National Council on Aging

Chronic Care Management
INFORMATION RESOURCE

Contents

Purpose

This resource is designed to provide information to help community-based organizations (CBOs) deliver the chronic care management (CCM) Medicare Part B benefit as they work toward integrated, sustainable program networks for chronic disease self-management education (CDSME) programs. It contains the basic foundational information and practical considerations for implementing CCM services. The information is not all inclusive and should be applied within the context of an overall understanding about Medicare, integrative health, and business acumen. Additionally, the diversity of CBOs and their unique practices should be taken into consideration when putting this information into practice.

To gain the maximum benefit from the information that follows, CBOs should be willing to commit the necessary time, effort, and resources to develop an implementation plan and business model for CCM. While not a Medicare requirement, it is recommended that a staff member be designated as program coordinator to carry out the series of tasks associated with implementing and obtaining reimbursement for CCM. By assigning these responsibilities to a program coordinator, the organization is making a commitment to the process of securing Medicare reimbursement. Building a viable business model doesn't happen overnight, but the effort will be well worthwhile in the long run.

What Is CCM?

Chronic care management (CCM) is a Medicare Part B benefit delivered under the supervision of a physician or non-physician provider (i.e., nurse practitioner or physician assistant) for individuals with two or more chronic conditions expected to last at least twelve months or until death, who are at significant risk of functional decline, deterioration, acute exacerbation, or death.

The CCM benefit allows eligible providers to offer services outside of doctor's office visits to help individuals with two or more chronic conditions follow their medical care plan, practice preventive health care, and more effectively manage their health. CCM services are designed to keep Medicare beneficiaries healthier and are expected to be delivered each calendar month over a 12-month period. Services include communication with Medicare beneficiaries and health professionals to provide chronic care management and coordination in-person, over the phone, and electronically.

Background

As of January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) began providing reimbursement for CCM. The benefit covers 20 minutes of time per month over a 12-month

period. In 2017, the benefit was expanded to include two new CPT codes for complex CCM for individuals who require more than 20 minutes of clinical staff time each month.

Initiating Visit and Person-Centered Plan

Before CCM services can be offered, there must be an initiating face-to-face visit with a Medicare qualified provider for new patients or patients who have not been seen within one year prior to the commencement of CCM services. In addition, advance verbal or written consent must be obtained from the beneficiary (see Documentation Requirements, pages 7-9).The initiating visit can be an annual wellness visit, an initial preventive physical exam, transitional care visit, or other qualifying evaluation and management visit. This visit is not part of CCM services and is billed separately.

Once the initiating visit has been provided (for new patients or those not seen within a year of the commencement of CCM services), a comprehensive person-centered plan for CCM is developed. An add-on face-to-face visit may be provided to complete the person-centered plan. The clinical team, including staff from the CBO, should provide input into development of the person-centered plan under the direction of the qualified physician or non-physician provider (i.e., nurse practitioner or physician assistant).

Clinical Supervision

All CCM services are provided under the general supervision of a physician or non-physician provider (i.e., nurse practitioner or physician assistant). **General Supervision** means that the services are offered under the overall direction and oversight of the qualified provider, but he/she does not have to be present or on site when the intervention is offered. The general supervision requirement allows flexibility for CCM services to be delivered in community settings outside the provider's office.

Qualifications for Personnel Who Deliver CCM Services

There are no specific credentialing requirements for personnel who deliver CCM services, as long as they operate under the general supervision of a qualified physician or non-physician provider as described above. However, it is expected that they will have the necessary knowledge, skills, training, and experience to serve the target population. A trained Chronic Disease Self-Management Program (CDSMP) lay leader, health coach, or other person with training and background in chronic disease management and care coordination may be appropriate for this role. Each organization should ensure that personnel who deliver CCM

services have the appropriate qualifications to carry out the roles and responsibilities of the position and meet the needs of the target population.

