Understanding and Promoting the Value of Chronic Care Management Services

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February 21, 2017

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Acronyms in this Presentation

- CCM – Chronic Care Management
- CMS OMH – Centers for Medicare & Medicaid Services Office of Minority Health
- CPT – Current Procedural Terminology
- CY – Calendar Year
- ER – Emergency Room
- EHR – Electronic Health Record
- FORHP HRSA – Federal Office of Rural Health Policy at Health Resources and Services Administration
- FQHC – Federally Qualified Health Center
- PFS – Physician Fee Schedule
- RHC – Rural Health Clinic

Agenda

- Welcome

- The Value of Chronic Care Management Services

- Changes for Calendar Year (CY) 2017 to Support Adoption

- Chronic Care Management Resources to Support You

- Questions-and-Answers Session

- Next Steps

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 84 percent of national health care spending

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

CMS + CHRONIC CARE

- Medicare benefit payments totaled $597 billion in 2014

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

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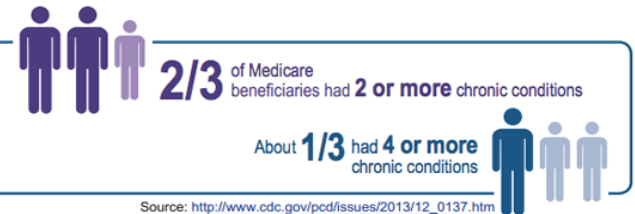
Source: http://www.cdc.gov/pcd/issues/2013/12_0137.htm

Sources: CMS, CDC, Kaiser Family Foundation, AHRQ

The Value of Chronic Care Management Services

What is 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

What is CCM?

- Comprehensive Care Management
  - Electronic, person-centered care plan tracking all health issues, periodically reviewed and updated
  - Ensure receipt of preventive services
  - Medication management and reconciliation
  - Transitional care management – facilitate and coordinate referrals and follow-up after ER or facility discharge
  - Coordinate with home- and community-based clinical service providers
- Timely sharing of health information within and outside the billing practice
  - Certified electronic health record (EHR)- structured recording of a limited data set
- Continuity of Care with Designated Care Team Member
- Enhanced Communication (e.g., secure patient email)
- 24/7 Access to Address Urgent Needs
- Advance Beneficiary Consent
- For complex CCM, moderately or highly complex medical decision-making by the billing practitioner

What is CCM?

- CCM is a critical component of care that contributes to better health outcomes and higher patient satisfaction

- CCM is person-centered

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

What is 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

Eligible Patients and Providers

- Eligible beneficiaries have:
  - Two or more chronic conditions expected to last at least 12 months or until death, that place them at significant risk of death, acute exacerbation, or functional decline
  - No other diagnostic limitations
  - A given beneficiary receives either non-complex CCM (CPT 99490) or complex CCM (CPT 99487,9) for a given month

- Eligible reporting practitioners, providers and suppliers:
  - Physicians, Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives
  - RHCs and FQHCs
  - Hospitals (including critical access hospitals)
  - Only 1 practitioner and 1 hospital can report CCM per month

What is New for CY 2017

Significant changes starting in 2017 based on feedback from stakeholders

- Increased payment amount through 3 new billing codes (PFS)
  - 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 - Beginning January 1, 2017

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

Summary of Changes for CY 2017

- **Complex CCM service codes provide higher payment for complex patients**
  - Those for whom the billing practitioner is addressing problems of moderate or high complexity during the month
  - Who also require 60 or more minutes of clinical staff time and substantial care plan revision (or care plan establishment)
- **Facilitated patient consent –** Verbal rather than written consent allowed (must still be documented in the medical record)
- **Reduced technology requirements –** Retained requirement for certified EHR (limited data set), but change focus to timely exchange of health information (the care plan and transitional care document(s)) rather than specific electronic technology for these pieces
  - Care plan no longer has to be available electronically to individuals providing CCM after hours, as long as they have timely information
  - Fax is discouraged but can count for electronic exchange, if timely
- Improved alignment with CPT language and simplified documentation
- Initiating visit only required for new patients or those not seen within a year prior (rather than for all patients)

CCM Cost Sharing

- Currently CMS lacks authority under the law to remove the usual Part B cost sharing that applies to CCM services

- However, Medigap plans must provide wrap-around coverage of cost sharing for CCM, and most beneficiaries have Medigap or other supplemental insurance

- The majority of dually eligible beneficiaries (Qualified Medicare Beneficiaries) are exempt from cost sharing

CCM in RHCs and FQHCs

- RHCs and FQHCs can receive payment for CCM when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim

- The RHC and FQHC face-to-face requirements are waived when CCM services are furnished to a RHC or FQHC patient

- Payment is based on the Medicare PFS national non-facility payment rate.

