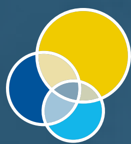
Chronic Care Management (CCM) Toolkit

Your implementation guide for patients with chronic conditions



Quality Improvement Organizations
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Health Quality Innovation Network

Chronic Care Management Toolkit

Your implementation guide for patients with chronic conditions

Thank you for using the Chronic Care Management (CCM) Toolkit. This guide is intended to help you and your team implement or expand CCM for your targeted patients with chronic conditions. You can either develop CCM processes with your own team, or you can use this guide to help you form a collaborative partnership between a physician practice and a local pharmacist.

How to use this resource...

1. **Review the Overview Section on pages four through six.**
   a. The Challenge
   b. Solution
   c. Team Members
   d. Requirements and Components of a CCM Program

2. **Identify your implementation team to develop your next steps.**
   a. Your internal champion and team members
   b. Community Pharmacist option

3. **Assess Implementation Strategies for Successful CCM Trial**

4. **Choose individual Appendices for:**
   a. Team tools
   b. Easy-to-use templates
   c. Supplemental CCM resources

5. **Contact HQIN for technical assistance:** CCM@hqi.solutions

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Overview

The Challenge

- Chronic diseases are the leading causes of death and disability and account for 90% of the nation's 3.8 trillion in health care expenditures. Currently, six in 10 adults are living with at least one chronic disease, and four in 10 have two or more chronic conditions.[1] Black and Hispanic Medicare patients have higher prevalence rates of many chronic conditions (hypertension, diabetes, stroke, and depression) than their white counterparts[2] and racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care.
- People with chronic conditions often require care and support between physician visits. Gaps in care may occur when that support is lacking due to factors such as a person's high-risk situation (i.e., uncontrolled blood glucose levels), follow-up challenges, or even lack of services. That gap places people at risk for complications, worsening symptoms, and hospital visits.
- Clinicians are accountable for their patients' chronic disease outcomes and clinical improvements. Programs and services need to be sustainable while impacting patient engagement, satisfaction, and outcomes.

Solution

Chronic Care Management (CCM) services offer routine non-face-to-face services to help Medicare beneficiaries who have multiple, significant chronic diseases better manage their conditions. Refer to **Appendix D** for a summary of CCM benefits.

Implementing at least a four-month trial will enable your care team to experience the numerous benefits (summarized in **Appendix D**) along with enough data collection to measure patients' improved engagement and outcomes. When a physician practice adds a community pharmacist to the team, the benefits can be even greater.

Team Members

- **Qualified Healthcare Professionals** (Physician, Physician Assistant, Nurse Practitioner)
- **Clinical Staff** (Pharmacist, Nurse, Social Worker)
- **Non-Clinical Staff** (Pharmacy Tech, Office Manager)

Requirements and Components of a Chronic Care Management Program

Patient Eligibility

Chronic Care Management (CCM) services are available to Medicare beneficiaries who have two or more chronic conditions expected to last at least 12 months, or until the death of the patient. To bill for the CCM services you provide to your eligible patients, various components must be in place to successfully implement your CCM program in your practice. These components include:

Patient Consent

Before CCM services can be billed, either verbal or written patient consent must be obtained. The patient must be informed about the services offered, applicable cost-sharing, and the right to end services. To prevent duplicate practitioner billing, patients must be aware that only one practitioner can provide and bill CCM services. Patient consent must be documented in the medical record, whether participation is accepted or declined.

Comprehensive Care Plan

A "Comprehensive Care Plan" must be established, implemented, revised and/or regularly monitored in an electronic format for the patient to track health issues and share with their care team and/or caregiver as appropriate (See **Appendix A** for an example care plan template). For complex CCM, the care plan must be established or substantially revised. Some care plan elements could include the following:

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and responsibilities
- Medication management
- Community services orders
- Coordination of services needed outside the practice
- Periodic review of the care plan

Continuity of Care

Continuity of care for CCM recipients must be provided through a designated care team member with whom the patient can schedule appointments and who is in regular contact with the patient to help them manage their chronic conditions.

Electronic Health Records (EHRs)

Certified Electronic Health Records (EHRs) must be used to record certain patient data, including the patient's demographics, medical problems, medications, and medication allergies. Your EHR can help to identify high-risk and at-risk patients for participation in your CCM program and help you to effectively manage chronic conditions and population health.

24/7 Access to Care Team

CCM recipients must be provided with a way to contact their care team regardless of the time of day or day of the week to address urgent care management needs.

CCM Care Team Roles and Responsibilities

Legend
✓ = QHP required
O = Team members or QHP

	Qualified Healthcare Professionals (Physician, Physician Assistant, Nurse Practitioner)	Clinical Staff (Pharmacist, Nurse, Social Worker)	Non-Clinical Staff (Pharmacy Tech, Office Manager)
Consent Patient	✓		
Collect Structured Data	O	O	O
Develop Comprehensive Care Plan	✓		
Maintain/Inform Updates for Care Plan	O	O	
Manage Care	O	O	
Provide 24/7 Access to Care	O	O	
Document CCM Services	O	O	
Bill for CCM Services	✓		
Provide Support Services to Facilitate CCM		O	O

Implementation Strategies for a Successful CCM Program

Most practices that implement CCM services do it within the confines of their own practices. An effective CCM program can increase your revenue potential, maximize clinical outcomes, enhance practice efficiency, and improve patient care. Below are seven key strategies to consider for implementing a CCM in your practice.