Health Coaches: There are no uniform national standards for credentialing health coaches, but they should obtain training as deemed appropriate by the qualified Medicare provider in coordination with the CBO. The American Medical Association (AMA) has developed an online training module, Implementing Health Coaching, for physicians who want to incorporate health coaches into their practices.

Eligibility Requirements

- Two or more chronic health conditions expected to last at least 12 months or until the death of the beneficiary who is receiving the services
- Chronic conditions place the individual at significant risk of functional decline, decompensation, acute exacerbation, or death
- Medicare Part B coverage
- Advance verbal or written consent for CCM services (see Documentation Requirements, pages 7-9)
- An initiating visit for new patients or those who haven't been seen within one year of the commencement of CCM services
- A comprehensive person-centered plan reviewed and approved by a qualified physician or non-physician provider (i.e., nurse practitioner or physician assistant)
- All services provided under the supervision of a qualified physician or non-physician provider
- Provider accessibility 24 hours a day
- For CCM, 20 minutes of clinical staff time per month; for complex CCM, 60 minutes of clinical staff time per month

CCM and Complex CCM

CCM (also referred to as regular or non-complex CCM) covers 20 minutes of clinical staff time per month. There is also a complex CCM benefit that covers 60 minutes of time and allows for moderate to high complexity decision making. Beyond the 60 minutes, an additional 30 minutes of clinical staff time can be billed each month under complex CCM. (See CPT codes below.) All CCM services (regular and complex) must be provided under the supervision of a physician or non-physician provider (i.e., nurse practitioner or physician assistant). During any given month, a Medicare beneficiary can receive CCM or complex CCM, but NOT both. Only one qualified provider entity can bill for CCM services each month.

Examples of CCM Services

Many CBOs already offer services that may be provided as a component of CCM if all requirements for this Medicare benefit are met. Therefore, they are well positioned to offer CCM services to help health care providers improve performance under value-based payment models.

Examples of CCM Services that CBOs Can Offer Under The Direction of a Physician or Non-Physician Provider:

- Care management and transitional care management services
- Communicating with the Medicare beneficiary in person, by phone, or electronically for care coordination
- Communicating with other health professionals and agencies in person, by phone, or electronically for care coordination
- Community resource referral and linkage
- Coordinating community and social support services
- Disease self-management education and support
- Health education, including health literacy
- Symptom management
- Medication management
- Health coaching
- Preventive health counseling
- Interventions to reduce falls or risk factors for falls

CPT Codes

The Common Procedural Terminology (CPT) codes are a set of medical billing codes developed and owned by the American medical Association. CPT ® is a registered trademark of the American Medical Association. All Rights are reserved. Table 1 below provides a list of the CPT codes for CCM and complex CCM, along with the rates for each code. An initiating visit has to be made (for new patients or those not seen within one year of the commencement of CCM services), and the beneficiary must provide advance consent to receive CCM services before the codes below can be billed. Only one qualified Medicare provider entity can bill for CCM each month.

Table 1: CCM CPT Codes and Rates*

CPT Code	Definition	Time	Description	Rate
G0506	Add-On to CCM Visit	N/A	Assessment and CCM care planning	$64
99490	CCM	20 minutes	Ongoing oversight, direction, and management; care planning established, implemented, revised, or monitored	$43
99487	Complex CCM	60 minutes	Ongoing oversight, direction, and management; medical decision making of moderate to high complexity; care planning established or substantially revised	$94
99489	Complex CCM Add-On	Each additional 30 minutes	Ongoing oversight, direction, and management; care planning established or substantially revised	$47

Concurrent Billing

CCM and complex CCM cannot be billed during the same month. There are also some other restrictions regarding when CCM cannot be billed. For instance, CCM cannot be billed during the same month or period of time when the following services are provided:

- Home health care supervision
- Hospice care supervision
- Certain end-stage renal disease services
- Transitional care management services
- Prolonged evaluation and management services

CPT instructions should be consulted for additional information about concurrent billing. Note - There may be additional restrictions for a CMS sponsored model or demonstration program.