- The rate is updated annually and has no geographic adjustment

CCM in RHCs and FQHCs Implemented as of January 1, 2017

- RHCs and FQHCs can furnish CCM services under general supervision requirements instead of direct supervision requirements

- Revised Scope of Service Requirements (initiating visit, electronic care plan, beneficiary consent, etc.) consistent with PFS scope of services changes

CCM in RHCs and FQHCs

- New Complex CCM Codes (CPT 99487 and 99489) and Initiating Visit Add-on (G0506):

  - Payments for RHC and FQHC services are not adjusted for length or complexity of the visit.

  - RHCs and FQHCs are not authorized to bill these three new codes.

  - These codes should not be billed by RHCs/FQHCs, and would be subject to recoupment if they are paid.
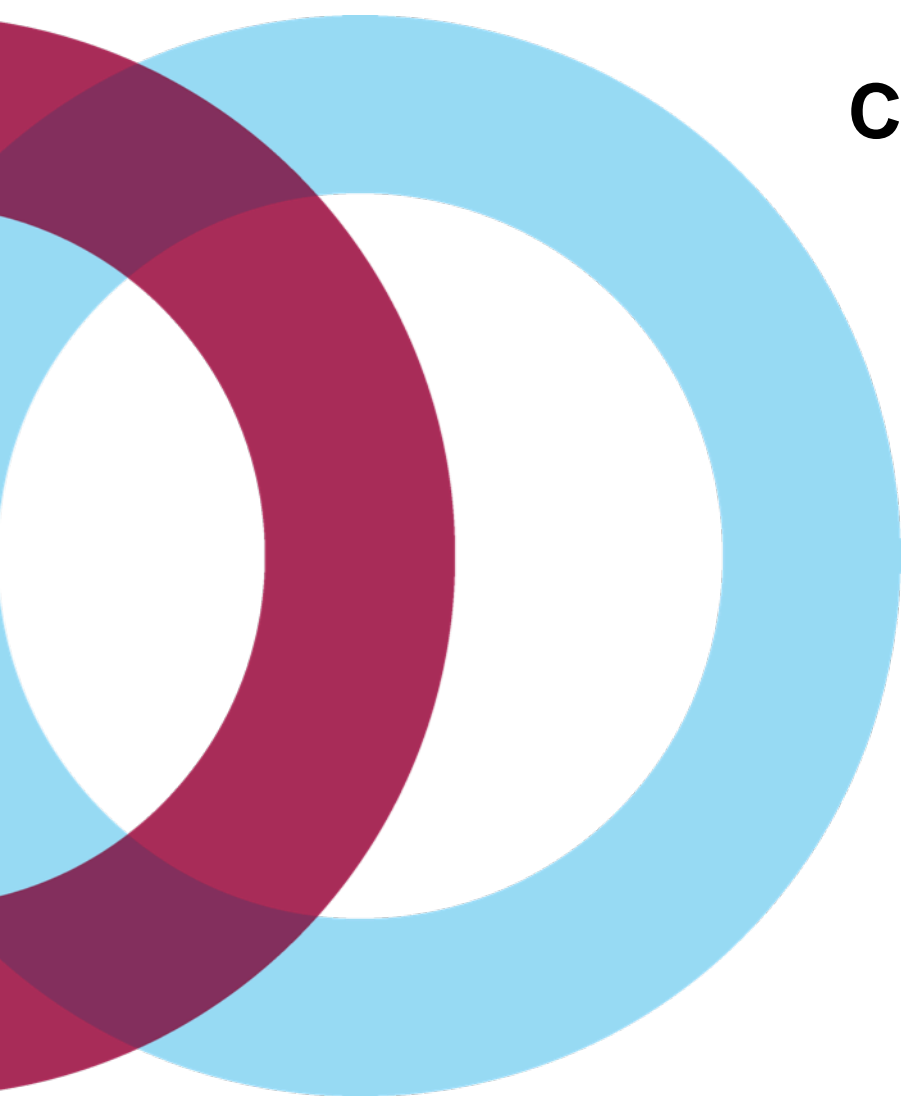
CCM Education Campaign

