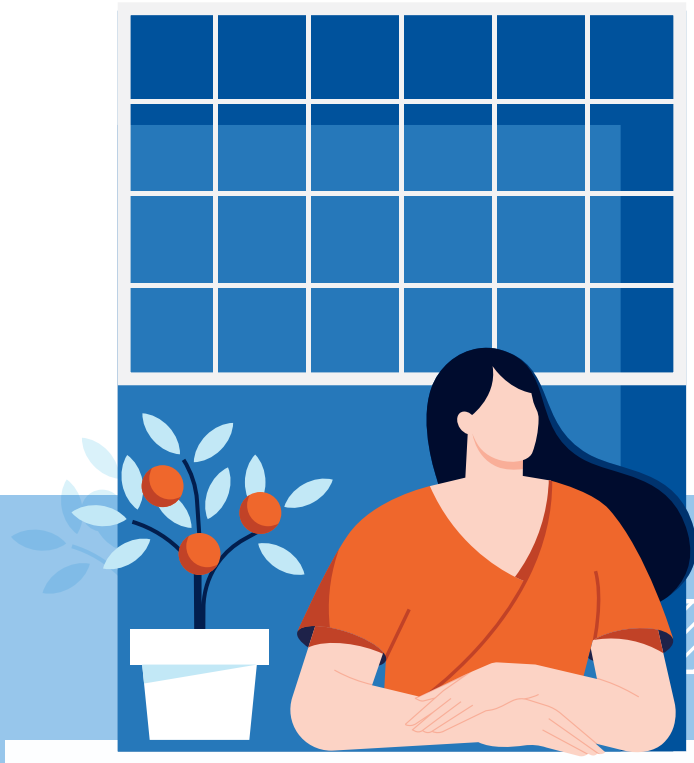
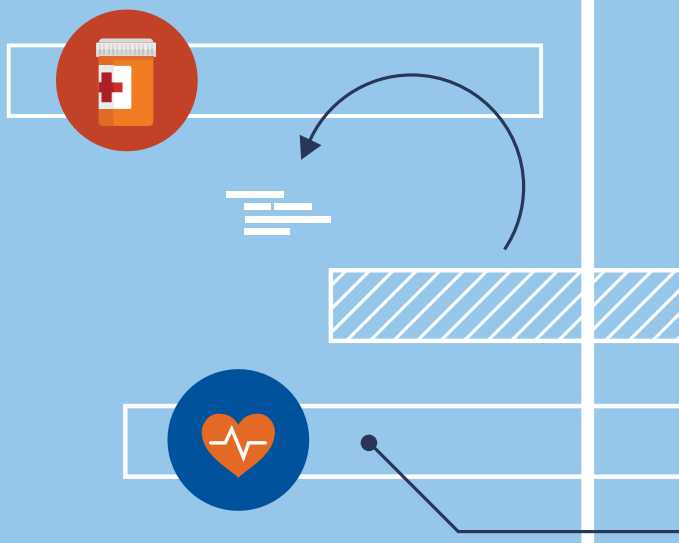
CHRONIC CARE MANAGEMENT AT-A-GLANCE



Chronic care management (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. According to estimates from the Centers for Medicare & Medicaid Services, one in four adults, including 70% of Medicare beneficiaries, have two or more chronic health conditions, qualifying them for CCM.[1]

CCM services may be billed by:

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



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BENEFITS OF CCM

CCM engages patients in their own care and educates them on their chronic conditions. Separate from traditional primary care, it provides access to care outside of and in between doctors' visits. CCM can be delivered to people with many different types of health conditions.

For your patients

- Team of dedicated health care professionals to plan for better health and stay on track for good health
- Comprehensive care plan to support disease control and health management goals, including outside resources, community support, referrals, and educational information
- Additional support between visits and more frequent communication with providers

For your practice

- Improved care coordination and health outcomes
- Increased patient satisfaction, compliance, efficiency, and connection
- Decreased hospitalization and emergency department visits
- Ability to sustain and grow your practice, including additional resources to care for high-risk, high-needs patients
- Reduced operational costs and additional payment

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OUTCOMES OF CCM

According to a Centers for Medicare & Medicaid Services analysis[2], CCM services improve health outcomes for patients and allow health care providers to be reimbursed for services many already provide. The analysis of two years' worth of data found that, with CCM, hospitalizations decreased by nearly 5% and emergency department visits declined by 2.3%. Providers also reported improved patient satisfaction and adherence to recommended therapies, along with improved clinician efficiency.

CCM responsibilities and requirements for health care providers

- Obtain the patient's consent and document it in their medical record
- Talk with the patient about the benefits of CCM
- Develop a comprehensive assessment and care plan
- Share the care plan with the patient and any caregiver
- Review and revise the plan as needed
- Provide person-centered care and continuity of care through regular contact with the patient
- Provide the patient with a way to contact the practice 24/7 to address urgent needs
- Equip the patient with tools to manage their chronic conditions and any medications
- Record patient data through Electronic Health Records (EHRs)
- Manage any care transitions, like referrals or discharges from facilities

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PAYMENT INFORMATION

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

Initiating visit

- Required for new patients or those not seen in an office visit within one year before starting CCM
- Billable separate from monthly CCM services
- Add-on code can cover time spent outside of usual efforts

Monthly billing codes

- Pay for 20+ minutes of clinical staff time spent on non-complex CCM requiring creation or review of the care plan
- Alternative codes are available for complex care requiring at least 60 minutes of clinical staff time per month

RHC/FQHC billing codes

- RHCs and FQHCs use specific codes for CCM services
- Payment is based on rates for both CCM and behavioral health integration services

INFORMED CONSENT NOTIFICATION

Patients must give consent to receive CCM services, which can be given in written form or verbally and documented in the medical record. Patients need to provide informed consent only once unless they switch to a different CCM practitioner. Patients may also choose to discontinue services at any time. See the CCM toolkit for more information on informed consent, including suggested language.

Consider these questions when seeking consent:

- Do you have any questions about CCM services?
- Do you agree to receive CCM services?
- Do you understand that a monthly fee could apply?
- How do you prefer to be contacted, and what is the best time to contact you?

References

[1] Lochner KA, Cox CS. Prevalence of multiple chronic conditions among Medicare beneficiaries, United States, 2010. Prev Chronic Dis. 2013 Apr 25;10:E61. doi: 10.5888/pcd10.120137.

[2] Schurrer J, O'Malley A, Wilson C, McCall N, Jain N. Evaluation of the diffusion and impact of the chronic care management (CCM) services: Final report. CMS.gov. Published November 2, 2017. Accessed August 8, 2023. https://innovation.cms.gov/Files/reports/chronic-care-mngmt-finalevalrpt.pdf

Learn more about CCM and download resources at **go.CMS.gov/ccm**

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