1. Establish a Workflow

It is important to consider what your initial workflow may look like to meet the requirements of the program, accommodate organizational capacities/ resources and be able to generate revenue while also providing a high level of customer satisfaction (See **Appendix B** for a sample workflow and **Appendix C** for care team workflow).

2. Define your CCM Process

Based on the initial workflow, practices and community partners should further define the who, what, when, and how. This will vary depending on individual organizational variables. It is best to start small and improve over time. For example, start with one provider identifying higher risk patients with one disease state that is typically associated with an additional chronic condition comorbidity and get comfortable with this before increasing scope. Identifying the initial CCM patient is important. Potential populations for consideration include:

- Patients with diabetes since they often have a secondary chronic condition
- New patients
- Dually eligible Medicare/Medicaid patients for co-pay coverage

3. Prepare for Reimbursement

CCM claims should be submitted timely each calendar month. It is important to ensure your EHR/Practice Management system meets your billing needs and reimbursement staff are adequately trained to ensure proper reimbursement.

4. Establish Ongoing Monitoring and Quality Improvement

As with all new endeavors, it is especially important to routinely measure and monitor the new program to ensure that it is working as expected. Areas that should be monitored include:

- Staff/community partner comfort with process
- Patient satisfaction
- Billing and reimbursement
- Sustainability
- **Consult the FQHC/RHC Care Management FAQ**

Once you have stabilized your processes and outcomes, consider spreading the scope of the services to other providers or additional populations.

5. Identify Opportunities with Commercial Payers

Although most of these tips are specific to the Centers of Medicare & Medicaid Services (CMS)-covered CCM services, it is important to explore Chronic Care opportunities with commercial payers. Some may have higher rates of reimbursement for more engagement with patients who have chronic conditions and sometimes with fewer requirements.

6. Leverage Digital Tools

Consider using virtual or online platforms to reduce face-to-face visits for routine chronic disease management. These digital tools can also be used to arrange group visits for patients with similar chronic diseases focusing on behavior change.

7. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

- CCM service can be billed using the general care management code G0511, either alone or with other payable services.
- If CCM services are billed on the same claim as an office visit, both will be paid.
- 2021 payment rate remains at $66.77.
- Patient coinsurance and deductibles do apply.
- Special rules apply. Consult the FQHC/RHC Care Management FAQ for more information.
- Principal Care Management (PCM) services can be done but only require one chronic condition using same code (G0511).

Refer to **Appendix J** for an itemized checklist of specific items to consider when implementing a CCM program.

8. CCM and Telehealth during a Public Health Emergency (PHE)

Due to COVID-19, patients who have chronic conditions may have an increased risk for severe illness and even death if they are avoiding getting the care they need including emergent care, routine screenings, and behavioral health assistance.

Because of the Public Health Emergency (PHE), an add-on G-code was identified by CMS as a "telehealth allowed service" and can meet the billing requirements through an audio-only visit, (but only during the PHE). G0506 should be billed separately from the monthly care management services codes.

Impact of Public Health Emergency on Chronic Care Needs

40% decrease in treatment for severe heart attack

600% increase in suicide hotline calls

Estimated 150,000 missed cancer diagnoses

Please refer to the Federal Register for the Medicare Physician Fee Schedule Final Rule (pg. 80245) for specific guidance on the use of this code.

During a PHE, actively screen for changes to behavioral health status including depression, anxiety, or substance abuse. It is common for patients to struggle with mental health during periods of social isolation and anxiety, and these complications can create negative clinical outcomes related to managing chronic care conditions.

G0506: *"Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service" can be used when the beneficiary requires an "extensive face-to-face assessment and care planning by the billing practitioner" and the "billing practitioner personally performs and meaningfully contributes to the establishment of the CCM care plan when the patient's complexity warrants it."*

Maximize Your CCM Program - Collaborate with a Pharmacist

The key to optimizing your CCM program is to partner with a pharmacist or local pharmacy. This collaboration engages partners to assist with a variety of CCM activities, many of which can be provided virtually such as medication review and reconciliation opportunities. This partnership can be easily implemented with a four-month trial to test processes, collect data and measure patient outcomes.

Also, a trial demonstrates how your practice can provide CCM services to patients without additional burden and overhead costs. Cost-sharing can be arranged where CCM services can provide needed revenue to both the practice and the pharmacist while improving chronic care management for your most vulnerable patients. It is important to establish the roles, responsibilities, and expectations for each community partner you select for your CCM program.

To help facilitate this collaboration, refer to the Pharmacy Partner Checklist in **Appendix E** for considerations when selecting your partners.

