

## MEDICARE CHRONIC CARE MANAGEMENT PROGRAM (CCM Program)

**THIS HANDOUT PROVIDES INFORMATION ABOUT CHANGES TO SERVICES WE HAVE PROVIDED TO PATIENTS WITHOUT THE NEED FOR AN OFFICE VISIT.** (SEE SECTION ON “WHY SHOULD I PARTICIPATE”)

Medicare has implemented an important health benefit for patients and doctors. The CCM Program now pays doctors for non-face-to-face medical services provided to patients with two or more chronic conditions. The goal of the CCM Program is to make patients healthier and reduce hospital admissions. The program is meant for patients to participate with their Primary Care Physician (PCP).

Health insurance companies recognize that Primary Care Physicians (PCPs) are in a unique position to improve the individual and overall health of patients with complex medical conditions. By reaching out to their patients with two or more chronic medical conditions, PCPs can improve health and reduce hospital admissions by helping patients with diet, medications, activity level as well as monitoring things like heart rate and blood pressure to name a few.

Medicare recognizes that these non-face-to-face communications take time and staffing to perform. PCPs have traditionally performed many non-face-to-face services for patients that have never been compensated. A few examples are refilling medications, reviewing lab and diagnostic imaging results, referring and scheduling visits with specialists, answering patient questions and reviewing and coordinating patient health with other physicians. Now, PCPs will not only be compensated for those services, **but more importantly, they will be able to provide outreach services to their more complex patients to help prevent hospitalizations and other adverse medical events.**

Deductible and coinsurance amounts apply to CCM services similar to other Medicare services. Your Medicare supplement will pay for CCM deductible and coinsurance similar to other services.

### How will the CCM program improve patient health?

To start – remember the CCM program will be used only for Medicare age patients who have at least two serious chronic health conditions such as diabetes or high blood pressure. Thus, the program is reaching out to patients who have substantially life threatening issues. Any program that can impact those conditions in a positive manner is a good thing.

Historically, the delivery of healthcare in our country has been as a reaction to an existing health problem – i.e. a patient becomes sick and goes to a doctor. Going forward, the goal of healthcare delivery is to be proactive in preventing disease or at the very least attempt to detect disease early enough so that better patient health and quality of life outcomes will result. Working together, doctor and patient can achieve these goals.

For some patients all that may be needed is a yearly wellness visit and one or two follow up visits to track health status, review lab results, or renew medications. For those patients, the CCM program will play a minor role if any. At most, my non-face to face time may include reviewing lab results or renewing medications a few times a year.

On the opposite end of the spectrum may be a patient for whom a call from one of our staff once or twice a month would be very helpful in helping that patient stay on a proper diet, take their medications correctly or track their weight or blood pressure. It is very possible that such communications may reveal a serious issue and prevent a hospital admission or worse. For patients with that level of complexity the CCM program threshold of 20 minutes may be reached every month.

### Why should I participate?

To me it comes down to this – I certainly want my patients to live healthy, happy, and active lives. I value the care I provide to my patients and I take the time to listen to my patients so that I can provide the best health care possible. The question is – do patients value the services I provide? For patients who participate in the CCM program, the providers and staff of Fairhope Family Medicine will be able to:

- Identify and reach out to medically complex patients who can benefit from a higher level of communication with their doctor's office; and/or
- Continue providing **non-urgent** medical services without requiring an office visit. Examples are, refilling medications or reviewing non-urgent lab or diagnostic imaging results.

It is also important that you understand that the CCM program is meant for patients to participate along with their **Primary Care Physician** and that a patient can **authorize only one physician to bill Medicare for CCM services**. Designating a CCM provider in no way limits your ability to see other physicians such as your cardiologist, rheumatologist or orthopedic surgeon to name just a few.

If you have already signed a CCM consent form with another physician - you can make a change to Fairhope Family Medicine if you wish. Ask our staff how to do that. **Remember, the physician you authorize to bill Medicare for CCM services should be the physician you consider to be your PCP.**

If you choose another physician to be your CCM provider, I will consider that physician to be your PCP. **Only one physician can be your PCP.** Fairhope Family Medicine will continue providing you with medical care for **acute issues only**. If you decide I am not your PCP, I cannot continue to manage your chronic issues, refill your chronic medications or order and review lab work or diagnostic tests.

**For patients who choose not to participate in the CCM program**, I will be happy to continue to act as your PCP and provide you with medical care. However, you will be asked to schedule an office visit for all future medication refills, reviewing all lab and diagnostic imaging results and for other medical services that could be handled as a CCM non-face-to-face service.

Thank you for choosing Fairhope Family Medicine as your medical home. Yours in good health,

Regan M. Andrade, M.D.