

Physicians Slow Embrace of Chronic Care Management and its Impact on Senior Living

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As Medicare's chronic care management "CCM" payment program begins its third year, there is expectation that more physicians will sign-onto bill CCM thanks to recent revisions to the program which increases monetary incentives while reducing some onerous eligibility requirements. Seniors are now living with more chronic illnesses: 68.4% of older adults have two or more chronic conditions while 36.4 %have 4 or more chronic conditions. ¹ The presence of multiple chronic illness has been steadily rising because people are living longer but with suboptimal lifestyles while medicine has improved particularly in early detection of disease and improved interventions. ² Expanding CCM to elderly Medicare beneficiaries should be welcome news to senior assisted living (AL) communities as most AL residents meet the eligibility requirements to obtain CCM services and AL nurses stand to benefit significantly if they can gain access to the residents' medical teams by phone or email to help address health status changes in real time among other benefits. ³

CCM has been slow to stimulate interest from medical providers even though many physicians were already performing services which would fall within CCM but for which they could not be reimbursed. In the first two years of the program, only about 684,000 beneficiaries mostly from southern states out of the nearly 34 million eligible seniors received CCM services while a majority of physicians' who billed CCM were solo practitioners who managed on average only about 10 patients enrolled in the CCM program. ⁴ In January, 2015, Centers for Medicare and Medicaid, CMS, began paying Physicians who bill fee-for-service and non-physician practitioners (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, and Certified Nurse Midwives) and supervised staff, collectively "practitioners" on a monthly basis to perform an array of "non-face-to-face" services with patients and their caregivers, such as through telephone, email or text, in order to manage their chronic illnesses outside of an office visit. (CPT Code 99490)⁵

The new program was viewed as a major policy shift at CMS which traditionally would not pay physicians for non-face-to-face encounters with patients except in rare instances such as telemedicine for rural communities and managing was not considered "treatment". CCM was designed to streamline processes of care, improve the patient experience, and reduce hospitalizations, all savings

¹ Expert Rev Pharmacoecon Outcomes Re. 2015; 15 (5): 823-832

² Id.

³ It is assumed that almost all senior living residents receive Medicare or Medicare advantage health care coverage

⁴ Mathematica Policy Research to the Centers for Medicare and Medicaid Innovation Centers, November 2, 2017- "MPR Report".)

⁵ Criteria includes two or more chronic conditions such as Alzheimer's and CHF expected to last at least 12 months and which places the patient at risk of death, acute exacerbation, or functional decline.

goals intended to offset the additional cost to the government from CCM. (MPR Report) However, the promises of improved efficiencies and reduced hospitalizations failed to materialize as predicted. CMS acknowledged that the early roll-out failed to garner interest from practitioners in large measure because the monetary benefits for practicing CCM were outweighed by a strict set of burdensome eligibility requirements, including increased documentation, the need to obtain patients' written consent, and the requirement of providing patients 24/7 access to their electronic care plan. (MPR Report)

Nevertheless, for those patients who were enrolled into the CCM program, CMS was able to confirm through data reviews that on average patients who received CCM experienced a lower growth rate of health care expenditures compared to those who did not receive CCM services. (MPR Report) The decreased growth rate was driven by decreased expenditures for inpatient hospital services, skilled nursing facilities, and all-cause emergency department visits according to the MPR Report.

A survey⁶ examining the reasons for why physicians were not enrolling in CCM after its role-out found that there were several key barriers which needed to be overcome: 1. Insufficient reimbursement (47% surveyed); 2. Lack of awareness regarding the opportunity (43%); and 3. Compliance concerns (39%). Other barriers: patient involvement is difficult and time consuming, co-pays create concerns from patients, electronic health records requirements, and CCM services may require an investment physicians are not able or willing to make. CMS acknowledged that barriers to enrollment needed to be reduced and financial incentives increased if more practitioners were to enroll in the program.

In 2017, CMS, implemented revisions to the CCM program which includes both financial incentives to attract increased interest by practitioners and reduced eligibility requirements to reduce barriers slowing enrollment.⁷ CMS added new billing codes to compensate practitioners appropriately for managing more complex chronic illnesses, and added codes not strictly within the chronic care billing program which expands the ability of practitioners to bill Medicare for non-face-to-face encounters with patients under the spectra of "evaluation and management" services.

