CONNECTED CARE TOOLKIT

Chronic Care Management Resources for Health Care Professionals and Communities

Overview of CCM

Chronic care management (CCM) is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients. The Centers for Medicare & Medicaid Services (CMS) recognizes that providing CCM services takes provider time and effort. CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible (Medicare and Medicaid) patients need to stay on track with their treatments and plan for better health.

CCM codes can be billed for services furnished to patients with two or more chronic conditions who are at significant risk of death, acute exacerbation or decompensation, or functional decline. Two thirds of Medicare beneficiaries have two or more chronic conditions, which means many of your patients can benefit from CCM services, including the help provided between visits. CCM can help you deliver coordinated care to your patients that will improve their health, increase satisfaction with their care, and make care more person-centered.

This toolkit includes information for health care professionals, professional and patient organizations, and community groups, including tips for getting started, fact sheets on the requirements for providing CCM in practices, and educational materials to share with patients.

What Is CCM?

CCM is the care coordination that is outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. It can be delivered to people with many different types of health conditions.

Medicare began paying for CCM services separately under the Physician Fee Schedule (PFS) in 2015. Practitioners may now bill for CCM for a calendar month when at least 20 minutes of non-face-to-face clinical staff time, directed by a physician or other qualified health care professional, is spent on care coordination for a Medicare patient with multiple chronic conditions. This time may be spent on activities to manage and coordinate care for eligible Medicare and dual eligible beneficiaries who have.

Ways to Use This Toolkit

Thank you for your interest in advancing CCM services! The *Connected Care Chronic Care Management Toolkit* contains educational materials and resources to raise awareness about the importance of CCM services for Medicare and dual eligible patients with multiple chronic conditions.

This toolkit is designed to be used in two ways:

1) as a resource for health care professionals to successfully build out CCM services in their practices and ***2)*** as a tool to educate colleagues, members of professional societies, patients, and advocates about the importance of CCM in improving patient health and satisfaction.

If You Are a Health Care Professional

If you are a health care professional, this toolkit may be used to support your practice with resources to answer common questions and guide discussions with patients and staff. It also provides educational materials to share with your patients so they can better understand CCM services.

If You Are an Organization that serves Patients, Caregivers, Health Care Professionals or the Community

In addition, this toolkit provides suggestions for activities, resources, and templates for sharing information about both CCM and the materials CMS has developed to support health care professionals and leaders of community and patient organizations. This includes conversation guides and presentations to share with colleagues and staff, as well as with members of organizations that represent both health care professionals and patients. It also includes template language for sharing information through websites, newsletters, emails, blogs, and social media.

Making Coordinated Care Happen: Benefits to Your Patients and Practice

Thank you for working to implement CCM services in your practice. CCM is a critical component of primary care that contributes to better health and care for patients, and even caregivers.

Two thirds of people on Medicare have two or more chronic conditions, which means many of your patients can benefit from CCM services. CCM can help you deliver coordinated care to your patients to improve their health and increase satisfaction with their care.

Why Is CCM Important?

Patients Benefit from CCM

- **Your patients will gain a team of dedicated health care professionals who can help them plan for better health and stay on track for good health.** Services, such as monthly check-ins and ready access to their care team, improve patient care coordination, including improved communication and management of care transitions, referrals, and follow-ups.

- **Patients will receive a comprehensive care plan**. The plan will help support disease control and health management goals, including physical, mental, cognitive, psychosocial, functional, and environmental factors. Patients may also receive a list of suggested resources and community services. Additionally, patients may be encouraged to keep track of referrals, community support, and educational information. Care plans can also help caregivers who are furnishing unpaid care.

- **Encouraging patients to use CCM will give them the support they need between visits.** Having a regular touch point may help patients think about their health more and engage in their treatment plan, for example, by becoming more conscious of taking medications, managing fall risk, and other self-management tasks. Getting this help may also encourage patients to stay on track and improve adherence to their treatment plan. More frequent communication can also help make patients feel more connected to you and your staff.

CCM Supports Your Practice

- **Improve care coordination.** Chronic care management can help improve care coordination and health outcomes, and you will receive payment specifically in support of your provision of care using this approach for a patient when you provide a minimum of 20 minutes of CCM services in a month. Encouraging patients to use CCM services will give them the support they need between visits to your office.

- **Support patient compliance and help patients feel more connected.** Some health care professionals have reported that making CCM services available to their patients has helped to improve their efficiency, improve patient satisfaction and compliance, and decrease hospitalization and emergency department visits.