Provision of CCM Services to Support CDSME Programming

Some of the most researched evidence-based self-management interventions are the suite of CDSME programs, originally developed at Stanford University. The hallmark of the CDSME programs is providing support and assistance to participants to learn appropriate goal setting, disease self-management techniques, and communication with their health care providers. Persons with two or more chronic conditions can be easily overwhelmed by the enormity of disease self-management. Therefore, participation in a CDSME program may serve as an appropriate component of CCM services if the qualified provider determines that it is medically indicated and the beneficiary consents to the services. The role of the qualified provider is to supervise the CDSME group intervention and to monitor each participant's progress toward attaining the goals that were mutually agreed upon in the person-centered plan.

The following CDSME programs in English or Spanish could be offered as a component of CCM services:

- Chronic Disease Self-Management Program (CDSMP)
- Chronic Pain Self-Management Program (CPSMP)
- Cancer: Thriving and Surviving Program (CTSP)
- Positive Self-Management Program (CPSMP)

Note - The Diabetes Self-Management Program (DSMP), originally developed at Stanford University, should be billed as a DSMT benefit when the appropriate wrap-around structure (including and national accreditation and clinical supervision that meets Medicare requirements) are in place.

Participation in a CDSME program should be included in the person-centered plan that is completed under the supervision of the qualified provider and billed as a complex CCM service. Attending a specific CDSME class would be listed as an intervention, and the goal would be improved self-management. The progress notes should reflect the curriculum content and weekly action planning/goal setting, including the participant's response to or progress with attaining the weekly goals. At the conclusion of CCM, the extent the goals were achieved and the outcomes associated with participating in the CDSME class should be documented in the clinical record (see Documentation Requirements, pages 7-9).

Up to one and a half hours of service are billable per month under the CCM benefit. Therefore, for a CDSME class, which is offered for six weeks over a two-month period, only three hours of the 15-hour course curriculum are billable for each participant who has Medicare Part B.

While there is a limit to the amount of time that can be billed for the CDSME class, services associated with offering CDSME before the class starts and after it ends can be provided under the CCM benefit. Billable services routinely provided a month or two before the class begins could include outreach, engagement, and enrollment. Motivational interviewing could be offered as part of the engagement process to help individuals resolve resistance or ambivalence about enrolling in a class. Other services that could be included as part of the CCM person-centered plan are transportation assistance, and/or referrals to other community resources. All services should be individualized and based on the person-centered plan or revision of that plan.

Once the CDSME class ends, CCM services can be extended over the course of the 12-month period to provide ongoing self-management education and support and other services that are needed for optimal disease management, prevention and control, including care coordination, community resource referrals and linkages, and additional evidence-based health promotion programming. These interventions may be billed as regular or complex CCM, depending on the time, intensity, and level of medical decision making required.

Offering CCM in Conjunction with other Medicare Benefits

CCM can be offered in conjunction with other Medicare Part B benefits, such as Diabetes Self-Management Training (DSMT) and/or Health or Behavior Assessment and Intervention (HBAI). For example, if someone who is receiving DSMT needs assistance with transportation or has concerns about managing co-occurring chronic condition(s), CCM services can be provided to address those unmet needs. Additionally, CCM can be provided prior to the start of DSMT for outreach, engagement, and transportation assistance and after the DSMT services are completed for ongoing diabetes self-management education and support and other chronic disease-related services. Offering multiple services provides a more comprehensive approach to meet the needs of the target population. Further, doing so can give your organization a competitive advantage in the marketplace by offering a menu of services from which health care providers can select.

Documentation Requirements

Documentation in the clinical record must support claims that are submitted for payment of CCM services. All claims must be filed by the Medicare provider entity responsible for the provision of CCM services.