In reducing CCM practice eligibility requirements, CMS no longer requires prior written consent of patients (it may be verbal) to enroll into CCM, and practices need only perform initiating visits with new patients before enrolling them into CCM. Moreover, CMS no longer requires 24/7 access to electronic care plans.⁸ The revised rule requires 24/7 access to patients who have critical care needs but practitioners need not be available to address an urgent chronic care need after hours. Finally, the revised rule has relaxed the requirement that all practitioners must have immediate access to the complete electronic medical plan of care: a summary of the medical records of patients may now be transmitted via fax or by secure email.⁹

⁶ The National Chronic Care Management Survey, 2015, PYA and ENU, Health Intelligence 2015

⁷ CMS, Changes to Chronic Care Management Services for 2017 Fact Sheet

⁸ CMS, Changes to Chronic Care Management Services for 2017 Fact Sheet

⁹ CMS, Changes to Chronic Care Management Services for 2017 Fact Sheet

24/7 access to practitioners is a key element of CCM's objective in reducing emergency visits or hospitalizations and re-hospitalizations as practitioners can evaluate the patient's change in condition over the phone and depending on the amount and type of information gathered, make the appropriate referral which in many cases may not be to the hospital emergency department. However, the 24/7 access requirement continues to be a barrier to enrollment as many practitioners do not have resources to serve patients after-hours. Outsourcing on-call services has been made easier following the recent revisions to the CCM program. (On-call services have sprouted following introduction of CCM) The CCM program continues to require a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments to be available on short notice. There is cost sharing as well but supplemental coverage pays for CCM cost sharing obligations. Medicare Advantage Plans are required to offer CCM, but some are not, claiming to be offering CCM commercially.¹⁰

. Now, in addition to the base level CCM which yields approximately \$43 monthly for 20 minutes of staff time devoted to a patient with 2 or more chronic conditions, CMS introduced complex chronic care management services¹¹ which yields to practitioners approximately \$92 monthly and opportunity to apply add-on codes where the practitioner spent additional time consulting with patients during a month.¹² CCM can be billed in the same month as transitional care management if there is no duplicity of services but cannot be billed in the same month as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) and certain End Stage Renal Disease services (CPT code 90951-90970) because those services tend to overlap with CCM.

CMS also introduced an add-on code- HCPCS code G0506 which enables physicians to be paid separately for comprehensive assessment and care plans for chronically ill patients which go beyond the scope of an initiating visit and is billed in addition to CCM. (This is separate from HCPCS code G0505-care planning for patients with dementia and may be billed at an initial Annual Wellness Visit, AWV, or initial Preventive Physical Exam or transitional Care Management service)¹³

CMS also expanded coverage for "non-face-to-face" prolonged Evaluation & Management services.¹⁴ Prolonged E & M services must be related to a face-to-face E & M service. Physicians may not report prolonged E & M services during the same service period as complex CCM services or transitional care management services. The national average reimbursement for a prolonged E & M service is \$113.¹⁵ These codes are often used for extended records reviews and/or coordination of care and physicians may bill code section G0505-506 in addition to prolonged E & M where

¹⁰ CMS, Changes to Chronic Care Management Services for 2017 Fact Sheet

¹¹ CPT code 99487 is billed for complex chronic care management billing eligibility-multiple chronic illness plus moderate or high complexity medical decision-making requiring 60 minutes of staff-time per month and for additional time bill under CPT code 99489)

¹² CMS had introduced transitional care management services (CPT codes 99495 and 99496) which involves a combination of non-face-to-face and follow-up face-to-face services.

¹³ Medicare Learning Network statement, Chronic Care Management Services changes for 2017

¹⁴ CPT codes 99358-prolonged Evaluation and Management services before and after direct patient care for the first hour (with a minimum of 30 minutes) and CPT code 99359 billed for each additional 30 minute intervals.

¹⁵ CMS Transmittal No. 3678

appropriate.¹⁶ Physicians now have the means to evolve their busy office practices into delivering a suite of management services and remote monitoring to patients who struggle to self-manage chronic illness.

