table 1.0 Estimated PBPM impact of CCM on total expenditures and by expenditure category: 6-, 12-, and 18-month follow-up periods. (2014-2016 claims data).**

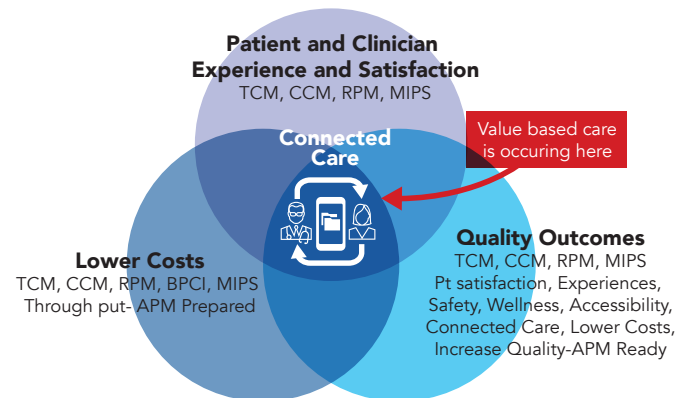
The Mathematica report referenced above [and here](#) describes some of the benefits and challenges of developing a CCM program. Specifically, it was reported that 75% of practices which initially decided to outsource the work requirements to call center vendors retracted that plan and brought it all in-house for consistency and continuity of care reasons. Also, they simply cited that they did not want strangers calling their most fragile and complex patient base (page 34, of the report cited above). The initial results from the earliest adopters of CCM is overwhelmingly positive. The overall decline in total Medicare expenditures is telling; it shows that patients use costly acute services less.

#### Brief Background- Why the Focus on Connected Care?

Technology is the essence of Connected Care strategies. It is right to look towards technology as a centerpiece to Connected Care. Looking in the rear-view mirror over the last decade is a reminder that use of an EMR through Meaningful Use, measures management through PQRS and previously the Value-based Modifier which provided differential payments based on utilization, all have culminated in refined models for 'value-based care' we now call the Quality Payment Program (QPP). Innovation is present. Its right to look to technology as a focus on how to increase access to care and improve outcomes on cost and quality. Efforts to do this have been persistent so let's level-set on why Connected Care is so important right now.

**Connected Care is so important because the data is near real-time.** Breakthroughs in business intelligence have certainly helped with understanding where costs can be cut. Lengthy data aggregation projects, interfaces and data warehousing all have tried to offer insight into trends and Big Data to help healthcare

systems perform in population health focused payment models. But what about just asking the patient how they are doing or finding out some physiological data points today?



This is needed because nothing in our system of healthcare thus far has been able to tell us when a patient has deteriorated or begun a trend of more complex care and higher utilization until now with the prevalence of nearly all Americans having internet in their homes and a computer in their pocket wherever they go. [The Senior Living website is chock full of information on the likelihood of seniors using technology.](#)

A featured study included the [Pew Research Center](#) report indicating that only 14 percent of seniors had internet in their homes in 2000. As of 2017, that number increased to 67 percent for adults over 65. In addition, 51 percent have high-speed internet. Eighty-two percent of seniors 65 to 69 have internet, while 44 percent of those over 80 have internet in their home. For seniors who do use the internet, 71 percent are going online daily.

Families and loved ones connect seamlessly using the internet and their smart phones. The PHE for COVID 19 has advanced the evolution of technology adoption to stay connected. Physicians and Medicare Beneficiaries are destined for this level of connectivity if not there already.

Connected Care and the new Care Management codes released and updated in the Final Rule for 2021 can have the effect of being a significant propeller of performance in the new government Medicare programs such as Direct Primary Care Contracting and Bundled Payments for Care Initiative (BPCI) as well as Alternate Payment Models (APMs).

