

Care Providers — Primary Care Physicians

Accountable Care Services

Chronic Care Management Services Improve patient engagement and quality of care while increasing reimbursements



With McKesson Chronic Care Management Services™, providers can proactively learn more about their chronically ill Medicare patients while taking advantage of the new CMS reimbursement program for monthly non-face-to-face consultations.

Primary care physicians want to do more to support the care management of their chronically ill Medicare patients, but a lack of time and staff are against them. With McKesson Chronic Care Management Services™, physicians can get the support they need while being compensated for managing patients' chronic conditions outside of regular office visits.

Our patient-centered team can act as an extension of the primary care physician's office and provide non-face-to-face patient interactions — with virtually no upfront costs or additional staff.

The Centers for Medicare & Medicaid Services (CMS) has acknowledged the importance of chronic care management (CCM) and the cost savings that are within reach. CMS has started paying monthly reimbursements for non-face-to-face care coordination services under CPT® code 99490.



**BUSINESS
CARE
CONNECTIVITY**

Value-based Reimbursement

McKesson Chronic Care Management Services is just one service in our portfolio of Accountable Care Services that help hospitals and physicians assess and build the most effective management strategies.

Our step-by-step approach helps you build and manage effective provider networks combined with the revenue cycle management infrastructure and clinical care coordination to help control costs and generate revenues.

Regardless of where you are on your journey to value-based reimbursement, McKesson can help.

Favorable Economics

On average, reimbursement from CMS to providers that deliver 20+ minutes of non-face-to-face care coordination to Medicare beneficiaries with two or more chronic conditions is \$42.60 per enrolled patient per month.* If a practice were to enroll just 50 of its eligible Medicare patients into a CCM program, it would see estimated incremental revenue of \$25,560 annually.

**Estimated national average based on the CMS CY2015 Physician Fee Schedule*

Medicare's CCM Program Criteria

To be eligible for the program, certain inclusion criteria must be met by the physician or other qualified healthcare professional:

- Patient information in certified EHR technology
- 24/7 urgent care with access to the patient's electronic medical record
- Continuity of care with successive routine appointments
- Initiate CCM during an annual wellness visit, initial preventive physical exam or comprehensive evaluation/management visit
- Obtain Patient Consent Agreement form and upload signed document to certified EHR
- A minimum of 20 minutes, monthly, of non-face-to-face services
- Document annual receipt of care plan in certified EHR technology
- Transitional care management visits

Compliance with the program's requirements is essential for reimbursement, and meeting them can require technology investments and a commitment to additional staff.

McKesson Chronic Care Management Services

With McKesson Chronic Care Management Services, our nursing and other clinical support staff will provide the following program requirements, acting as an extension of the provider's office:

- Nurse care plan
 - Comprehensive assessment
 - Medication reconciliation
- Patient Care Advocate (PCA) scheduling
- 24/7 access to electronic care plans
- Patient welcome package and care coordination card
- Patient mailings (up to 15 per year)
- Provider welcome kit

As a result, physicians will:

- Gain more insight into patient behaviors
- Help increase practice revenue
- Have 24/7 access to care plans
- Make a concrete investment in value-based care, allowing this program to be a bridge between fee-for-service and value-based care

Contact us

To learn more, contact us today at 800.877.0171 or ccmservices@mckesson.com.

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