CONNECTED
CARE

THE CHRONIC CARE
MANAGEMENT RESOURCE

go.cms.gov/ccm

Chronic Care Management Services Campaign

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

- Inform professionals and consumers of the benefits of <u>chronic care management</u> services for individuals with chronic care needs, and
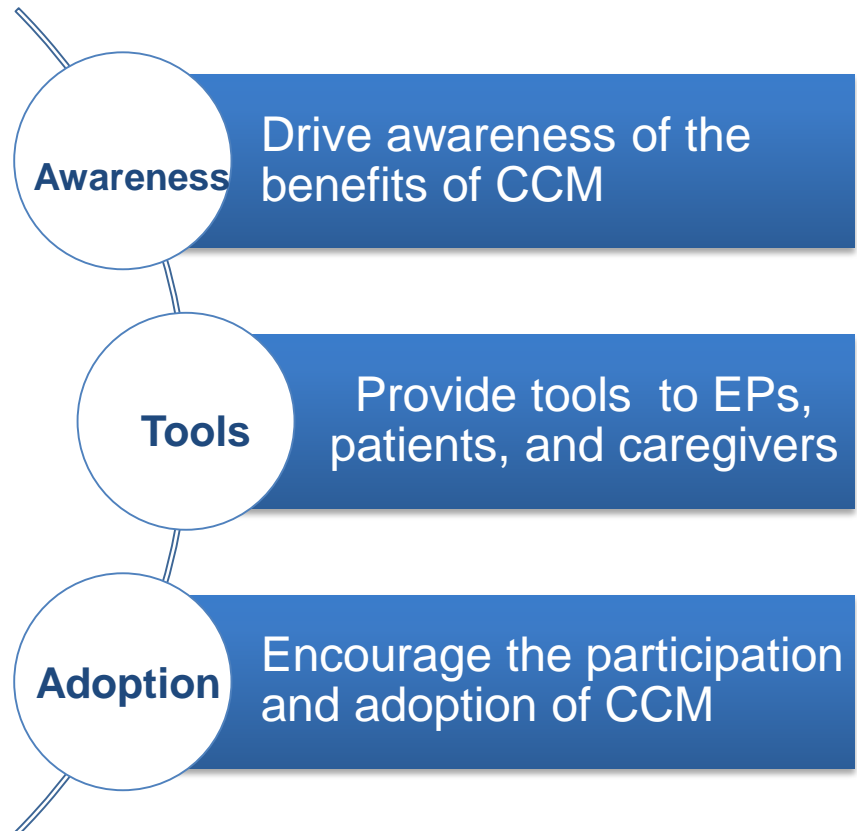- Focus on encouraging participation by <u>underserved rural populations and racial and ethnic minority populations</u>.

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
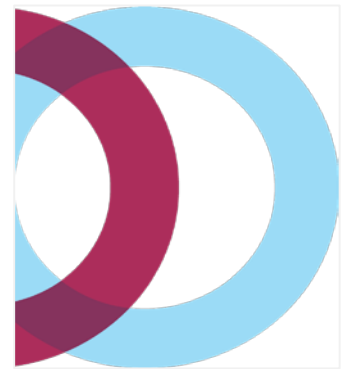
Secondary Audience

