CONNECTED CARE

THE CHRONIC CARE MANAGEMENT RESOURCE

"Connected Care: What Nurses Should Know About Chronic Care Management"

June 7, 2017

3-4pm EST

go.cms.gov/ccm

WELCOME AND INTRODUCTIONS

Logistics

- **Discussion**: This will be an interactive discussion, and we want your input. During the presentation there will be spaces for questions and discussion; 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 http://bit.ly/2rQTZLR

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

Agenda

- Welcome and Introductions
- The Burden of Chronic Diseases
- Chronic Care Management Services
- *Connected Care* Resources to Support You
- Question & Answer Session
- Closing and Thank You

THE BURDEN OF CHRONIC DISEASES IN THE UNITED STATES

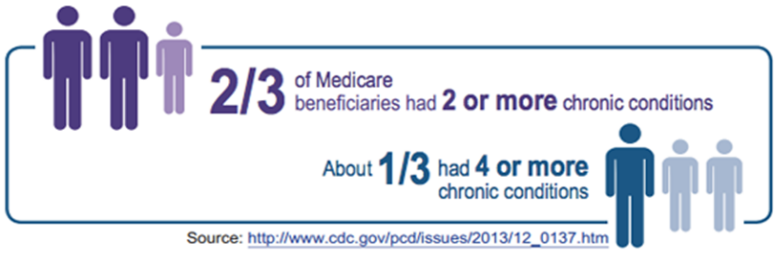
Chronic Disease Burden in the United States

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

Chronic Disease Burden Among U.S. Hispanics

Hispanic Medicare beneficiaries have higher rates of hypertension, diabetes, and depression compared with non-Hispanic white beneficiaries:

- 73% have hypertension, compared with 66% of whites
- 38% have diabetes, compared with 23% of whites
- 35% have depression, compared with 27% of whites

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost and Use File, 2011. Profile of Medicare Beneficiaries by Race and Ethnicity: A Chartpack, March 9, 2016, accessed from http://kff.org/report-section/profile-of-medicare-beneficiaries-by-race-and-ethnicity-chartpack/

A 2014 study of Medicare beneficiaries showed disparities in control of blood pressure, cholesterol levels, and glycated hemoglobin:

- 1.6% higher adjusted difference in controlling blood pressure
- 1% higher adjusted difference in controlling cholesterol levels
- 3.4% higher adjusted difference in controlling glycated hemoglobin levels

Ayanian, J. Z., Landon, B. E., Newhouse, J. P., & Zaslavsky, A. M. (2014). Racial and Ethnic Disparities among Enrollees in Medicare Advantage Plans. The New England Journal of Medicine, 371(24), 2288–2297. http://doi.org/10.1056/NEJMsa1407273

Disparities in Care Coordination

Hispanic Medicare beneficiaries report more difficulty and dissatisfaction with the health care they receive. According to an analysis of 2013 Medicare data:

- 8% report having no usual source of care, compared with 4% of whites
- 9% report having trouble getting needed care, compared with 5% of whites
- 13% delayed seeking care due to cost, compared with 10% of whites
- 5% reported being dissatisfied or very dissatisfied with the quality of care compared with 3% of whites

Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Access to Care File, 2013. Profile of Medicare Beneficiaries by Race and Ethnicity: A Chartpack, March 9, 2016, accessed from http://kff.org/report-section/profile-of-medicare-beneficiaries-by-race-and-ethnicity-chartpack/

Another study of more than 260,000 Medicare beneficiaries found that Hispanic participants reported that:

- Their persona doctor had their medical records/relevant information about their care less often
- They experienced greater difficulty getting timely follow-up on test results
- They received help managing their care less often

Source: Martino, SC, et al. Racial/Ethnic Disparities in Medicare Beneficiaries' Care Coordination Experiences. Medical Care, Volume 54, No. 8, August 2016 pp 765-771. https://doi.org/10.1097/MLR.0000000000000556

The National Association of Hispanic Nurses is committed to providing access to educational, professional, and economic opportunities for Hispanic nurses and improving healthcare in our communities.

http://www.nahnnet.org/

CHRONIC CARE MANAGEMENT SERVICES

What Is Chronic Care Management?

