Chronic Care Management (CCM) **Toolkit**

Your implementation guide for patients with chronic conditions

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Thank you for using the Chronic Care Management (CCM) Toolkit. This guide is intended to help you and your team implement or expand CCM for your targeted patients with chronic conditions. You can either develop CCM processes with your own team, or you can use this guide to help you form a collaborative partnership between a physician practice and a local pharmacist.

PART ONE
Overview

The Challenge

- Chronic diseases are the leading causes of death and disability and account for 90% of the nation's 3.8 trillion in health care expenditures. Currently, six in 10 adults are living with at least one chronic disease, and four in 10 have two or more chronic conditions. Black and Hispanic Medicare patients have higher prevalence rates of many chronic conditions (hypertension, diabetes, stroke, and depression) than their white counterparts and racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care.
- People with chronic conditions often require care and support between physician visits. Gaps in care may occur when that support is lacking due to factors such as a person's high-risk situation (i.e., uncontrolled blood glucose levels), follow-up challenges, or even lack of services. That gap places people at risk for complications, worsening symptoms, and hospital visits.
- Clinicians are accountable for their patients' chronic disease outcomes and clinical improvements. Programs and services need to be sustainable while impacting patient engagement, satisfaction, and outcomes.

Solution

Chronic Care Management (CCM) services offer routine non-face-to-face services to help Medicare beneficiaries who have multiple, significant chronic diseases better manage their conditions.

Implementing a short four-month trial will enable your care team to experience the numerous benefits and collect valuable data to measure patients' improved engagement and outcomes. When a physician practice adds a community pharmacist to the team, the benefits can be even greater.

Refer to General CCM Benefits for a summary of CCM benefits.

Team Members

Qualified Healthcare Professionals

Physician, Physician Assistant, Nurse Practitioner

Clinical Staff

Pharmacist, Nurse, Social Worker

Non-Clinical Staff

Pharmacy Tech, Office Manager

Requirements and Components of a CCM Program

Patient Eligibility: Chronic Care Management (CCM) services are available to Medicare beneficiaries who have two or more chronic conditions expected to last at least 12 months, or until the death of the patient. To bill for the CCM services, various components must be in place to successfully implement your CCM program in your practice. These components include:

- **Patient Consent:** Before CCM services can be billed, either verbal or written patient consent must be obtained. The patient must be informed about the services offered, applicable cost-sharing, and the right to end services. To prevent duplicate practitioner billing, patients must be aware that only one practitioner can provide and bill CCM services. Patient consent must be documented in the medical record, whether participation is accepted or declined.
- **Comprehensive Care Plan:** Must be established, implemented, revised and/or regularly monitored in an electronic format for the patient to track health issues and share with their care team and/or caregiver as appropriate. Refer to the Sample CCM Care Plan Template. For complex CCM, the care plan must be established or substantially revised. Some care plan elements could include the following:
  - Problem list
  - Expected outcomes and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions and responsibilities
  - Medication Management
  - Orders for other services in community
  - Coordination of services needed outside the practice
  - Periodic review of the care plan
- **Continuity of Care:** Must be provided through a designated care team member with whom the patient can schedule appointments and who is in regular contact with the patient to help them manage their chronic conditions.
- **Electronic Health Records (EHRs):** Must be used to record certain patient data, including the patient's demographics, medical problems, medications, and medication allergies. Your EHR can help to identify high-risk and at-risk patients for participation in your CCM program and help you effectively manage chronic conditions and population health.
- **24/7 Access to Care Team:** Recipients must be provided with a way to contact their care team regardless of the time of day, or day of the week, to address urgent care management needs.