- **Sustain and grow your practice.** Ongoing care management outside the in-person visit has not always been separately billable in payment, making it difficult for practices to sustain service provision. Offering care management activities CCM can provide you with additional resources to help your practice care for high risk, high needs patients.

Read on to find out how your practice can begin to provide and seek separate payment for CCM services.

CMS has developed fact sheets and FAQs with information about CCM services and payment:

- CCM Services Fact Sheet
- Chronic Care Management Services
- Chronic Care Management Services Changes for 2017

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are also authorized to receive payment for CCM services. See the Chronic Care Management Services in Rural Health Clinics and Federally Qualified Health Centers Frequently Asked Questions for specific information about billing and payment for CCM services.

Additional information on CCM in RHCs and FQHCs can be found at https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html, and https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html.

Getting Your Practice Started with CCM

CCM will help you deliver the coordinated care your patients need and deserve. Offering CCM may enable you to sustain and grow your practice and improve patient satisfaction. The full details for introducing or growing CCM services in your practice, including eligibility, included services, billing requirements, how to spend time, and payment amounts, can be found on the Connected Care Hub.

Additional resources can be found on:

- CMS Care Management Site
- CCM Services Fact Sheet
- Care Management Physician Fee Schedule
- CCM Services Changes for 2017
- CCM Services FAQs
- Care Coordination Services and Payment for RHCs and FQHCs
- RHC & FQHC CCM FAQs

Eligibility

Patients eligible for separately payable CCM services are Medicare fee-for-service and dual eligible (Medicare and Medicaid) beneficiaries with two or more chronic conditions expected to last at least twelve months or until the death of the patient, when those conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. These are the only diagnostic criteria.

Examples of chronic conditions include, but are not limited to, the following: Alzheimer's disease and related dementias, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease, depression, substance use disorders, diabetes, hypertension, and infectious diseases such as HIV/AIDS.

CCM services may be billed by:*

- Physicians and certain Non-Physician Practitioners (Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals (CAHs)

**Only one physician, NPP, RHC or FQHC, and one hospital, can bill for CCM for a patient during a calendar month.*

Many activities can count toward the minimum monthly service time to bill for CCM. These include:

- Providing CCM for patients outside of in-person visits, such as by phone or through secure email. CCM includes care coordination activities that are not typically part of a face-to-face encounter with the patient, and can include telephone communication, review of medical records and test results, self-management education and support, and coordination and exchange of health information with other practitioners and health care professionals. It may also include some face-to-face interaction with the patient or other health care professionals.
- Sharing patient's health information, including their electronic health plan, with the patient's other health care professionals and providers.
- Managing care transitions, including providing referrals and facilitating follow-ups for patients after they are discharged.*
- Coordinating with home- and community-based services providers and documenting this activity in the patient's medical record.

**Please note that you cannot bill for transitional care management services (TCM) during the same month as CCM.*

The following is a sample of actions that are required to bill for CCM:

- Obtaining the patient's verbal or written agreement to receive CCM services after informing them of applicable cost sharing, that they can stop receiving CCM services at any time, and acknowledgment that only one practitioner (and/or hospital) can provide CCM services for them in a calendar month. Patient consent must be documented in the patient's medical record.
- Establishing, implementing, revising or monitoring an electronic "Comprehensive Care Plan" for the patient that tracks their health issues, and sharing it with the patient, or their caregiver when appropriate. For complex CCM, the care plan must be established or substantially revised. Share the plan with their other health care providers as appropriate.
- Providing continuity of care for patients through a designated care team member with whom the patient can schedule appointments and who is regularly in touch with the patient to help them manage their chronic conditions.
- Recording certain data through certified Electronic Health Records (EHRs), including: patient's demographics, medical problems, medications, and medication allergies.
- Providing patients with a way to contact your practice at any time to address urgent care management needs.

For more information about CCM billing and to review the details above, visit the Connected Care Hub or the: CCM Services Fact Sheet, the Chronic Care Management Services Changes for 2017, and Frequently Asked Questions about Physician Billing for Chronic Care Management.

For billing details for RHCs and FQHCs, see the Chronic Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions and Care Coordination Services and Payment for RHCs and FQHCs.

Speaking with Staff about Chronic Care Management

The information below is designed to help health care decision-makers explain CCM services to staff. This information does not replace the official guidance on providing and seeking payment for CCM services.

What Is CCM?

Chronic care management or CCM is the provision of care management and coordination services to patients with two or more chronic conditions.

