CONNECTED CARE

THE CHRONIC CARE
MANAGEMENT RESOURCE

"Connecting to Chronic Care
Management Services"
Partner Webinar

March 15, 2017

3-4pm EST

go.cms.gov/ccm

WELCOME AND INTRODUCTIONS

Agenda

- Welcome and Introductions

- Opening Remarks

- Overview of *Connected Care:*
  The Chronic Care Management Resource

- Stories from the Field

- Questions and Answers

Logistics

- **Discussion**: This will include a question-and-answer segment, and we want your input, so please participate!

- **Questions/Comments**: Feel free to share questions and comments in the chat window on the right side of your screen

- **Closed Captioning**: Access real-time transcription of this event at **http://bit.ly/WebinarClosedCaptioning**

- **Technical Assistance**: If you have any technical issues, please contact GoToWebinar at (855) 352-9002

Speakers

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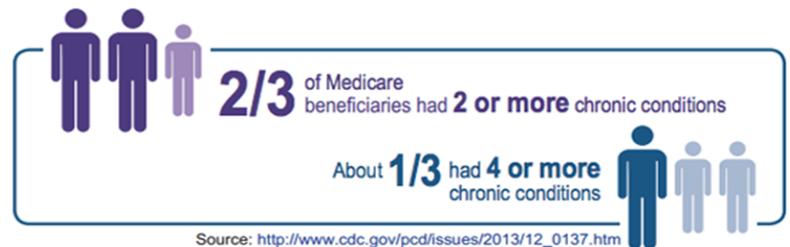*Moderator [C]*
CMS Office of Minority Health

Chronic Disease Burden in the United States

Chronic Care Overview

- Half of all adult Americans have a chronic condition – 117 million people

- One in four Americans have 2+ chronic conditions

- 7 of the top 10 causes of death in 2014 were from chronic diseases

- People with chronic conditions account for 86% of national healthcare spending

- Racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care

CMS and Chronic Care

- Medicare benefit payments totaled $597 billion in 2014

- Two-thirds of Medicare beneficiaries have 2+ chronic conditions

- 99% of Medicare spending is on patients with chronic conditions

- Annual per capita Medicare spending increases with beneficiaries' number of chronic conditions

2/3 of Medicare beneficiaries had **2 or more** chronic conditions

About **1/3** had **4 or more** chronic conditions

Source: http://www.cdc.gov/pcd/issues/2013/12_0137.htm

Rural Health and Chronic Disease

- Higher rates of chronic illness and poor overall health are found in rural communities when compared to metropolitan or urban populations

- Greater supply of health care providers in metropolitan/urban counties
    - Rural residents often live farther away from health care resources, which can add to the burden of accessing care

- Compared with urban counterparts, rural county residents are older, poorer, and sicker with a higher percentage having activity limitations due to chronic conditions

- Life expectancy for U.S. residents decreases as the level of rurality increases
    - In 2005-2009, people living in large metropolitan areas had a life expectancy of 79.1 years compared with 76.7 years for those in rural areas

    - Several chronic diseases contributed to lower expectancy, including heart disease, COPD, lung cancer, stroke, and diabetes

Source: 2014 National Healthcare Quality and Disparities Report Chartbook on Rural Health Care, Agency for Healthcare Research and Quality (August 2015)

What Is Chronic Care Management (CCM)?
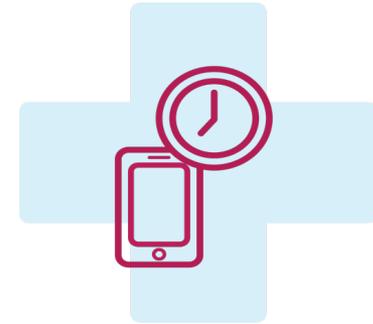
Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist and/or Certified Nurse Midwife) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

- CCM is a critical component of care that contributes to better health and care for individuals

- CCM offers more centralized management of patient needs and extensive care coordination among practitioners and providers

What Is Chronic Care Management (CCM)?