ROI analyses of chronic care billings dating back before the new 2017 revisions show that when physicians' offices properly supervise a staff of qualifying practitioners such as APRN's and allow them to perform many of the CCM services, the office can yield reasonably high returns on investment.¹⁷ As long as a practitioner uses an electronic medical record, and is set up with a call-in medical service provider to field after-hours calls, they are eligible to bill for CCM. To be eligible for billing CCM, medical practices would need to segregate likely Medicare beneficiaries appropriate for CCM, invest a modest amount of time and money operationalizing CCM, enrolling patients, and then practicing CCM. The following is a workflow chart which outlines the efficient use of CCM services from which a stream steady stream of revenues may be generated to the practice:

1. Schedule face-to-face office visit with a Medicare beneficiary to perform a preventive service such as annual wellness visit or preventive physical exam, comprehensive E & M visit or transitional care management service, all of which are billable:

2. Evaluate whether the patient has at least two chronic conditions or has multiple chronic condition which required complex medical decision-making:

3. If eligible for CCM request verbal consent and discuss co-pay issues with patient, making note of the consent:

4. Practitioners can conduct a further evaluation of the patient at the initial visit if warranted, billing an E & M code:

5. The practitioner may create an electronic comprehensive plan of care and bill for that service using code-ICPCS code G0506 (G0505 for dementia) (If outsourcing CCM, the practitioner must set up remote access to the POC by the on-call service)

6. Care must be taken to not bill CCM during a month the practitioner bills for services which conflict with CCM, such as prolonged E & M services.

7. Services which are often communicated over the phone or through secured email include case management-making sure scheduled appointments are kept, review of medical records, identifying patient needs which reoccur each month such as medication reconciliation, adjusting orders, monthly health status assessment, revising/updating POC, monitoring compliance with self-management of chronic disease: and educating patients about reducing risky behaviors such as falls, alcohol use, or poor diets, which is categorized often as motivational or educational counseling.

As more primary care physicians operationalize CCM for chronically ill older patients, it is likely that practitioners who see patients residing in senior living communities will assume a larger role

¹⁶ CMS Transmittal No. 3678

¹⁷ Annals of Medicine Study, October 20, 2015, Vol. 163, Issue 8.

in their overall care. In fact, the growth of CCM within primary care should stimulate interest by practitioners to work more collaboratively with AL nurses concerning the health of residents. CCM is available to residents of senior assisted living facilities.¹⁸ Approximately 75 % of residents residing in residential care settings have at least 2 of the 10 most common chronic conditions found in the setting which are Alzheimer's and other dementias, (42%) heart disease (34%), depression (28%) arthritis (27%), osteoporosis (21%) diabetes (17%), COPD (and allied conditions (15%), cancer (11%), and stroke (11%).¹⁹ A major problem physicians' encounter when treating elderly patients is the relative asymmetry of medical knowledge which exists between the doctor and patient, which is made more complex by the presence of multiple chronic illness.²⁰ Improving methods of communication with elderly patients has proven in studies to improve the access to appropriate treatments.²¹ Senior living nurses, who gain the trust of residents from their frequent if not daily interactions, offer opportunity as professional caregivers, to become more involved with patient choice and preference for certain types of treatments when presented with options by the doctor which will improve outcomes.

The argument for increasing collaboration among AL nursing staffs and residents' medical teams concerning the health of AL residents is *not* an advocacy to *medicalize* the assisted living's social model to be on par with nursing homes. Assisted living forms an important and popular choice within the continuum of care options for seniors which ranges from informal supports at home to nursing home care, with assisted living occupying its place in between. Studies show that newer model assisted living communities are displacing nursing home beds due in part because assisted living promotes a philosophy of care which emphasizes self-determination, autonomy, independence and privacy.²² Assisted living is the fastest growing long-term care option because seniors place high value on having more autonomy and choice over their health needs. However, the niche which assisted living enjoys is being challenged by the increasing acuties of residents as there are higher demands for medical oversight and monitoring which comes with an older, sicker population. AL nurses are tasked with having to balance resident autonomy with safety concerns sometimes on a daily basis.²³

Senior assisted living encompasses a variety of residential settings, but is generally viewed as a residential long term care option that provides housing, 24-hour oversight, personal care services, health related services, or a combination, on an as-needed basis; physician involvement in assisted living has been minimal.²⁴ Typically, an AL nurse places a call to a resident's doctor when an acute health concern arises; otherwise, nursing care delivered in assisted living is autonomous, not subject to direct medical supervision.²⁵ Because of the lack of medical oversight of care delivered in the AL setting, there are limits in care capacity which must be evaluated by AL managers. Studies show that assisted living communities while accepting residents who have similar needs as nursing home

¹⁸ CMS FAQs, January 18, 2017-taken from a national survey of Residential Care Facilities

¹⁹ CDC data from the 2010 National Survey of Residential care facilities.