Examples of chronic conditions include, but are not limited to:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS
- Substance Use Disorders

What Do We Need to Do to Furnish and Bill for CCM?

Please note that the following is not a complete list. A comprehensive list of actions associated with furnishing CCM services can be found on the CCM Fact Sheet.

- The clinician's practice must meet specific requirements to be eligible to bill for CCM services. While it may take some time and effort to get fully up to speed, these changes and services will help to continually improve the care that you provide.

- Practices will be able to provide comprehensive care management focused on management of the patient's chronic conditions and preventive care to ensure the patient receives all recommended preventive services and that patients are better able to better manage their chronic conditions.

- For each patient who receives CCM services, the clinician develops a comprehensive assessment and care plan. The plan will be maintained to address all health issues, including medical and psychosocial issues, with special focus on the patient's chronic conditions. The practice will also:

    - Engage and educate the patient by developing and sharing the care plan with him or her (and any caregiver).
    - Review the care plan periodically and revise as needed.
    - Provide care that is tailored to the individual (also known as "person-centered" care).
    - Work with home- and community-based services providers as needed by the patient. These could include adult day health programs, personal care workers or an agency furnishing personal care, home-delivered meal providers, etc.

- Clinical staff will educate the patient and give them the tools they need to monitor and manage their chronic conditions and any medications. They will also provide continuous care by reconciling the medication list with medications prescribed by other health care providers (e.g., by a specialist or during a hospital stay), and make sure the patient has access to medication, especially after care transitions.

- Clinical staff will manage any care transitions (referrals or discharges from facilities) by sharing information timely within the practice and with other health care providers involved in the patient's care. They will follow up with patients on a timely basis after facility stays or referrals.

- The practice will use standardized electronic technology to assist in sharing information on a timely basis with other health care providers. Clinical staff will record "core" patient health information (demographics, problems, medications, and allergies) in the medical record using a certified Electronic Health Record.

- The patient will have access to continuous care, such as:

    - 24-hour-a-day, 7 day-a-week access to a qualified health care professional who has access to necessary health information to address any urgent needs after hours.
    - Enhanced methods of patient communication. Patients will be able to contact the practice at any time by methods other than just telephone (e.g., secure email portal).

- Time spent providing these services will be tracked by [insert recommended workflow based on practice needs].

What Is Required of Patients?

Patients must give advance consent to ensure they are involved with their treatment plan and aware of any applicable cost sharing. They must understand that only one health care practitioner and/or one hospital can provide these services, so they can't receive it from each doctor they see and should not provide consent to receive these services from anyone else. They should also know that they can request to stop CCM at any time. Informed consent can be given verbally, though you may choose to do it electronically or via a paper form.

Please note: The usual cost-sharing rules apply to these services, so many patients are responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if they do not have supplemental ("wrap-around") insurance. Please note that the majority of dual eligible beneficiaries (patients with Medicare-Medicaid) are not responsible for cost sharing. Medigap plans provide wrap-around coverage of cost sharing for CCM, and many beneficiaries have Medigap or other supplemental insurance.

How Will We Be Paid for Providing CCM Services to Medicare Fee-for-Service Beneficiaries?

- There are several Medicare billing codes to pay for CCM services (payment rates noted below are under the Medicare physician fee schedule):

    - A CCM initiating visit: Annual Wellness Visit (AWV), Initial Preventive Physical Exam (IPPE), or Transitional Care Management (TCM) or other qualifying face-to-face E/M) is only required for new patients or those not seen in an office visit within a year prior to commencing CCM. The CCM initiating visit (where applicable) is billable separate from the monthly CCM services. There is also an add-on code that can cover the health care professional's time and effort to provide extensive comprehensive assessment and CCM care planning to patients outside of the usual effort described by the initiating visit code.
    - There are additional billing codes, billable monthly, to pay for 20 minutes or more of clinical staff time spent on non-complex CCM that requires establishment, implementation, revision, or monitoring of the care plan. Alternative codes are available for complex care that requires at least 60 minutes of clinical staff time during a month.
    - RHCs and FQHCs are to use an RHC/FQHC-specific code for CCM services on or after January 1, 2018. Payment for this code is based on rates for both CCM and behavioral health integration services.

The current list of billing codes can be found on the CMS care management page.

For billing details for RHCs and FQHCs, see the Chronic Care Management Services in Rural Health Clinics and Federally Qualified Health Centers Frequently Asked Questions and Care Coordination Services and Payment for RHCs and FQHCs.

