CONNECTED CARE

THE CHRONIC CARE MANAGEMENT RESOURCE

Connected Care Partner Toolkit
PowerPoint Presentation

go.cms.gov/ccm

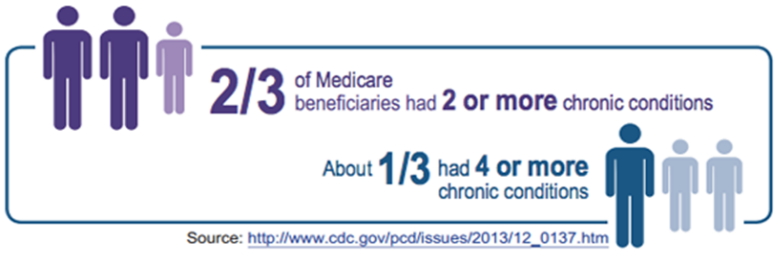
Chronic Disease Burden in the United States

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



Sources: CMS, CDC, Kaiser Family Foundation, AHRQ

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

- Timed services – threshold amount of clinical staff time performing qualifying activities is required per month

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

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

What is Chronic Care Management (CCM)?

- Ongoing CMS effort to pay more accurately for CCM in "traditional" Medicare by identifying gaps in Medicare Part B coding and payment (especially the Medicare Physician Fee Schedule or PFS)
  - Initially adopted **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

What is new for 2017

Significant changes starting in 2017 based on feedback from stakeholders.

- Increased payment amount through 3 new billing codes
  - G0506 (Add-On Code to CCM Initiating Visit, $64)
  - CPT 99487 (Complex CCM, $94)
  - CPT 99489 (Complex CCM Add-On, $47)
- CPT 99490 still effective for Non-Complex CCM ($43)

For all CCM codes: Simplified and reduced billing and documentation rules, especially around patient consent and use of electronic technology.

CCM Coding Summary

BILLING CODE	PAYMENT (PFS NON-FACILITY)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
Non-Complex CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised or monitored	Ongoing oversight, direction and management
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
CCM Initiating Visit (AWV, IPPE, TCM or Other Face-to-Face E/M)	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

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

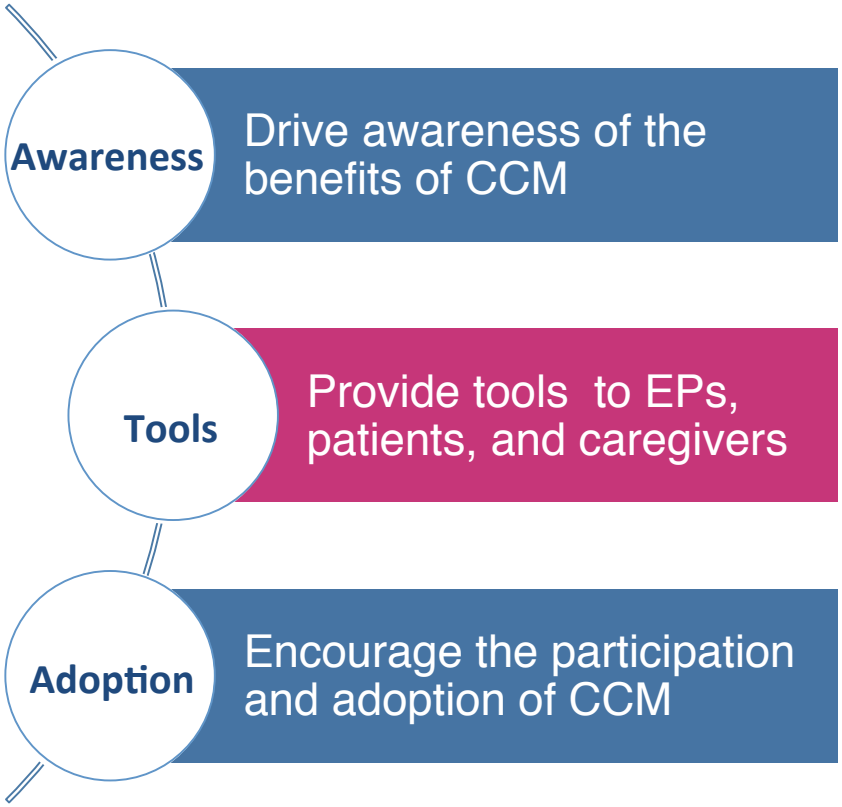
Primary Audiences

- **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)

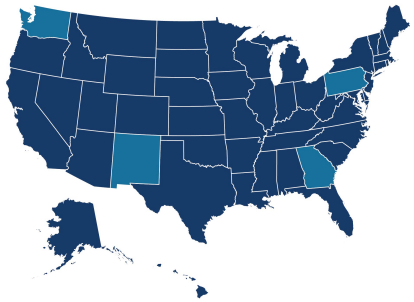
- **Consumers/Patients:** Medicare and dual-eligible beneficiaries (Medicare & Medicaid) with two or more chronic conditions, with a focus on underserved rural populations and racial and ethnic minority populations