- Medicare initially provided payment for **CPT code 99490** beginning January 1, 2015 to separately identify and value clinical staff time and other resources used in providing CCM

- Beginning January 1, 2017, CMS adopted **3 additional billing codes (G0506, CPT 99487, CPT 99489)**

- Detailed guidance on CCM and related care management services for physicians available on the PFS web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

CONNECTED CARE: THE CHRONIC CARE MANAGEMENT RESOURCE

Connected Care
The Chronic Care Management Resource

The CMS Office of Minority Health (CMS OMH) is partnering with Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) under legislation to design and implement an **education and outreach campaign** to:

- Inform professionals and consumers of the benefits of chronic care management services for individuals with chronic care needs, and

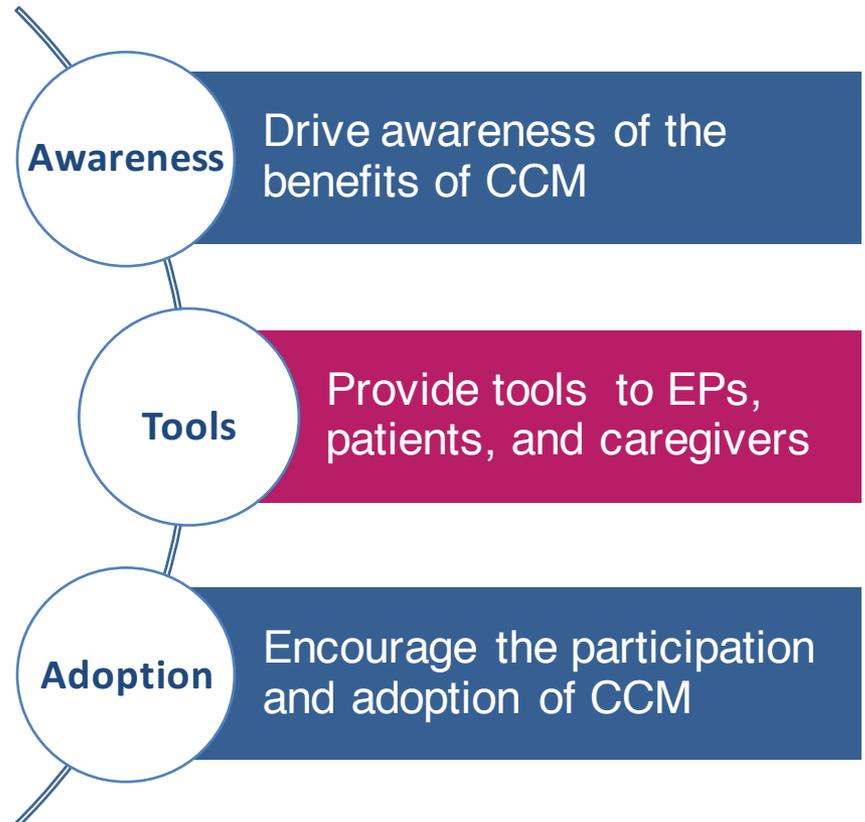- Focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

Campaign Audience

Primary Audiences

- **Eligible practitioners (EPs) and Suppliers:**
    - **Eligible practitioners:** Physicians, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants
    - **Eligible suppliers:** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- **Consumers/Patients:** Medicare and dual-eligible beneficiaries (Medicare & Medicaid) with two or more chronic conditions, with a focus on underserved rural populations and racial and ethnic minority populations

Secondary Audience

- **Caregivers** of patients

Awareness — Drive awareness of the benefits of CCM

Tools — Provide tools to EPs, patients, and caregivers

Adoption — Encourage the participation and adoption of CCM

Campaign Markets

- *Connected Care* is a national public education campaign

- CMS OMH and FORHP will target four states with more focused communications.

- Using Medicare claims data, planners identified two markets—one rural county and one urban area—in four target states to implement more localized campaigns that include media promotion and community outreach
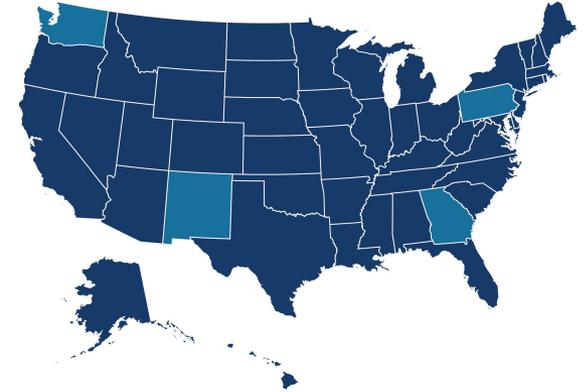
State	City (Urban)	County (Rural)
Georgia	Atlanta	Wilkinson County
New Mexico	Albuquerque	Colfax County
Pennsylvania	Philadelphia	Snyder County
Washington	Seattle	Clallam County

Campaign Pillars

Connected Care Resource Hub

- **Information for Health Care Professionals**
  - Access resources and tools explaining the benefits of CCM and how to implement this service

- **Information for Patients**
  - Access easy-to-read information on the benefits of CCM for Medicare beneficiaries living with two or more chronic conditions