- Chronic Care Management (CCM) includes 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 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 Chronic Care Management?

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's new for 2017

Significant changes starting in 2017 based on feedback from stakeholders.

Additional separate payment amount through three 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 – as of January 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

CCM in RHCs and FQHCs

- 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
- 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 CAMPAIGN OVERVIEW

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

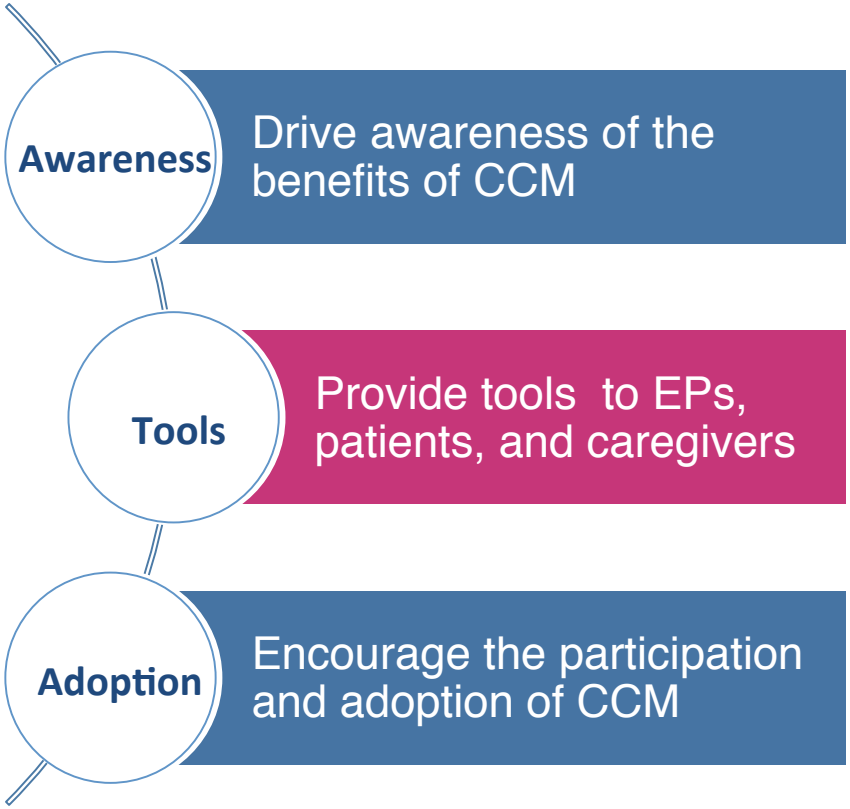
Primary Audiences

- **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)

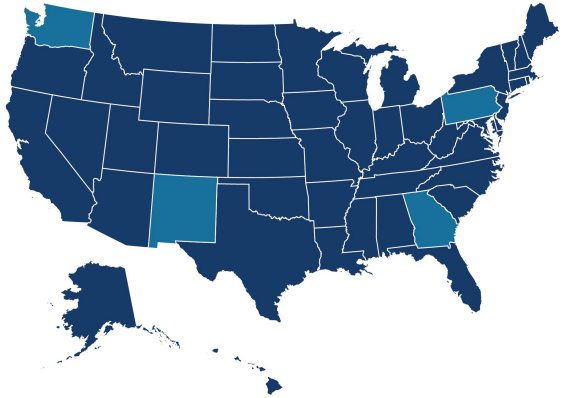
- **Consumers/Patients:** Medicare and dual-eligible beneficiaries (Medicare & Medicaid) with two or more chronic conditions, with a focus on underserved rural populations and racial and ethnic minority populations