Advance Consent

Advance consent must be obtained from the beneficiary prior to starting the services and documented in the clinical record. The consent may be written or verbal and must include the following:

- The availability of CCM services and applicable cost-sharing
- That only one provider entity can furnish and be paid for CCM services during a calendar month
- The right to stop CCM services at any time (effective at the end of the calendar month)
- Date that the consent was obtained, which must be prior to starting CCM services

Initial Assessment and Person-Centered Plan

Members of the clinical team can contribute to the initial assessment. Based on findings from the assessment, the physician or non-physician provider, together with the clinical team and the beneficiary, establishes a comprehensive person-centered plan to guide the CCM services that will be provided. The physician or non-physician provider should review and approve the final plan. If during the course of the 12-month period, a change in the beneficiary's health status requires a revision of the care plan or goals, the qualified provider would be expected to meet with the individual to reassess his/her status and update the person-centered plan accordingly.

The following should be documented in the comprehensive assessment:

- Physical, mental, cognitive, psychosocial, functional, cultural, and environmental factors affecting the individual's management of their chronic conditions

The following should be documented in the person-centered plan:

- Problem list
- Planned interventions to address health issues, with a focus on chronic health conditions that extend over a 12-month period
- Measurable goals and time frame to achieve the goals
- Beneficiary's agreement with the goals and plan
- Planned frequency and duration of services
- Schedule for review and, when applicable, revision of the care plan

When disease self-management is a goal, CDSME may be an appropriate component of CCM. If so, participation in a CDSME class should be included as an intervention in the

person-centered plan. The frequency and duration of the class, i.e., once a week for six weeks/2.5 hour sessions, should also be noted.

Monthly Progress Notes

Monthly progress notes should contain the following:

- Start and stop time of each intervention provided for the beneficiary during the calendar month
- A brief description of the services that are provided each month, including any referrals to community resources
- The individual's response and progress as a result of the services provided
- Any change in the frequency or duration of services should be documented

When CDSME is an intervention, the class content and weekly action planning/goal setting, including the participant's response, should be documented in the monthly progress notes.

Reassessment

At the end of the 12-month period, the qualified provider should meet with the individual to reassess his/her health status, review the progress that was made, and determine if further CCM services are needed. The following information should be documented in the clinical record:

- Reassessment to determine if the beneficiary continues to need additional CCM services, including the physical, mental, cognitive, psychosocial, functional, cultural, and environmental factors affecting the individual's management of their chronic conditions
- A revised person-centered plan if additional CCM services are indicated

Coinsurance

Medicare Part B requires a co-insurance payment of 20% of the coverage limit. The individual receiving services is responsible for the coinsurance payment amount. Medicare provides education about the Medicare Part B coinsurance requirement when individuals sign up to participate in Original Medicare.

Medigap Policies

Medigap policies, which are sold by private insurance companies, pay some of the health care costs not covered by Original Medicare, e.g., copayments, coinsurance, and deductibles. Consumers are educated about their right to select a Medigap policy, and many elect to

purchase one. For Part B services, such as CCM, Original Medicare pays 80% of the fee schedule rate, and the coinsurance (20%) is the responsibility of the beneficiary.

Providers are expected to collect the coinsurance either from the beneficiary or by billing the appropriate Medigap policy. If a Medicare beneficiary has a Medigap policy, the provider should collect the necessary Medicare coverage information and applicable Medigap policy information prior to delivering services. Applicable co-insurance coverage can be billed to the Medigap policy once the service requirements have been met as a Part B benefit of Original Medicare.

Dual Eligible Beneficiaries

Depending on the State requirements, some low-income Medicare beneficiaries may be eligible for Medicaid. Medicaid is a means-tested health coverage program administered by the participating state Medicaid agency and jointly funded by the Centers for Medicare & Medicaid Services (CMS). A Medicare beneficiary that meets the means test requirement for Medicaid and is enrolled in a Medicaid program is commonly referred to as a "dual eligible beneficiary." For dual eligible beneficiaries, Medicaid is the Medigap policy. Therefore, dual eligible beneficiaries have full coverage. Medicare covers the primary 80%, and Medicaid is mandated to cover the remaining Part B coinsurance—20% of the coverage.