**There are pressures which are building within the Medicare payment models to reduce costs and take on risk then move to more advanced levels of participation. Let's not forget why.**

In the spring of 2015, when Congress repealed the Sustainable Growth Rate formula (SGR), an Executive signature with a Republican Congress and Democratic President together ratified the future of value-based care. Due to the signing to law of the Medicare Access and CHIP Re-authorization Act (MACRA) and the subsequent creation of the Quality Payment Program (QPP), a hyper sensitivity to healthcare cost and quality has emerged from the Centers for Medicare and Medicaid Services (CMS). Payment models which attempt to guide physicians to low cost and high quality are under development and refinement by CMS and its innovation center CMMI. Until 2021, the Alternative Payment Model (APM), one track of the QPP, was innovating and refining faster and with plurality compared to its counterpart, The Merit Based Incentive Payment System

(MIPS), the other track of the QPP. MIPS has really been evolving as a 'catch all' for physicians not in APMs and is in a 're-thinking' phase right now. The new vision is referred to as MIPS Value Pathways (MVPs). The ongoing mantra of MVPs still revolves around categories of performance for interoperability, quality and costs as its primary pillars. [More on MVPs here.](#)

Here is the deal with MIPS and MVPs: unforeseen high participation rates of eligible clinicians (ECs) have created a tough scenario for CMS and physicians. The big squeeze is on as CMS will recoup the money it promised to Congress through rebalancing of categories and emergence of cost measures to influence an expected tighter performance threshold. Cost measures and performance on outcomes measures which are specialty specific will drive the new MVPs. While they are designed to be more 'user friendly' and offer a more specialty specific focus the cost of care component is where the math starts to 'kick-in' for savings to CMS.

**The Question is: Has Healthcare Transformed Enough yet for Physicians to Succeed in These Value-based Payment Models?**

The question needs to be answered. But by whom? Physicians need to know if they will succeed in the non-FFS future of Medicare and commercial models, too. Physicians who want to be out in front of the transformation to these new models can hone their skills in utilization reduction and improved quality by using Care Management mantras to exercise their performance capability in value-based care. The MVPs and APM tracks are transformational models as well to help physicians move from a volume focused healthcare economy to a more balanced value-based one. Medicare is 'doubling down' on reimbursing providers for activities which reduce costs to CMS. Since the inception of Transitional Care Management (TCM) back in 2013 and in 2015 with just that one 99490 CCM code, the puzzle pieces the healthcare delivery system as a whole is grappling with have started to fit together: managing care transitions, integrate mental health and manage chronic illnesses.



With the CMS imposed MVPs non-negotiable payment model serving as the gymnasium, providers can essentially exercise their skills for performance in commercial models or Federal APMs which might offer significant upside risk, while being paid to do so. The cadence of Care Management propels improvement data in utilization and quality while the reimbursements support increased practice efforts and strategy in Care Management. Practice transformation is ultimately being facilitated through the adoption of billing codes shown below for Care Management in Chart 1.0.

### CMS's Value-based Care Agenda is Further Realized

#### Through the New Reimbursements for Non-face to Face Time Spent with Patients.

The effect of using these codes may actually be the roadmap to the quadruple aim. Clearly the value-based care agenda of CMS is inclusive of the physician experience, patient experience and outcomes on cost and quality. The Final Rule for 2020 introduced Principal Care Management (PCM) and its still here in 2021 as a way for specialty specific chronic care needs to be addressed and is for 30 minutes of time for patients with just one chronic disease. It pays for physician and staff time. The Remote Physiological Monitoring Category is growing since its unbundling

in 2018. RPM codes for increments of 20 minutes of time start at \$54 dollars per month per patient for interactive communication for the first 20 minutes and use of CPT code 99458 for each additional 20 minutes of time which was new in 2020.

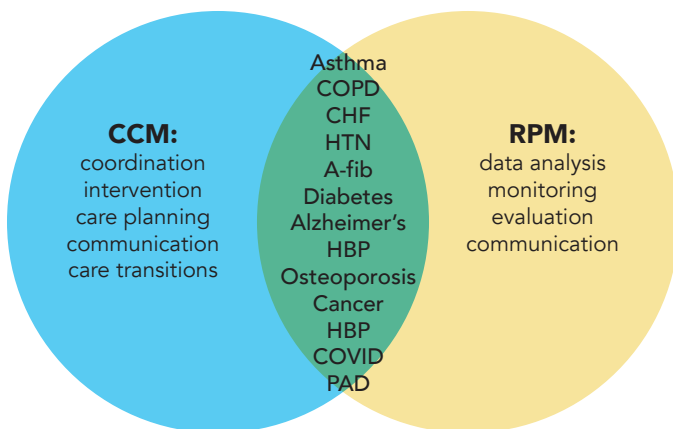
This code set was further clarified by CMS in the [2021 Final Rule Fact Sheet referenced here](#) to be defined as follows: 'We clarified that for CPT codes 99457 and 99458, an "interactive communication" is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012. We further clarified that the 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication.' The set-up of patients consenting to RPM requires use of an FDA defined device for code 99454. Not the typical rubber bladdered blood pressure cuff but a digital device: 'We clarified that the medical device supplied to a patient as part of RPM services must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.' There is a requirement to gather 16 days of data to be compliant with CPT code 99454 and 99453.