Benefits

The Benefits of Offering CCM Services in Your Practice:

- Improved care for patients, improved patient satisfaction
- Increased payment for the practice for the coordinated CCM services provided.

The Benefits of Offering CCM Services to Your Patients:

- By offering CCM services and billing for them under Medicare, eligible patients are provided with help from a member of the team who is dedicated to overseeing their care, a person that they regularly interact with and know. That team member can help them plan for better health and stay on track with treatments, medication, referrals, and appointments through regular check-ins and reminders.
    - For regular or "non-complex" care, patients may receive at least 20 minutes a month of time dedicated to care coordination services.
    - For "complex" CCM, patients may receive additional time (60 minutes or more) and services.
- Encouraging patients to use CCM services may offer them the support they need between visits.

Explaining CCM to Patients

The information below is designed to help health care professionals talk to patients and caregivers about chronic care management (CCM) services, their benefits to the patients and their caregivers, and their role in the process of coordinating these services.

What Is Chronic Care Management, or "CCM?"

If you have Medicare or both Medicare and Medicaid, and have two or more chronic conditions, Medicare is offering CCM services to help you manage your health and spend more time doing the things you enjoy, in good health.

If you have more than one chronic condition like Alzheimer's disease and related dementia, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease, depression, diabetes, hypertension, substance use disorder, or, and infectious diseases such as HIV/AIDS, CCM is an important piece of the care that we can offer.

What Are the Benefits of CCM?

- Regular CCM means you can better manage your care and spend more time focusing on your health. CCM can help you work toward your health and quality of life goals. Better care management can help you avoid health events such as trips to the emergency department, a fall, or worsening health.

- Coordinated care means you will get personal attention and help from a health care provider you know and who knows about your health conditions and helps to keep you healthy.

Informed Consent Notification

Patients must give consent to receive CCM services. This can be given in written form or verbally and documented in the medical record. This documentation in the medical record must include 1) the patient's consent to participate in CCM, 2) that the patient was informed that she/he can stop receiving CCM services at any time, and 3) that only one health care professional or hospital can provide CCM in a calendar month. Information about applicable cost sharing should be included as well.

The language below is intended to be a guide for conversations seeking verbal consent. Please consider the key points below.

Your dedicated care team will review your records and may contact you if needed. They may also connect with you about how they are working for you and your health.

- Do you have any questions about the CCM services?
- Do you agree to receive the CCM services?
- Do you understand that a monthly fee could apply to the CCM services?
- How do you prefer to be contacted?
- What is the best time for us to contact you?
- Tip: Refer to Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method

This also means that the care team in the practice will share information about your health with me to make sure we can talk about everything when we meet again.

- Do you have any questions about the CCM services?
- Do you agree to receive the CCM services?
- Do you understand a monthly fee could apply to the CCM services?
- How do you prefer to be contacted?
- Tip: Refer to Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method

(If applicable): We want to work with [specialist/service agency 1], [specialist/service agency 2], and [specialist/service agency 3] to coordinate care and services for you with the goal of improving your health. This is called chronic care management, or "CCM."

CCM services will help us work more closely with your other doctors, and help you maintain your health and wellness. If you don't think you need CCM, you can ask us to stop at any time.

- Do you have any questions about the CCM services?
- Do you agree to receive the CCM services?
- Do you understand that a monthly fee could apply to the CCM services?
- How do you prefer to be contacted?
- Tip: Refer to Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method

Please note: *The usual cost-sharing rules apply to these services, so many patients are responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if they do not have supplemental ("wrap-around") insurance. Please note that the majority of dual eligible beneficiaries (patients with Medicare-Medicaid) are not responsible for cost-sharing. Medigap plans also provide wrap-around coverage of cost sharing for CCM, with many beneficiaries have Medigap or other supplemental insurance.*

CCM Resources & Educational Tools

Learn more about what CCM is, why it is important, and how to get resources for a successful program.

Visit go.cms.gov/CCM to download the following tools and resources to educate your members or communities about the benefits of chronic care management. Printed copies of the *Connected Care* postcards and posters can be ordered at no cost to your organization. Visit the *Connected Care* Product Ordering page to learn how to place an order.