²⁰ Applied Economics, 39: 16 2133-2142

²¹ Id.

²² The Gerontologist Vol. 43, Issue Suppl_ 2, 1April, 2003, pages 107-117

²³ Assisted Living Nursing, A Manual for Management and Practice, Resinick and Mitty, 2009

²⁴ Scope and Standards of Assisted Living Nursing Practice for Registered Nurses, 2007

²⁵ J Am Geriatr. Soc. 2011 Dec; 59 (12): 2326-2331

residents, nevertheless tend to be more restrictive on admission/retention criteria than nursing homes because of limits (some self-imposed, others regulated) in the amount and intensity of health services which can be offered in the AL setting: Whereas, in nursing homes, viewed as an institutional residential care option in part due to the presence of nearly constant medical oversight, admissions staff are able to accept and retain the sickest and most dependent persons.²⁶

The growth of physician-directed CCM if popularized within assisted living settings can serve as a catalyst for increasing the care capacity of assisted living to be near par with nursing home care, but without transforming AL social model into the institutional character of a nursing home. Nursing homes have traditionally integrated medical plans of care with non-medical personal care under the direction of a physician, but within an agonizingly complex regulatory environment. CCM shows promise to jump-start interest within the AL settings to integrate at least some aspects of a residents' medical plan of care with AL services plans under the general supervision of the residents' medical team. There is already collaboration occurring between physicians and AL staff concerning assistance with self-administered medications to reasonably good effect.

Despite CCM's potential to transform the way medical support is delivered in assisted living, several obstacles remain which will continue to slow innovation in this area. In a study by John G. Schumacher, titled *Examining the Physician's Role with Assisted Living Residents*, the researcher discusses the opportunities and challenges to having physicians assume expanded roles in caring for AL residents.²⁷ The biggest challenge to increasing physician collaboration in the AL setting is the lack of uniformity in care capacities which exists across the industry-assisted living evolved organically as a social model which includes independent housing with and without services, a hospitality model with some level of personal care services, a hybrid-model which introduces nursing oversight and personal care services, and continuum care retirement communities which have on-site nursing homes; all except the nursing home being regulated at the state level.²⁸ Physicians have little to no information on what level of expertise in caregiving a particular AL community's nursing staff is capable of providing and at what quality. This lack of information poses a barrier to building trust among staffs.

Schumacher notes that to overcome the challenges toward fostering collaboration, physicians would need to know and understand the quality of care which the particular AL community staff is capable in delivering, the timeliness of services to be delivered, the communication patterns which exist and which can evolve between AL staff and medical staff, and the precise role the physician is expected to undertake when working cooperatively with the AL nursing staff.²⁹ Schumacher cites improved communication between providers as well as integration of all types of health services, including mental health services, allied health services, and non-medical services into medical plans of care as optimal target areas for innovation of physician services within the AL setting.³⁰ Schumacher's argument for increasing the role of residents' physicians in overseeing service plans, medication

²⁶ *The Gerontologist* Vol. 43, Issue Suppl_2, 1April, 2003, pages 107-117

²⁷ *Journal of American Medical Director's Association*, John G Schumacher, July, 2006

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

management, and other care management services is echoed in a recent article published by Barbara Resnick, and colleagues, titled *The Role of Physicians Practicing in Assisted Living: What changes Do We Really Need?*³¹

To respond to the variability in care capacities within the assisted living setting, assisted living organizations should adopt protocols which allows staff to critically evaluate caregiving capacity concerning both atypical health conditions and the top ten chronic conditions which persist in AL settings.³² For each such chronic condition ask staff to answer the following at a care planning meeting:

- Can we accommodate this condition?
- How are we managing this condition?
- Are we capable of addressing this condition?
- Do we need to partner with a home-health agency, physical or occupational therapist?
- Is there a particular consultant could be retained to help guide the planning of care to address an atypical problem?
- Can our staff research best-practices and apply to a particular case?³³