- **Caregivers** of patients

Awareness — Drive awareness of the benefits of CCM

Tools — Provide tools to EPs, patients, and caregivers

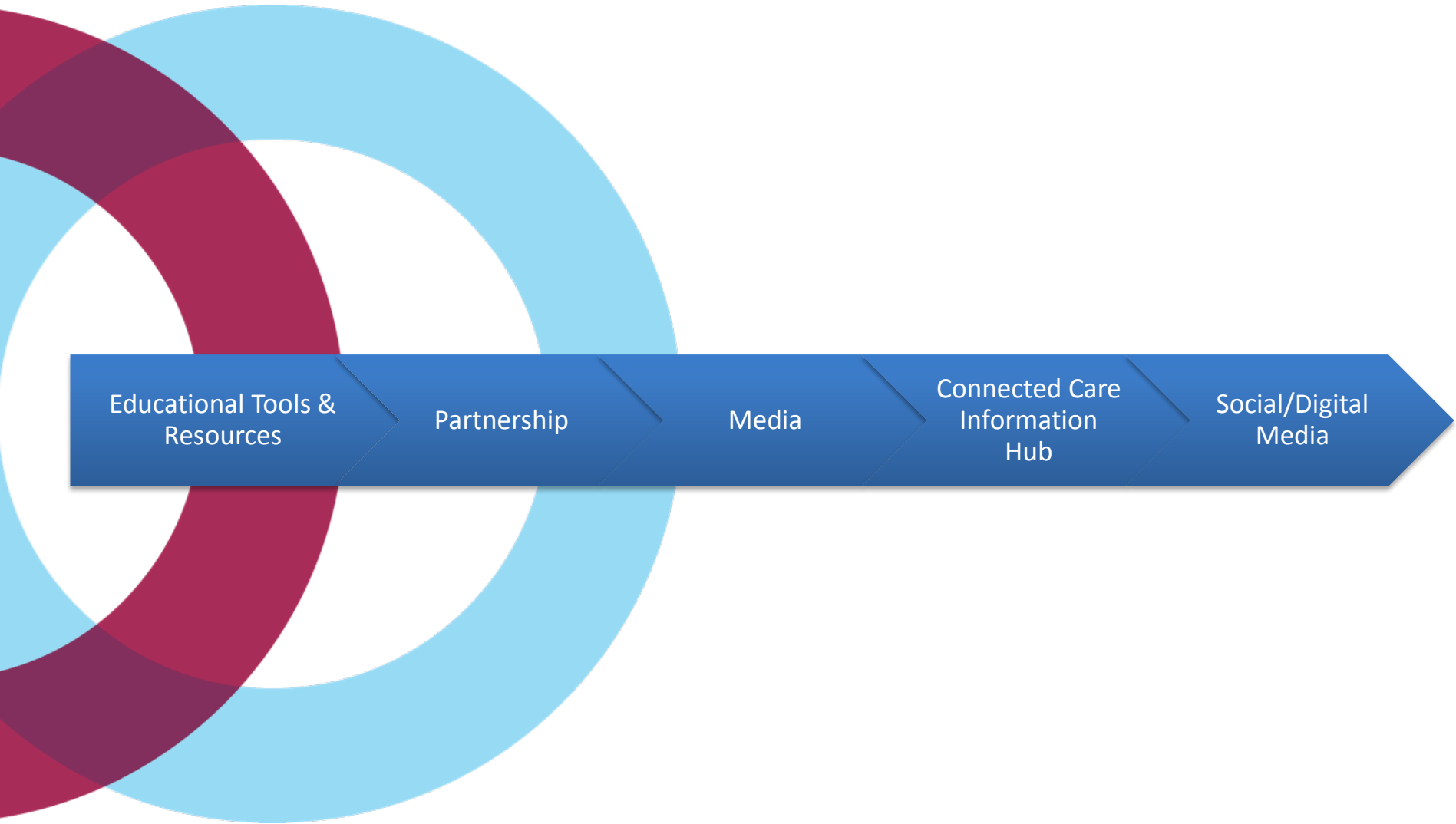**Adoption** — Encourage the participation and adoption of CCM

Connected Care Campaign Overview

- Campaign launched nationally

- Four targeted states with a focus on rural & urban representation
    - Georgia: Atlanta (city) and Wilkinson County (rural county)
    - New Mexico: Albuquerque (city) and Colfax County (rural county)
    - Pennsylvania: Philadelphia (city) and Snyder County (rural county)
    - Washington: Seattle (city) and Clallam County (rural county)

