BridgepointMD Connections

Bridging the complexities encountered in shifting to value-based care

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Care Navigation (CCM) Services: *Misconceptions and Realities*

Most Medicare and Medicare Advantage beneficiaries can benefit from care navigation services, though only a small fraction receive them. Expanding access to care navigation improves patient engagement, clinical outcomes, and can prevent exacerbation of chronic conditions. Misconceptions about providing care navigation services via chronic care management (CCM) CPT codes can prevent primary care and specialty providers from extending these beneficial services to their patients.

Misconceptions	Realities
x Only primary care physicians can offer care navigation	✓ CMS allows all specialties to bill for 'chronic care management (CCM)' codes and encourages as many patients as possible to benefit from services.
x Most patients already receive care navigation from primary care	✓ Currently only 3-4% of Medicare beneficiaries nationwide receive CCM services. Many primary care practices focus on the highest risk patients, leaving many rising risk patients not yet engaged. Primary care may benefit from specialists identifying and relaying gaps in care that arise.
x Care navigation doesn't impact patient outcomes	✓ Care navigation can identify and address care gaps, leading to improved patient outcomes and increased satisfaction. Monthly touchpoints drive improved patient engagement.
x Most patients don't qualify for care navigation	✓ Patients with two or more chronic conditions qualify, as long as they are documented via HCC codes.
x Care navigation requires 20 minutes of phone conversations	✓ Care navigation services include phone calls, text messages, medication management, health monitoring, care planning, facilitating transportation, addressing food insecurity, and coordination with other providers, among others.

This simple guide emphasizes the benefits of extending care navigation services to rising risk patients from both the primary care and specialty practice realms. Additional resources from the Centers for Medicare and Medicaid Services are linked below:

- https://www.cms.gov/files/document/chronic-care-management-toolkit.pdf
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Contact us at info@bridgepointmd.com if you are considering adding care navigation services to your Medicare and MA patient population. Our CarepointMD solution will meet all your needs.

Update Corner

- **Shareholder's Update**: BridgepointMD has decided to end its engagement with Carta and will now manage stock records and capitalization services in-house. This change does not affect any Shareholder's ownership. For questions, contact Joe Murray, CAO and General Counsel, at jmurray@bridgepointmd.com.
- **Business Update – *A Smarter Way to Handle Pre-Authorizations*:** Stay tuned for a new solution to simplify and streamline the pre-authorization process. Backed by industry expertise and AI-powered support, this partnership will reduce administrative burden, speed up approvals, and let you focus more on patient care.

A Narrative on Barriers to Change

The Human Elements Erecting Barriers to Change: *Perception, Resistance, Guarded Acceptance*

The Final Chapter

In the first two parts of this series, we discussed how our perception of the world around us is influenced by our experiences, and how we seem to be internally programmed to resist change because it removes us from our comfort zone. We know and understand that change is inevitable and necessary for advances and innovation, yet we inherently resist when confronted with transitions that require effort beyond our 'current' norm.

However, history tells us that we can overcome the obstacles of resistance and the desire to remain within our realm of comfort. We have the capacity to understand the values that am innovative evolutionary process can have. We can identify that the consequences of change can result in better performance, reduced burden, better experiences, and more. Yet, we are guarded in our approach, constantly looking for a kink in the armor, a small nugget to indicate that engaging in change is too much work. This is the functional barrier that we must overcome to push the frontier forward.

Fortunately, the barriers to acceptance of change can be eased when the value proposition is made clear, incentives align with operational goals, and the outcomes exceed 'the old standard' for all stakeholders. We have learned and accepted that change can be positive. To finalize the process, we must re-format our thought processes to embrace change despite the efforts it might take to accomplish the transition. It is easy to revert to 'same-old, same old,' but patience and determination are required to break through the obstacles and barriers to reach a new and better solution. Maintenance of the 'new norm' will likely involve editing old habits to fit the new paradigm and possible generating new pathways.

Change is seemingly never easy, but the results can be extremely rewarding. The capacity is there. Our willingness to do the work and expand our horizons determines the future. May we all succeed in the evolution of change.

CMS Activity Update

In May 2024 the Center for Medicare & Medicaid Innovation (CMMI) released a strategy update detailing new directions for accountable care. The graphic below provides a brief synopsis of the proposed strategy.

1. PROMOTE EVIDENCE-BASED PREVENTION

- **Embed preventative care** in all models and create **patient and provider incentives**
- Measure impact of preventative care to identify policies that **impact cost and outcomes**
- Future model features:
  - Engage providers and beneficiaries on disease prevention, including collaboration with community-based organizations
  - Waivers to incentivize preventative care
  - Access to evidence-based alternative medicine
  - Evaluate preventative outcomes, such as days at home for frail patients

2. EMPOWER PEOPLE TO ACHIEVE THEIR HEALTH GOALS

- Unlock **data access and improve transparency** for people and providers to enable data-informed decision-making and goal setting
- Align **financial incentives** with health for both individuals and providers
- Future model features:
  - Beneficiary access to information and tools for disease management and healthy living
  - Publish cost and quality performance data about providers and services to inform beneficiary decision-making
  - Waivers for predictable cost-sharing for certain services, drugs, or devices

3. DRIVE CHOICE AND COMPETITION FOR PEOPLE

- Increase **independent, community-based, and rural provider** participation in value-based payment arrangements
- Promote **choice in care** for health plans and where to receive care
- Improve value-based payment programs by reducing **administrative burden**
- Future model features:
  - Expand advanced shared savings and prospective payment programs
  - Reinvest hospital capacity and change certificate-of-need requirements
  - Standardize quality measures

FOUNDATIONAL PRINCIPLE: PROTECTING THE FEDERAL TAXPAYER

- All APMs involve downside risk, and a growing proportion of Medicare and Medicaid beneficiaries in global downside risk arrangements
- Providers required to bear some financial risk, conveners cannot hold all financial risk
- State government has reduced role in rate setting
- Refine and simplify benchmarking
- Ensure healthcare funds are distributed through proper non-discriminatory provisions
- Incentivize and prioritize high-value care, reduction of unnecessary utilization
- Ensure all model tests fiscally sound with a path to certification

Visit www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again for additional details.