Assisted living nursing departments with assistance from marketing personnel should regularly update area physicians about the care capacity of the organization and be prepared to discuss those capabilities and limitations with any physician practice which may interested in working collaboratively with staff.³⁴ One area for which collaboration with physicians would be most optimal is in jointly constructing a geriatric assessment. The geriatric assessment is a core competency of the assisted living nurse, while also required in most state regulatory schemes. The geriatric assessment differs from a standard medical evaluation by including nonmedical domains with emphasis on functional ability and quality of life.³⁵ The geriatric assessment aids in the diagnosis of health-related problems, development of plans and treatments, coordination of care, the need for aging support services, and the optimal use of health resources.³⁶ Comprehensive geriatric assessments address the following: functional ability including ability to perform activities of daily living; physical health including hearing vision, continence, and balance are assessed; cognitive and mental health including depression; decision-making capacity; quality of life; and environment.³⁷

The physician's primary role in the geriatric assessment is diagnosis, drug regimen review, prescribing, ordering tests, issuing medical orders, and performing treatments.³⁸ Other members of the care team who may contribute to an assessment include social work, psychiatry, pharmacy, and

³¹ AMDA, 2017: *The Society for Post-Acute and Long-Term Care Medicine*

³² *Provider magazine, Long-Term and Post-Acute Care*, Lisa Gluckman, April, 2013

³³ *Id.*

³⁴ *Id.*

³⁵ *American Family Physician*, January 1, 2011: Vol. 83: No. 1

³⁶ *Id.*

³⁷ *Assisted Living Nursing, A Manual for Management and Practice*, Resinick and Mitty, 2009

³⁸ *The Merk Manual of Geriatrics*, 3rd Ed. Pg.76

allied health care agencies such as home health, physical and occupational therapy.³⁹ Physicians practicing CCM can now bill to perform more comprehensive assessment services on their elderly patients who have chronic conditions and for reviewing and updating the care plans. The use of geriatric assessments is especially important when caring for older adults with multiple chronic conditions (multi-morbidities)⁴⁰ According to guidelines established by the American Geriatrics Society, clinicians who treat older adults with multi-morbidities should shift focus away from a single-disease treatments and onto a more holistic appraisal of health problems which would include patient preferences, framing clinical decision-making within the contexts of risks, burdens, benefits, and optimizing therapies and care plans which maximize benefits, minimizes harms, but which enhances quality of life.⁴¹ The AL nurse has much to offer in assisting in the process of evaluation and management of residents who have multiple chronic illnesses.

Other areas for which collaboration between AL nurses and residents' physicians could have significant benefits to residents include frailty, falls, incontinence, gait impairment, nutrition, dizziness, visual impairment, chronic pain, prevention, and managing physical activity.⁴² In all of these geriatric syndromes and conditions, medical and non-medical care planning and service delivery should be enhanced when there is improved professional collaboration.

Yet, perhaps the most important area in which to collaborate is in response to acute status changes of residents. When an AL nurse can gain immediate phone access to a resident's physician or staff, in real time to receive medical advice about an acute health status change, it will likely improve outcomes of care as unpopular transfers to emergency departments or a hospital admission may be avoided in some cases while exacerbations of the chronic illnesses may be quickly brought under control. AL nurses have typically relied on a call to 9-1-1 and an emergency department visit in response to an acute health status change which could not wait for a doctor's office visit. Physicians who practice CCM will be able to field calls 24/7 (whether or not outsourced) from AL nursing staffs and advise on appropriate responses to reported symptoms.

The partnering opportunity between physician practices and senior living organizations concerning CCM services offered to AL residents can be a win-win-win. CCM's overall impact on assisted living, if growth in physician enrollment induces more integration with AL staffs, is a significant increase in professional caregiving capacity within senior living. Whereas, If physicians' offices develop a CCM practice infrastructure which integrates assessments, planning and caregiving with non-medical providers, the time demands in performing non-face to-face management services per patient, per month from which revenues are generated from Medicare reimbursements, will be significant enough to more than justify the investment. Yet, the real beneficiary will be seniors who will receive a community-based long-term care option to age-in-place for longer, thus reducing the likelihood of being placed in a nursing home.

³⁹ *Id.*

⁴⁰ *J Am Geriatr. Soc.* 2012; Oct: 60 (10):1957-1968 –as comprised by an expert panel

⁴¹ *Id.*

⁴² *Assisted Living Nursing, A Manual for Management and Practice*, Resinick and Mitty, 2009