- Target locations selected on a a variety of factors, including:
    - Medicare-enrolled beneficiary data
    - Chronic disease burden & health disparities
    - Presence of racial and ethnic diversity
    - Rural and urban focused organizations
    - Presence of RHCs, FQHCs
    - EHR implementation
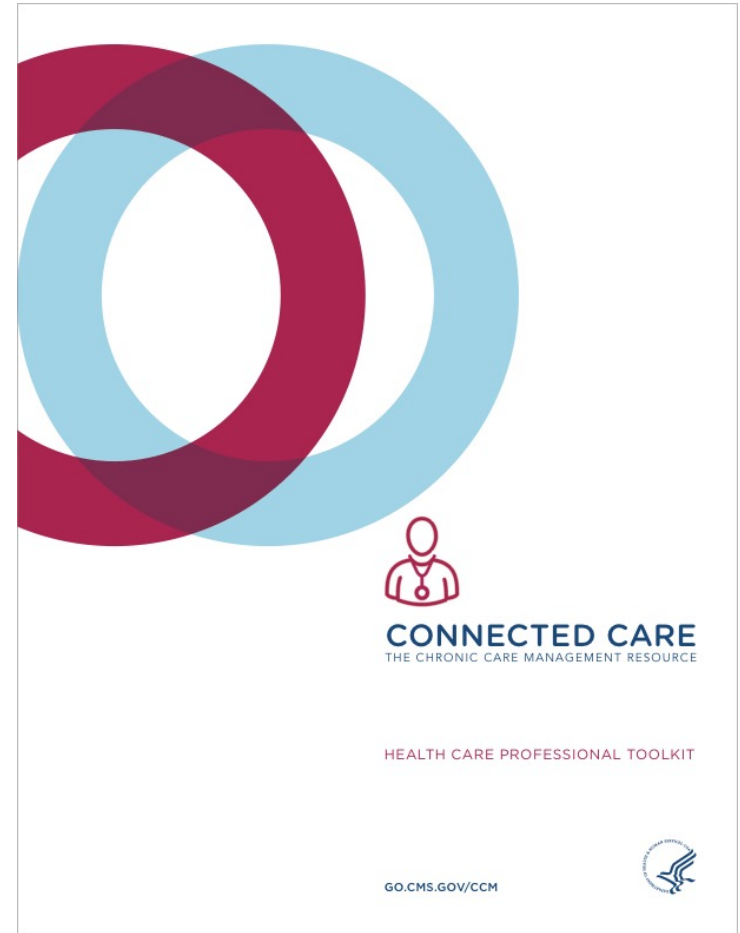   - CMS Regional Offices, and HRSA Regional Offices

Campaign Pillars

Educational Tools & Resources → Partnership → Media → Connected Care Information Hub → Social/Digital Media

Resources to Support You: HCP Toolkit

## The Health Care Professional Toolkit

- Created as a resource for health care professionals to increase awareness about CCM and support adoption

- Provides resources to help health care professionals engage staff about the value of CCM and educate eligible patients who could benefit from CCM
    - Detailed CCM Information
    - Resources to help Implement CCM
    - Educational resources for patients