If a dual eligible beneficiary is enrolled in a Medicaid managed care program or long-term services and supports managed care program, then the coinsurance coverage may be the responsibility of the applicable Medicaid managed care organization (MCO), depending on the requirements administered by the state Medicaid agency.

Dual eligible beneficiaries often have multiple medical conditions and may encounter a number of barriers to effectively manage their health. Therefore, they may be good candidates for CCM services.

Coverage of CCM Services by Other Health Plans

In addition to Original Medicare, a number of other insurance plans also cover CCM services. Prior to offering CCM services to a health insurance plan's members, it is important to notify the plan of the intention to provide CCM services, register as a provider, and inquire about whether there are prior-authorization requirements. Generally, rates for CCM services covered by commercial insurance carriers can be negotiated with each plan.

Medicare Advantage

All Medicare Advantage plans cover all Part A and Part B services. Since CCM is a current Part B benefit, all Medicare Advantage plans have CCM as a covered benefit for their enrolled members. Any Medicare beneficiary or Medicare Advantage beneficiary that meets the medical necessity requirements for CCM is eligible to receive the CCM services as a covered benefit.

Generally, commercial insurance plans offer CCM services as a covered benefit through their provider network. If a network provider has the infrastructure to deliver CCM services, a special contract is not required to provide CCM services for members enrolled in a Medicare Advantage health plan. However, some Medicare Advantage plans require prior authorization for the services to be offered.

Medicaid

State Medicaid agencies and Medicaid managed care organizations (MCOs) have the option of providing CCM as part of an enhanced benefit package. Community-based organizations should check with their state Medicaid division to determine if CCM is a covered Medicaid benefit.

Commercial Insurance Plans

A number of commercial insurance plans that are not part of the Medicare Advantage program also cover CCM services. If your organization wants to provide services to commercial insurance beneficiaries, it is important to check with each plan about their requirements. You should be prepared to negotiate rates for the services.

Example Models for Implementing CCM Services

Example Model 1 - The CBO Develops a Partnership with One or More Individual Medicare Providers to Offer CCM Services

The CBO may have an existing partnership with one or more qualified Medicare providers to make referrals to CDSME programs or to offer other services. The existing referral patterns for CDSME may include providers that have a desire to expand CCM to their existing population. Those providers could potentially contract with the CBO to provide CCM services.
Once a Medicare provider agrees to partner with the CBO to offer CCM, the two organizations would enter into contract negotiations to discuss and define the responsibilities of each organization, scope of services, payment rates, and payment schedule. (Please refer to the

Partnership section of NCOA's Community-Integrated Healthcare Toolkit for information on developing partnerships and contractual agreements with health care entities.) During the negotiation process, it is important for the CBO to consider the costs of providing the services and not agree to an amount that is lower than the costs. It is generally recommended that administrative costs for the provider be limited to 10% or less.

In this model, the Medicare provider is responsible for conducting the initiating visit for CCM, providing the clinical supervision, and submitting all claims to Medicare. The Medicare provider is also responsible for developing the comprehensive person-centered plan and may be interested in contracting with the CBO to complete it under the supervision of the provider. If the CBO assumes responsibility for developing the person-centered plan, the provider would be expected to review, approve, and sign off on it. The role and responsibilities of the CBO with regard to developing the person-centered plan should be discussed during the contract negotiations, considered in the rates that are agreed upon, and specified in the scope of services.

CCM services offered by the CBO are clinically integrated with the provider's practice. The Medicare provider is responsible for conducting the initiating visit for CCM, providing the clinical supervision, and submitting all of the claims to Medicare. Further, CCM services are documented in the provider's electronic health record.