Principal Care Management	Chronic Care Management	Behavioral Health Integration and Psychiatric Care Collaborative
G2064 - \$92	G0506 - \$64	
G2065 - \$39	99491 - \$74	
	99490 - \$42	99492- First 70 minutes - \$162.18
	99439- \$37	
Remote Physiologic Monitoring	99487 - \$94	99493- First 60 minutes in a subsequent month \$129.38
99453 - \$21	99489 - \$47	
99454 - \$69	Transitional Care Management	99494- Each additional 30 minutes \$67.03
99457 - \$54	99495 - \$187	
99458 - \$42	99496 - \$247	99484- General BHI \$48.65

**Chart 1.0 The Care Management Puzzle Pieces (Reimbursements may vary by state, below are mean whole amounts).**

It is less clear that a digital device is required to bill for codes 99457 and 58 and that remains to be clarified in a Final Rule announcement. There is no requirement for 2021 that a digital device be used in order to bill for codes 99457/58. These codes for interactive communication and care can be billed if the practice is collecting monthly vitals of any number of days from a Medicare patient. They may use an industry standard rubber bladdered BP cuff and share that data with the physician. The 20 minutes per month or more of time spent reviewing it and interacting around management of that high blood pressure is billable for code 99457/58.

RPM is different from CCM which is inclusive of 2 chronic diseases and includes work done like medication refills, and care coordination including phone time with the patient. RPM code 99457/58 is solely focused on the interactive component which may include more than just a phone or video discussion of vitals and device data but other discussions related to or around management of care. A provider can bill both RPM and CCM in the same month. This is allowed because CMS recognizes the kind of analysis involved in furnishing RPM services is complementary to CCM.



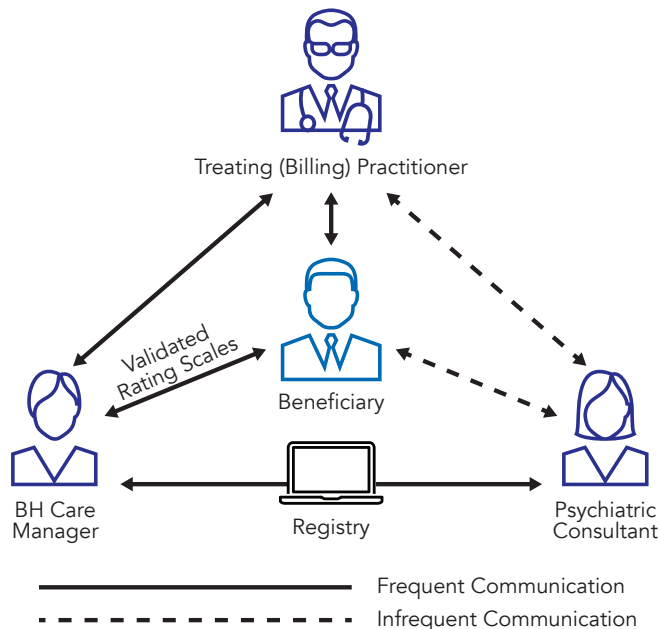
The internet-ready patient is a game changer for value-based approaches which rely on success in patient engagement and their outcomes. For example, having interactive communication for RPM code 99457 could be facilitated through phone or video check-ins with the patient. It is billable when 20 minutes of interaction is accumulated. Example: a 70-year-old submits data points using an FDA defined medical device and goes back

and forth with the practice for a total of at least 20 minutes in a month regarding an acute or chronic condition; this time is billable for \$54 dollars under CPT code 99457. If it's a digital device then code 99454 for \$69 dollars is paid by Medicare as well. What's great is that the patient is getting attention to details like oximetry, weight, blood pressure, and Physicians and Non-Physician Providers (NPPs) are offered awareness of their at-risk population without needing to be expensive data gatherers in order to operate at the top of their license.