- **Campaign Partnership Resources**
  - Access information about partnering to bring awareness to CCM through the *Connected Care* campaign

  Visit the *Connected Care* Hub at:
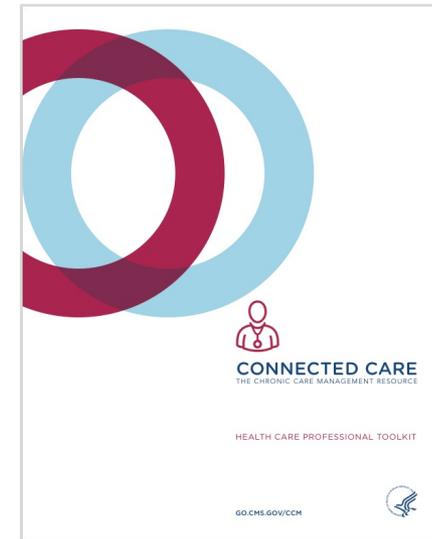 **go.cms.gov/CCM**

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Health Care Professional Resources

- Resources to help health care professionals learn the benefits of CCM services
  - *Connected Care* Health Care Professional Toolkit designed to help providers implement CCM and engage staff and patients about its value
  - Postcard for health care professionals
  - Testimonial video (Coming soon)
  - Links to CCM resources developed by CMS and professional health organizations

To download resources, visit:
http://go.cms.gov/ccm

CONNECTED CARE
THE CHRONIC CARE MANAGEMENT RESOURCE

HEALTH CARE PROFESSIONAL TOOLKIT

GO.CMS.GOV/CCM

CONNECTED CARE
THE CHRONIC CARE MANAGEMENT RESOURCE

The Centers for Medicare & Medicaid Services (CMS) has adopted a service code to improve payment and access to chronic care management (CCM) services for Medicare beneficiaries who have two or more chronic conditions.

Health care professionals have an opportunity to increase clinical revenue while improving self-management, health outcomes, and patient satisfaction.

Patient Education Resources

Resources to help health care professionals educate patients about CCM services:

- Overview of benefits of CCM for patients
- Waiting room posters
- Postcard to share with patients during visits
- Animated video (Coming soon)
- Links to prevention and disease education resources

To order materials, contact CCM@cms.hhs.gov

GET INVOLVED

Partnerships

- Partners are vital to the success of the *Connected Care* campaign

- Professional societies, national advocacy groups, and local organizations stand at the frontline to support patients and health care professionals

- Your support is critical to raising awareness about the benefits of CCM services

  To become a partner, e-mail us at: **CCM@cms.hhs.gov**

Partner Toolkit

- Use the Partner Toolkit to promote the benefits of CCM and share campaign resources with eligible health care professionals and patients

  - Suggested partner activities
  - Sample language for articles, blog posts, and emails for outreach
  - Links to educational tools for health care professionals and patients
  - Links to shareable media and graphics

To download the toolkit, visit go.cms.gov/CCM

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THE CHRONIC CARE MANAGEMENT RESOURCE

PARTNER TOOLKIT

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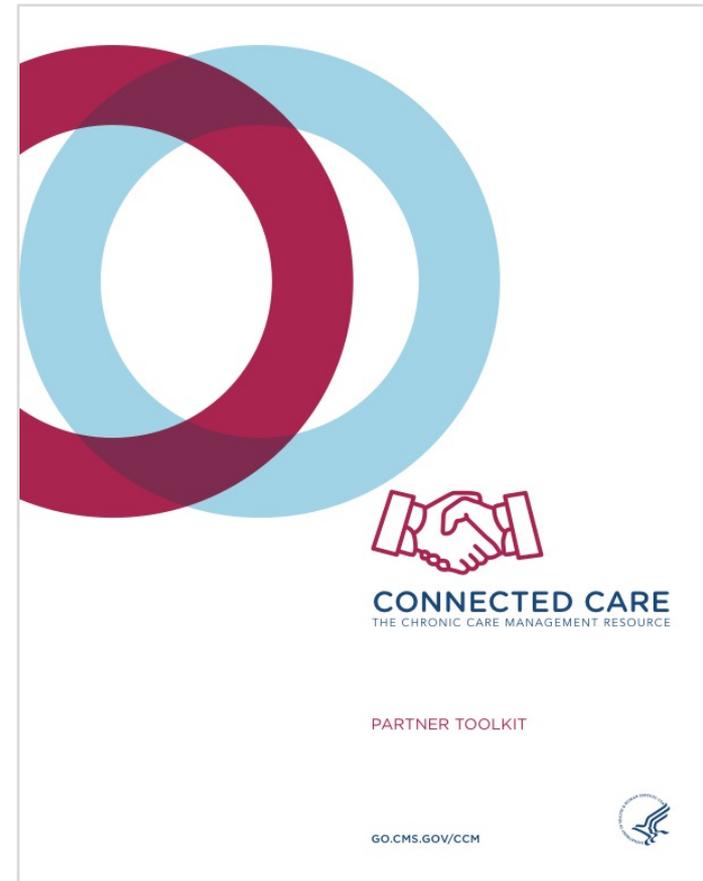
Promote CCM and Connected Care Resources