- Available for download at http://go.cms.gov/ccm

CONNECTED CARE
THE CHRONIC CARE MANAGEMENT RESOURCE

HEALTH CARE PROFESSIONAL TOOLKIT

GO.CMS.GOV/CCM

Patient Resources to Support You

Patient Education Materials

- Resources designed to help health care providers educate patients about CCM services
  - Overview of Benefits of CCM for Patients
  - Posters for your waiting room
  - Postcard to share with patients during visits
  - Animated video (coming soon)
  - Prevention and disease education resources
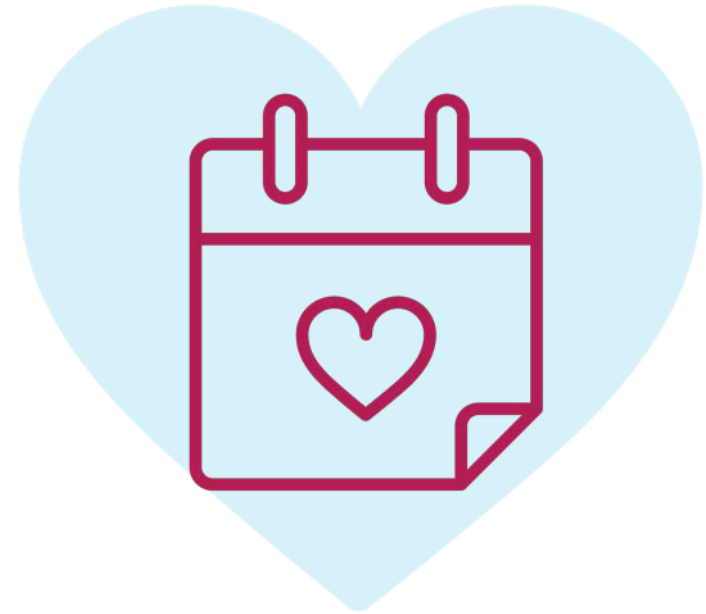
**To order materials contact:**
CCM@cms.hhs.gov

Partnership

- Collaborators are vital to success of CCM

- The partnership toolkit includes downloadable resources and suggested activities.

- If you are interested in partnering, contact: CCM@cms.hhs.gov

CONNECTED CARE
THE CHRONIC CARE MANAGEMENT RESOURCE

PARTNER TOOLKIT

GO.CMS.GOV/CCM

CCM Digital Hub

Connected Care Campaign Website

- Visit the *Connected Care* campaign website at [go.cms.gov/ccm](go.cms.gov/ccm)

- Designed as an information hub for health care professionals, patients, and partners who want to learn more about implementing CCM and download campaign resources

- Includes basic information for patients about the benefits of CCM services

- Provides information about partnering with CMS to bring awareness to CCM through the *Connected Care* campaign
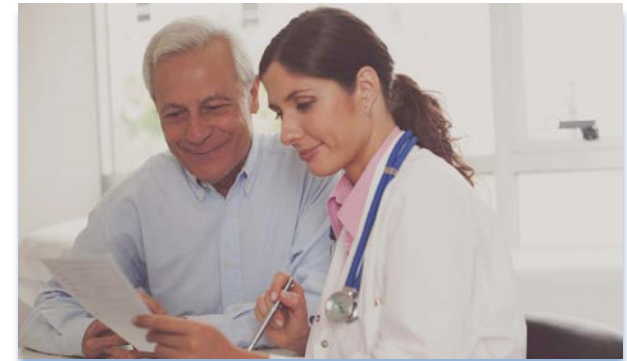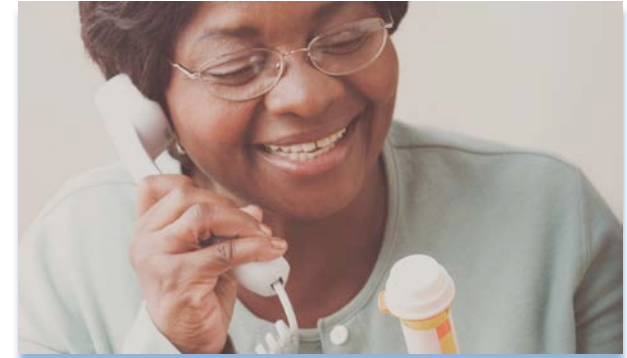
How to Get Involved

Health Care Professionals
- Talk to your patients about CCM services
- Order Connected Care posters and postcards for your office
- Let us know if there are partners or practices we should reach out to
- If you've successfully implemented CCM services, share your story with us

Partners
- Become a partner
- Speak about CCM to your stakeholders and in your community
- Host a community education event using the CMS OMH toolkit
- Share information about CCM on local, regional or national calls or webinars, listservs, newsletters, etc.
- Share campaign tools and materials

To become a partner, email CCM@cms.hhs.gov

CMS Contacts for CCM

- Email your CCM questions to CCM@cms.hhs.gov

- Stay connected and access CCM and patient education resources at: go.cms.gov/ccm

Questions-and-Answers

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.

- To complete the evaluation, visit http://npc.blhtech.com and select the title for today's call.

Thank You

- For more information about the MLN Connects® National Provider Call Program, visit https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html

- For more information about the Medicare Learning Network®, visit https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index.html

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