CCM and PCM, RPM as well as Transitional Care Management (TCM) are key pillars in Care Management. The emergence of new Care Management codes includes Behavioral Health Integration (BHI) models known as the Behavioral Health Psychiatric Collaborative Care Management Services, Collaborative Care Model (CoCM). As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to Medicare beneficiaries over a calendar month. This model is promoting integrated connectivity with a behavioral health care team. [Please see link to CMS fact sheet here.](#)

The American Psychiatric Association reports that the majority of mental health care is provided in primary care settings. Evidence shows that care and outcomes improve when psychiatric expertise is made available to primary care providers through an evidence-based psychiatric Collaborative Care Model (APA 2019). While this model has been well-studied, there was no consistent reimbursement mechanism in place to cover the cost of providing services until now (American Psychiatric Association 2019). This is the integration of primary care and behavioral health services into the primary care setting and reimbursement for remote communication and collaboration with a behavioral health care team.

Physicians will be reimbursed for 70 minutes of behavioral health care manager time the first month and 60 minutes subsequent months. An add-on code for 30 additional minutes any month is in place as well. The 2021 Final Rule also added HCPCS GCOL1: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities. Since the introduction of BHI, Medicare has continued to update the billing codes and expand the reimbursement opportunities for providers aiding the millions of Americans living with a mental health disorder. The model consists of behavioral services that are categorized into general BHI and the psychiatric collaborative care model (CoCM) [See source info here.](#)



The CoCM is the more complex model which includes the multiple CPT code reimbursements of 99492-4. The services in the graph show the intended relationship of Psychiatric Consultant to Primary Care and the Behavioral Healthcare Manager around the beneficiary. The General BHI services requirement which pays 48 dollars per patient per month is for 20 minutes of phone time per month and does not require the use of a certified EMR. In the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RUHCs) the Care Management payment for CCM and BHI are the same. The code is recognized and billable under G0511 at a rate of approximately \$66 dollars per patient per month. The CoCM payment is under code G0512 and pays \$141 dollars per patient per month.

This recognition of mental health services as a key component to beneficiary wellness and cost savings to CMS offers a very attractive business opportunity to Primary Care and various mental/behavioral health licensures including addiction treatment facilities. The envisioned business relationship for CoCM could include a psychiatrist approaching a primary care referral source or vice versa and working an agreement on how to share the reimbursements received by the billing physician (the PCP).

## CONCLUSION:

Connected Care models have continued to grow and evolve since the 2013 creation of TCM and the 2015 creation of CCM. The 2021 Final Rule solidified the expanded Care Management code sets which arrived from 2013 to 2020. The importance is not just about payment models and billable codes or pressures from MACRA; it's about a mindset that waiting for a decompensated patient to show up at the Emergency Room or be re-admitted to a hospital is a non-sustainable cycle for performance in the new Federal and commercial healthcare delivery models. Patient satisfaction and the wellness of families who care for seniors living with chronic physical and mental conditions is improved through Connected Care by aligning a strategy for chronic care with reimbursement.

Seven in ten deaths, 99% of Medicare's payments, and 86% of US healthcare costs overall are due to poorly controlled non-lethal chronic diseases. 1 in 5 seniors are readmitted in 30 days. This is preventable. Connected Care strategies are growing as CMS takes the lead in offering payment models which compel providers to perform in low cost and high-quality outcomes. Offering reimbursement for the actions of caring for patients through non-face to face methods of communication is a significant step by CMS to further its value-based care agenda and perhaps even attainment of the quadruple aim.

Physician practices, Independent Physician Associations (IPAs), Accountable Care Organizations and APM participants in CPC+ or Bundled Payments for Care Improvement (BPCI) stand to benefit from the paradigm of Connected Care. These Connected Care strategies are aligned with Care Management reimbursements by Medicare and are transformational in that they lead practices to greater scope of opportunities in the QPP and all value-based care programs. Implementing a strategy which is tied to reimbursements facilitates new revenue while offering patients greater access to care teams. And that is good, because most patients want to stay out of the hospital and be home with their loved ones if they can. Population Health's last mile is Connected Care. The current model of achieving on value needs an update. Why is reviewing claims data 30 days in arrears helpful to patient outcomes? How is a big data analysis of a longitudinal patient record helpful if the practice does not know who is trending in the wrong direction TODAY? The technology behind population health strategies other than software and data aggregation has largely been the telephone: call centers reaching out to patients to try and get ahead of the curve. But in 100 years the telephone has not done much for chronic disease management. So, a way to optimize technology and integrate it to patient care strategies aligned to reimbursement is really the essence of Connected Care. And why it is so important? That strategy will result in patients using technology to update the practice on their status and increase awareness of precisely when they are trending towards more costly care. How else can value truly be realized?





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