Information about CCM

- **Chronic Care Management Fact Sheet**
  Read a primer on CCM services separately paid by CMS, requirements, and how to bill for CCM.
- **Chronic Care Management Services Changes for 2017**
  Read about changes to CCM services separately paid by CMS introduced in 2017.
- **Summary of Policies for Calendar Year 2018**
  See changes and updates to telehealth services, including services related to CCM introduced in 2018.
- **Chronic Care Management (CCM) Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions**
- **Care Coordination Services and Payment for RHCs and FQHCs**
- **Frequently Asked Questions about Physician Billing for Chronic Care Management Services**
  Answers to common questions about CCM, what is separately paid by CMS, and requirements for billing.
- **Final Rule: Payment Policies under the Physician Fee Schedule CY 2017**
  Find out more about the fee schedule changes, including the addition of separate payments, in the Final Rule published in the *Federal Register*.
- **Final Rule: Payment Policies Under the Physician Fee Schedule CY 2018**
  Find updates on how RHCs and FQHCs may bill for CCM in 2018.
- **Care Management Resources**
  Additional CMS resources for CCM and other care management services.

Tools for Health Care Professionals

- ***Connected Care* Physician Testimonial Video about Chronic Care Management**
  Watch and share this video, in which one doctor shares how offering CCM is benefiting her Medicare patients and her practice in rural North Carolina.
- ***Connected Care* Postcard for Health Care Professionals**
  Designed for health care professionals, this postcard explains what CCM is and its benefits.
- **Certified Electronic Health Record Technology (CEHRT)**
  For information on EHRs and additional links for guidance on standards and incentive payments.
- **Resources for Health Care Providers**
  Access tools and resources developed by CMS to help implement a CCM program.
- **Medicaid Health Homes**
  For your patients with Medicaid (not Medicare), Health Homes is an optional Medicaid state benefit to coordinate care for people with Medicaid who have chronic conditions.

Tools for Educating Patients, Caregivers, Advocates, and Community Members

- ***Connected Care* "Connecting the Dots" Animated Video for Patients in English and Spanish**
  Use this video to help explain the benefits of CCM services to patients.
- ***Connected Care* Postcard for Patients in English and Spanish**
  Share this postcard with patients, caregivers, advocates, and other community members to explain what CCM is, who it is for, why it is beneficial, and how patients can ask for it.
- ***Connected Care* Poster for Patients in English and Spanish**
  Download and hang this poster in your practice for patients and caregivers to see.
- **Connected Care Web Badge**
- Post this graphic on your website to link directly to the CMS *Connected Care* resource hub.
- **Sample Language for Newsletter Articles, Blog Posts and Emails for Patient, Advocate, and Community Constituents**
  Use this sample language to communicate with patients, community advocates, and leaders about the benefits of CCM.
- **HHS Education and Training Curriculum on Multiple Chronic Conditions**
  Developed by the Office of the Assistant Secretary for Health, in collaboration with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, the HHS Education and Training Resources on Multiple Chronic Conditions (MCC) provides health professionals with education to care for people living with multiple chronic conditions.
- **Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method**
  The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand.
- **National Institute on Aging: Talking with Your Older Patient**
  This toolkit provides an array of resources to help improve communication with older people in different situations, such as understanding a patient's health history or sharing bad news.

Additional Resources on CCM

- **Noridian Healthcare Solutions Chronic Care Management Page**
  Noridian is a private health insurer that was awarded a Medicare Administrative Contract (MAC) and is responsible for administering both Medicare Part A and Medicare Part B claims. Their website offers information on billing, eligibility, documentation, and pricing.
- **PowerPoint: Chronic Care Management (CCM) Services Presented by Noridian Part B Medicare**
  This presentation offers an overview of CCM, eligibility, scope of services, billing, and additional resources.
- **TMF QIN CCM Network**
  TMF is one of CMS's Quality Innovation Network (QIN) Quality Improvement Organizations tasked with improving the quality of health care for all Medicare beneficiaries through data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, improve clinical quality, and spread best practices. The TMF QIN offers a CCM network including fact sheets, infographics, a business case, calculators, sample care plan, sample tracking log, checklist, and step-by-step guides.
- **Agency for Healthcare Research and Quality**
  AHRQ offers a Shared Care Plan to help health care professionals develop a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers.

Where to Go for More Information

For more information and updates on chronic care management, visit the CMS OMH Connected Care Hub, the Medicare Physician Fee Schedule Look-up Tool, and the CMS Care Management site.

For more information and tools to implement CCM, please visit: go.cms.gov/CCM. For more general questions about CMS, visit the Contact CMS Page.

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Note: This document was written by CMS and was printed, published, or produced and disseminated at U.S. taxpayer expense. The information is meant to be useful for community organizations that want to use Connected Care *as part of their consumer education and health literacy outreach efforts. Participation is voluntary and informal.*