✓ = QHP Required
✓ = Team Members or QHP

	CCM Care Team Roles and Responsibilities		
	Qualified Healthcare Professionals	Clinical Staff	Non-Clinical Staff
Consent Patient	✓		
Collect Structured Data	✓	✓	✓
Develop Comprehensive Care Plan	✓		
Maintain/Inform Updates for Care Plan	✓	✓	
Manage Care	✓	✓	
Provide 24/7 Access to Care	✓	✓	
Document CCM Services	✓	✓	
Bill for CCM Services	✓		
Provide Support Services to Facilitate CCM		✓	✓

PART TWO
Implementation Strategies for a Successful CCM Program

Most practices that implement CCM services do it within the confines of their own practices. An effective CCM program can increase your revenue potential, maximize clinical outcomes, enhance practice efficiency, and improve patient care. Below are eight key strategies to consider for implementing a CCM program in your practice.

1 Establish a Workflow

It is important to consider what your initial workflow may look like to meet the requirements of the program, accommodate organizational capacities/resources and be able to generate revenue while also providing a high level of customer satisfaction. Refer to both the Sample CCM Workflow and the Sample CCM Care Team Flow.

2 Define Your CCM Process

Based on the initial workflow, practices and community partners should further define the who, what, when, and how. This will vary depending on individual organizational variables. It is best to start small and improve over time. For example, start with one provider identifying higher risk patients with one disease state that is typically associated with an additional chronic condition comorbidity and get comfortable with this before increasing scope. Identifying the initial CCM patient is important. Potential populations for consideration include:

- Patients with diabetes since they often have a secondary chronic condition
- New patients who meet eligibility
- Dually eligible Medicare/Medicaid patients for co-pay coverage

3 Prepare for Reimbursement

CCM claims should be submitted timely each calendar month. It is important to ensure your EHR/Practice Management system meets your billing needs and reimbursement staff are adequately trained to ensure proper reimbursement.

4 Establish Ongoing Monitoring and Quality Improvement

As with all new endeavors, it is especially important to routinely measure and monitor the new program to ensure that it is working as expected. Areas that should be monitored include:

- Staff/community partner comfort with process
- Patient satisfaction
- Billing and reimbursement
- Sustainability
- Consult the FQHC/RHC Care Management FAQ if appropriate

Once you have stabilized your processes and outcomes, consider spreading the scope of the services to other providers or additional populations.

5 Identify Opportunities with Commercial Payers

Although most of these tips are specific to the Centers of Medicare & Medicaid Services (CMS)-covered CCM services, it is important to explore Chronic Care opportunities with commercial payers. Some may have higher rates of reimbursement for more engagement with patients who have chronic conditions and sometimes with fewer requirements.

6 Leverage Digital Tools

Consider using virtual or online platforms to reduce face-to-face visits for routine chronic disease management. These digital tools can also be used to arrange group visits for patients with similar chronic diseases focusing on behavior change.

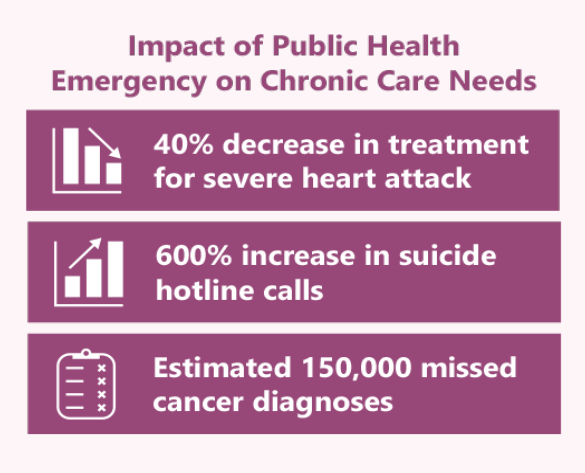
7 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

- CCM service can be billed using the general care management code G0511, either alone or with other payable services.
- If CCM services are billed on the same claim as an office visit, both will be paid.
- New 2023 care management payment rate is $77.94.
- Patient coinsurance and deductibles do apply.
- Special rules apply. Consult the FQHC/RHC Care Management FAQ for more information.
- Principal Care Management (PCM) services can be done but only require one chronic condition using same code (G0511).