In putting this model into practice, it is important to discuss the criteria for referring to CCM and how the referrals will be made. The CBO could offer to embed a health coach in the practice. The health coach would identify patients who can benefit from CCM and offer the services on site under supervision of the qualified provider and in coordination with the clinical team.

Advantages of this Model for the CBO:

- Quick startup, as the CBO doesn't have to go through the process of becoming a Medicare provider
- Steady source of referrals from the Medicare provider practice(s)
- Potential to replicate with other practices once successful with one Medicare provider
- Less burden on the COB, since it is not responsible for submitting the claims to Medicare

Disadvantages of this Model for the CBO:

- Requires separate contracts with each individual Medicare provider
- Need to learn and adopt the electronic health record of each Medicare provider
- Increased administrative costs to manage and track services if there are contracts with multiple providers

Example Model 2 - The CBO Contracts with a Management Services Organization (MSO) or other Medicare Provider That Works with Multiple Providers in the Marketplace

This example model is similar to Example Model #1 in that the CBO does not serve as the Medicare provider but rather contracts with a health care entity to offer CCM services. The difference is that the contract is with a Management Services Organization (MSO) or other entity that works with multiple providers in the marketplace.

A health care MSO is a business owned by a group of physicians or a joint venture between a hospital, health plan, or investors in conjunction with a group of physician practices. MSOs provide non-clinical services to support the physicians, generally providing management and administrative functions. The MSO accepts the risks, liability, and costs associated with the functions they provide, which may include the internet technology costs of an electronic health record platform. The role of the MSO allows physicians to focus on the clinical aspects of their practice. Services that MSOs offer can vary widely and some allow physicians to select from a menu of services that the MSO can provide. Often MSOs charge an administrative fee. MSOs can pass costs savings along to physicians due to the scale of their operation or economies of scale.

Advantages of this Model for the CBO:

- Ability to integrate with multiple providers in the market using one IT system platform
- Risks, liability, and IT costs may be borne by the MSO
- Potential lower administrative costs related to the use of one IT platform, tracking system, claims management process, and reporting venue
- Capacity for sophisticated reporting and population health management
- Revenue cycle management provided by MSO

Disadvantages of this Model for the CBO:

- Potential increased costs to the CBO associated with the MSO fee
- An internet technology (IT) platform that may not be flexible enough to meet the needs of the CBO

Example Model 3 - The CBO becomes a Direct Medicare Provider with the Appropriate Infrastructure to Deliver CCM Services

In the third example model, the CBO serves as the Medicare provider to deliver CCM services. To serve as a provider, the CBO would be required to have a Provider Transaction Action Number (PTAN) and National Provider Identifier (NPI) for Medicare Part B. Additionally, the CBO would need to have a physician, nurse practitioner, or physician assistant on staff or

through a contractual arrangement to provide the initiating visit and to supervise CCM services. Further, the qualified clinician would be required to have an NPI affiliated with the CBO.

Advantages of this Model for the CBO:

- No need to negotiate with third parties to offer the service
- Can immediately target current client base for referrals
- Ability to act autonomously in providing the service
- Keeps 100% of collections

Disadvantages of this Model for the CBO:

- Higher costs upfront
- Bears 100% of the risks and costs associated with providing the service, including costs of an integrated health IT system
- Must have the appropriate personnel and a process to complete a qualifying visit for each consumer
- Must establish a process for revenue cycle management
- Lack of economies of scale

Referral Patterns

Regardless of which model is selected, the CBO should consider how it will build referrals to create the volume of services necessary for a viable business model. It is important that all providers in the practice(s) served understand the value of CCM. Further, there should be a clear process for making referrals to CCM services. The CBO and the practice(s) should jointly develop a quality assurance process for monitoring and improving the referral process to ensure that individuals who can benefit from CCM services are being referred.

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