Secondary Audience

- **Caregivers** of patients



Campaign Markets



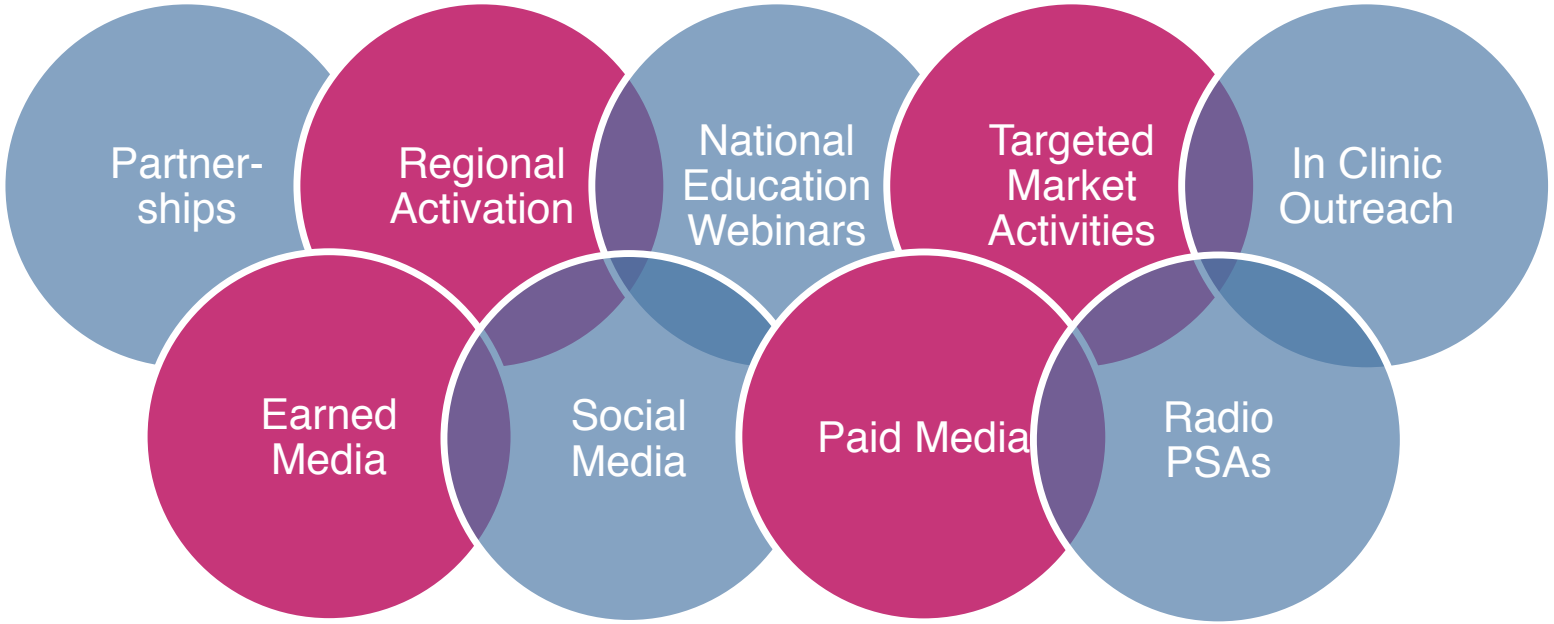
- **National** campaign for broad reach and creating surround-sound with messaging.

- **Regional** outreach with CMS and HRSA Regional Offices to reach stakeholders, partners, and communities.

- Targeted approach for in-depth engagement in 8 local markets in one city and one rural county in each state.
  - **Georgia**: Atlanta and Wilkinson County
  - **New Mexico**: Albuquerque and Colfax County
  - **Pennsylvania**: Philadelphia and Snyder County
  - **Washington**: Seattle and Clallam County

Targeted markets were selected based on Medicare claims data, chronic disease burden and prevalence of chronic conditions, use of Electronic Health Records, rural population and rural population density, overall and rural racial and ethnic diversity, and geographic diversity.

Campaign Pillars



Connected Care Resources

- **Information for Health Care Professionals**
  - Access resources and tools for health care professionals explaining the benefits of CCM and how to implement this service
- **Information for Patients**
  - Access resources and tools explaining the benefits of CCM for Medicare beneficiaries living with two or more chronic conditions
- **Information for Partners**
  - Access information about partnering to bring awareness to CCM through the *Connected Care* campaign

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

How to Get Involved

Health Care Professionals

- If you've successfully implemented CCM services, share your story with us.
- Let us know if there are partners or practices we should reach out to.
- Talk to your patients about CCM services.
- Promote CCM on local, regional or national calls or webinars, listservs, newsletters, etc.
- Share campaign tools and materials.

Partners

- Speak about CCM to your stakeholders and in your community.
- Host a community education event using the *Connected Care* Partner Toolkit.
- Promote CCM on local, regional or national calls or webinars, listservs, newsletters, etc.
- Share campaign tools and materials.

Contact Us

For more information about CCM and the *Connected Care* campaign:

- **Email**: CCM@cms.hhs.gov
- **CMS Care Management resources:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html
- **Visit our *Connected Care* website:** http://go.cms.gov/ccm