Refer to Considerations Prior to CCM Implementation for an itemized list of specific items to consider when implementing a CCM program.

8 CCM and Telehealth during a Public Health Emergency (PHE)

Due to COVID-19, patients who have chronic conditions may have an increased risk for severe illness and even death if they are avoiding getting the care they need including emergent care, routine screenings, and behavioral health assistance.



Because of the Public Health Emergency (PHE), an add-on G-code was identified by CMS as a telehealth allowed service and can meet the billing requirements through an audio-only visit, (at least through CY 2023 according to the Consolidated Appropriations Act (CAA) of 2023). G0506 should be billed separately from the monthly care management services codes.

Please refer to the Federal Register for the Medicare Physician Fee Schedule Final Rule (pg. 80245) for specific guidance on the use of this code.

During a PHE, actively screen for changes to behavioral health status including depression, anxiety, or substance abuse. It is common for patients to struggle with mental health during periods of social isolation and anxiety, and these complications can create negative clinical outcomes related to managing chronic care conditions.

PART THREE

Maximize Your CCM Program – Collaborate with a Pharmacist

The key to optimizing your CCM program is to partner with a pharmacist or local pharmacy. This collaboration engages partners to assist with a variety of CCM activities, many of which can be provided virtually such as medication review and reconciliation opportunities. This partnership can be easily implemented with a four-month trial to test processes, collect data and measure patient outcomes.

Also, a trial demonstrates how your practice can provide CCM services to patients without additional burden and overhead costs. CCM services can provide needed revenue to both the practice and the pharmacist while improving chronic care management for your most vulnerable patients through cost-sharing arrangements. It is important to establish the roles, responsibilities, and expectations for each community partner you select for your CCM program.

To help facilitate this collaboration, refer to the Pharmacy Partner Checklist for considerations when selecting your partners.

CCM Value Proposition for Pharmacist Partnership

Increased Revenue

- $40-$100+ per month per patient
- Potentially leads to incentive payment
- Enhanced practice reputation
- New patients, word-of-mouth recommendations
- Increases timely follow up when appointments are due

Improved Quality Measures & Patient Outcomes

- Improved Diabetes A1c results
- Timeliness of Immunizations
- Tobacco screening and counseling
- Improved blood pressure screening and control

Improved Practice Efficiency

- Reduce patient phone calls for refills
- Enhance referral follow-through
- Screen/triage less serious patient issues
- Streamline workflows resulting with a team-based model
- Coordinate care through specialist notes and communication

Improved Patient Care

- Optimize team-based care model
- Increase access
- Strengthen coordination of care

PART FOUR
Supplemental CCM Resources

Additional CCM Resources	Please refer to these supplemental CCM Toolkit resources.
Connecting to Chronic Care Management Services Partner Webinar	Hosted by CMS Office of Minority Health and the Federal Office of Rural Health Policy (FORHP), this webinar provides information on the benefits of chronic care management services and the Connected Care campaign. (52 minutes)
Connected Care: Physician Testimonials about Chronic Care Management	This video features a physician sharing her experience with offering Chronic Care Management (CCM) services to her Medicare patients in a rural North Carolina community. (2 minutes)
Care Management Services in RHCs and FQHCs - FAQs	FAQ document from CMS outlining care management services billing, claims processing, payment, and program requirements for RHCs and FQHCs.
CCM Patient Video: Connecting the Dots	This animated video provides chronic care management (CCM) services information for Medicare beneficiaries living with multiple chronic conditions. (30 seconds)
Chronic Care Management Services	This booklet from CMS provides background on payable CCM service codes, identifies eligible practitioners and patients, and details the Medicare PFS billing requirements.
Patient Postcard English and Spanish	Informational postcard for patients about Connected Care, encouraging beneficiaries with chronic conditions to ask their doctor about CCM services.
Healthcare Provider Postcard	Informational postcard for healthcare providers about Connected Care and the benefits of CCM services.

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