Secondary Audience

- **Caregivers** of patients



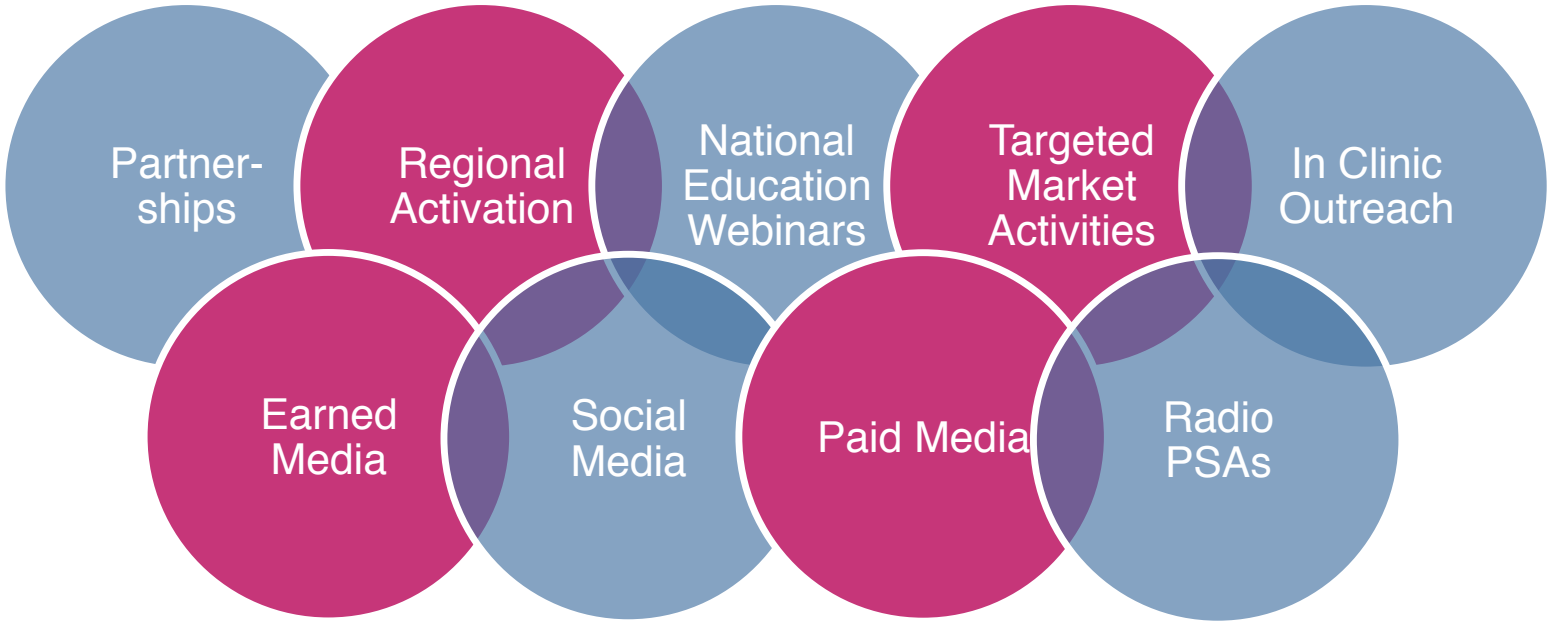
Campaign Markets



- *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 Nurses and Other 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

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

Three Ways to Get Involved Today

1. Download/order the patient education poster and postcards for your waiting rooms
2. Visit the *Connected Care* Hub to access the HCP Toolkit and get more details on implementing CCM in your community
3. Become a partner in the *Connected Care* campaign

CCM in the Regions

CCM is an essential element in patient care. I find gaps in care and troubleshoot ways to help patients manage their healthcare each day and it is very fulfilling to be able to do so. I regularly participate in diabetic management and education, social services, placement, and mental health coordination, family support, goal setting, and motivational interviewing for lifestyle improvements, problem solving, complex medication reconciliation and more.

- *Portland Adventist Medical - Care Manager RN*

Now that we can receive reimbursement for time spent doing complex care coordination for our patients with multiple chronic conditions, we're able to devote more staff time to manage them the way we know they need to keep them out of the hospital. All of our office staff is involved in this process and we huddle every morning before hours to review what needs to be done for all our patients that day.

- *Primary Care Practice Administrator and Nurse - New Jersey*

Regional CCM contacts

Regional CMS CCM Contacts

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QUESTIONS AND 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