eTransX



XCare Community | *Chronic Care Management Platform*

Earn New, Recurring Revenue While Helping Patients Better Manage Chronic Conditions

Under the new Chronic Care Management (CCM) program sanctioned by CMS, health care providers can bill for CCM using CPT Code 99490. Not only will CCM help health care providers better serve their sickest patient populations, it presents a unique opportunity for providers to generate new, recurring revenue and serves as a limited-risk opportunity to accelerate their pursuit of value-based initiatives.

Compliance with the physician fee schedule requirements is essential to assure reimbursement. Qualifying health care provides must offer additional capabilities not found in many practices, including the ability to maintain electronic care plans, share care plans across the care team and provide 24/7 access to enrolled patients.

While a certified EHR is required, in most cases an EHR alone does not support the key functionality essential to comply with the CCM program requirements. Additional care coordination solutions are needed to achieve compliance, protect your practice from CMS audits, and achieve maximum value from the program.

XCare Community is a cloud-based care coordination platform offering user-friendly tools that facilitate the transition to chronic care management. Sold as stand alone technology, or as a complete turnkey chronic care management solution including licensed clinical staff providing coordination services for your patients, XCare Community helps practices capture the CCM opportunity and improve outcomes of high-need, high-cost Medicare populations.

Financial Case for Chronic Care Management

With the new code, Chronic Care Management can provide a good source of revenue for practices, if designed, managed and billed correctly. CCM affords providers the financial resources to add services that will increase their revenue while offering more care to the most at-risk patients.

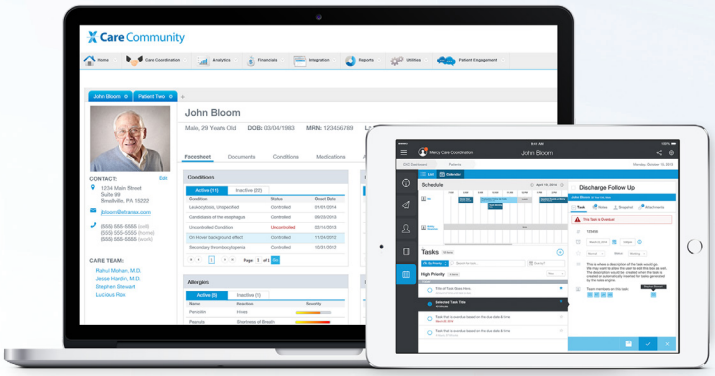
The potential revenue boost for physicians is remarkable. Practices can earn $40.39 per month providing care for each patient qualified for CCM. With 491 qualified patients, a practice could earn an additional $237,978 annually. Practices with 1,000 qualified patients have the opportunity to earn $484,680 in additional annual revenue without seeing more patients.

REVENUE PROJECTION:

Patient Panel Size[1]	**3,279**
% of Panel on Medicare[1]	**21.85%**
Total Medicare Patients	**716**
% of Patients Eligible for CCM[2]	**68.6%**
Total CCM Eligible Patients	**491**
Annual Billing Per CCM Patient	**$484.68**
Annual CCM Revenue Potential	**$237,978**

Meet All CCM Requirements

With an eye towards value-based, patient-centered care, CMS established a set of requirements that promote transparent, coordinated care. The XCare Community Chronic Care Management Platform (XCC) was designed to enhance the patient care experience while easily complying with all CCM requirements. XCare Community is a turnkey CCM solution that combines industry-leading care coordination technology with 24/7 care management services.



Patient Enrollment and Consent

Providers are required to secure a beneficiary's written consent to receive CCM services prior to billing for the services. XCC streamlines the onboarding process:

- Identify and risk stratify eligible patients
- Enroll/disenroll patients in the CCM program
- Manage the consent process
- Store consent forms

Electronic Care Plan (Care Pathway)

An electronic care plan must be created and be available at all times to care team members and to treating providers in other practices. With XCC you can:

- Set care plan goals and select interventions
- Share care pathway via portals to patients and other physicians
- Easily track patient alerts, tasks, and appointments from a central dashboard

20 Minutes of CCM Services/Month

At least 20 minutes per month of non-face-to-face services must be provided by eligible clinical staff to bill for CCM. With XCC, Care Coordinators can:

- Perform patient assessments
- Manage referrals
- Provide and track patient education
- Manage social services

Documentation of Services Provided

Detailed documentation of the CCM services provided is required and essential to protecting the medical practice from CMS audits. XCC simplifies documentation with:

- Embedded timer to track time spent on specific CCM activities
- Auto-documenting capabilities to reduce the burden on staff and manage any potential audits
- Time logs to view total time spent on care coordination for a specific patient

Care Coordination Services

The XCare Community solution was designed to make CCM easy and manageable for practices of all sizes. To assist those practices with limited human capital, we have partnered with CareHarmony to offer a complete, turnkey Chronic Care Management solution. The CareHarmony team will leverage eTransX's innovative CCM platform to offer 24/7 care coordination services. Certified clinical care providers function as a seamless extension of your practice and will work closely with your patients to manage chronic conditions, while achieving the 20 minute requirement for reimbursement from Medicare.

Footnotes:

1. MGMA Cost Survey for Single Specialty Practices: 2013 Report Based on 2012 Data specific to the specialty of family medicine. Includes Medicare A/B and Medicare Advantage
2. CMS.gov - County Level Multiple Chronic Conditions (MCC) Table: 2012 Prevalence, National Average

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