Use the tools in the Partner Toolkit to promote chronic care management and campaign resources through multiple channels, such as:

- Emails
- Listservs
- Newsletters
- Social media
- Phone Calls
- Webinars
- Events
- Meetings
- Conferences
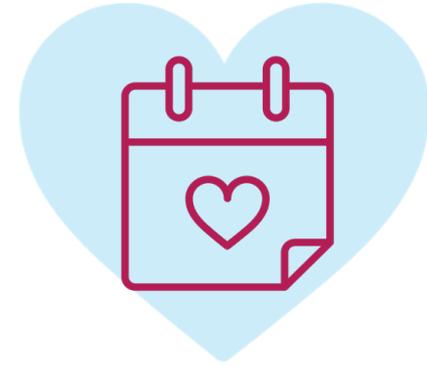
Promote CCM and *Connected Care* resources at community activities, conferences, or other events.

STORIES FROM THE FIELD

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Noridian Medicare and CCM

- Your Washington State Medicare Administrative Contractor (MAC) is here to assist!

- Separate detailed website presentation
  - https://med.noridianmedicare.com/ web/jfb/education/event-materials
  - Chronic Care Management (CCM) Overview
  - 2017 Updates
  - Eligible Beneficiaries and Providers
  - Scope of Service
  - CCM Billing and Documentation
  - Noteworthy Information and Resources

Noridian Medicare and CCM

- Other valuable resources for CCM

  - Dedicated webpage - Browse by Topic
  - https://med.noridianmedicare.com/web/ jfb/topics
  - 3-part CCM series recordings
  - Webinars provided quarterly to all 13 states
  - Involve state medical and specialty associations to promote CCM
  - Listserv provider emails frequently promoting CCM

TMF Health Quality Institute

- TMF is the Quality Innovation Network Quality Improvement Organization (QIN-QIO) for a five-state/territory area and offers quality improvement services under contact with the Centers for Medicare & Medicaid Services (CMS)
  - Arkansas, Missouri, Oklahoma, Puerto Rico, Texas
- Two-year contract with CMS for this Special Innovation Project
- Recruit and assist 100 clinicians to implement Chronic Care Management Services (CCM) in Arkansas, Oklahoma, Missouri and Texas
- Provide one-on-one virtual and in-person technical assistance with CCM implementation
- Provide educational webinars, tools and resources needed to implement CCM

How the TMF QIN-QIO Can Help

- Provide virtual and on-site technical assistance to recruited providers

- Assist with identifying eligible Medicare fee-for-service patients

- Educate on workflow processes, billing requirements, identifying staff to deliver CCM, enrolling patients, using telehealth

- Conduct regular educational webinars on CCM

- Assist with incorporating care plans into EHR and billing systems

- Provide tools needed to implement CCM, such as patient letters, care planning documents, contact tracking logs

- Provide a CCM website that contains useful links to resources, tools and educational events, including an online discussion forum

- Provide participating clinicians with periodic reports tracking hospital admissions, readmissions and emergency department use

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

TMF
Quality Innovation Network

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Networks > Chronic Care Management

Chronic Care Management

Welcome

As a member of the Chronic Care Management network, you have access to the latest news, resources, learning opportunities and forum discussions. Read the Chronic Care Management fact sheet for an overview of our purpose and goals.

Emerging Content | In the News

These items also available in the Resource Center

Providing and Billing Medicare for Chronic Care Management
This guide provides information about chronic care management including eligibility, billing and revenue.

Chronic Care Management and Other New CPT Codes
The American Academy of Family Physicians provides information and tools to help your practice bill for chronic care management services.

All Are Welcome

- To join, create a free account at http://www.TMFQIN.org/. Visit the Networks tab for more information.

- As you complete registration, you will be prompted to choose the network(s) you would like to join.

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QUESTIONS & ANSWERS

Contact Us

- Visit the *Connected Care* Resource Hub at:
  http://go.cms.gov/CCM

- For questions about the *Connected Care* campaign and its resources, contact, CCM@cms.hhs.gov

THANK YOU