CCM Value Proposition for Pharmacist Partnership

Increased Revenue

- $40-$100+ per month per patient
- Potentially leads to incentive payment
- Enhanced practice reputation
- New patients, word-of-mouth recommendations
- Increases timely follow up when appointments are due

Improved Quality Measures & Patient Outcomes

- A1C > 9.0%
- Immunizations
- Tobacco screening and counseling
- Blood pressure screening and control

Improved Practice Efficiency

- Reduce patient phone calls for refills
- Enhance referral follow-through
- Screen/triage less serious patient issues
- Streamline workflows resulting with a team-based model
- Coordinate care through specialist notes and communication

Improved Patient Care

- Optimize team-based care model
- Increase access
- Strengthen coordination of care

Team Tools and Sample Templates

Sample CCM Care Plan Template

Patient Name: ______________________________

Provider: ______________________________

Top Concern for Chronic Care Management:

- Diabetic condition management and patient self-monitoring

Expected Outcomes:

- Improved patient self-monitoring
- Improved medication adherence and synchronization
- Improved patient education related to diabetes
- Active patient medication list provided to physician using Blue Bag Initiative
- Smoking cessation addressed and improved

Measurement Improved:

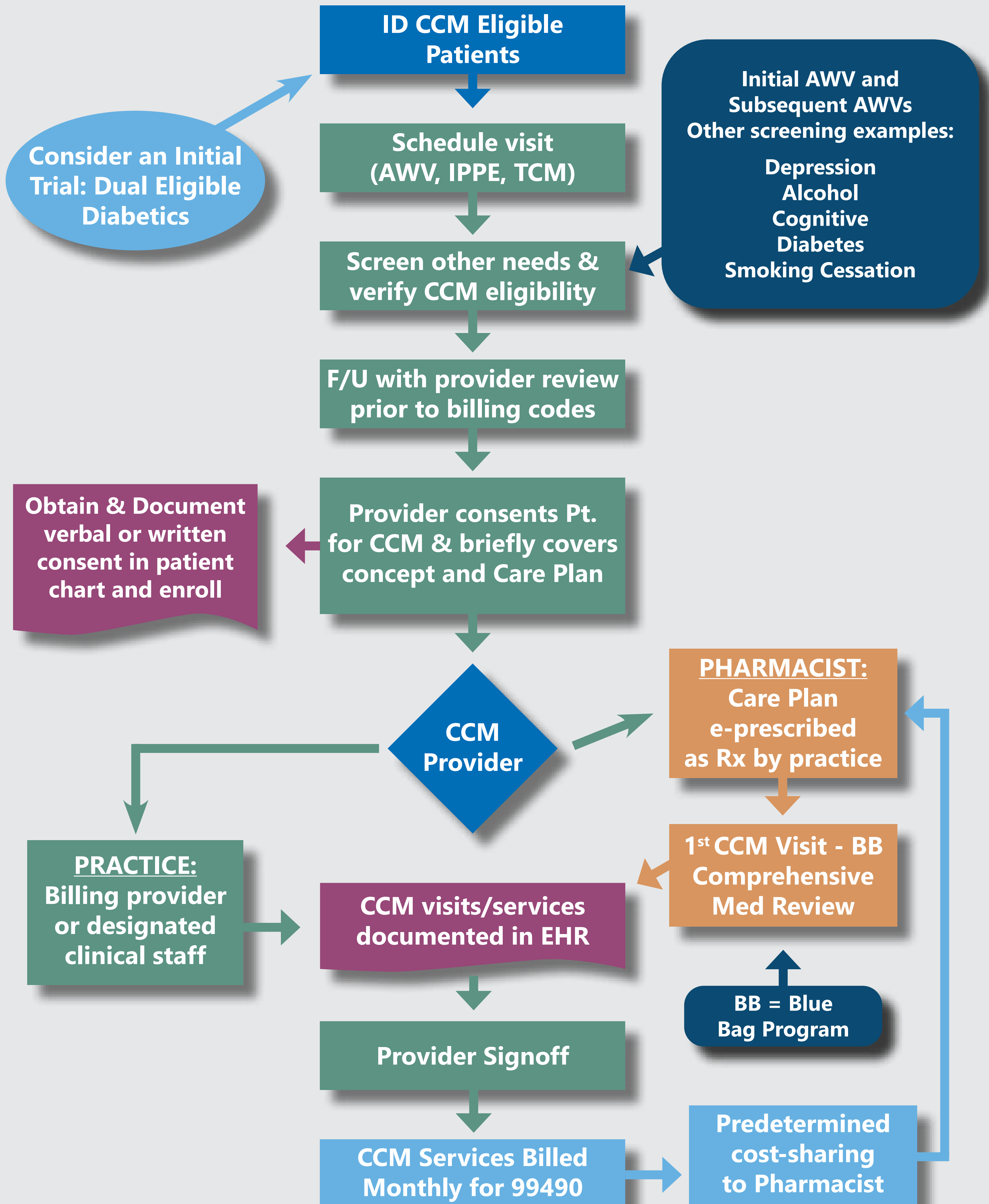
- Improved BG levels and/or A1C
- Improved body size, weight, and/or composition

Planned Interventions & Responsible Party:

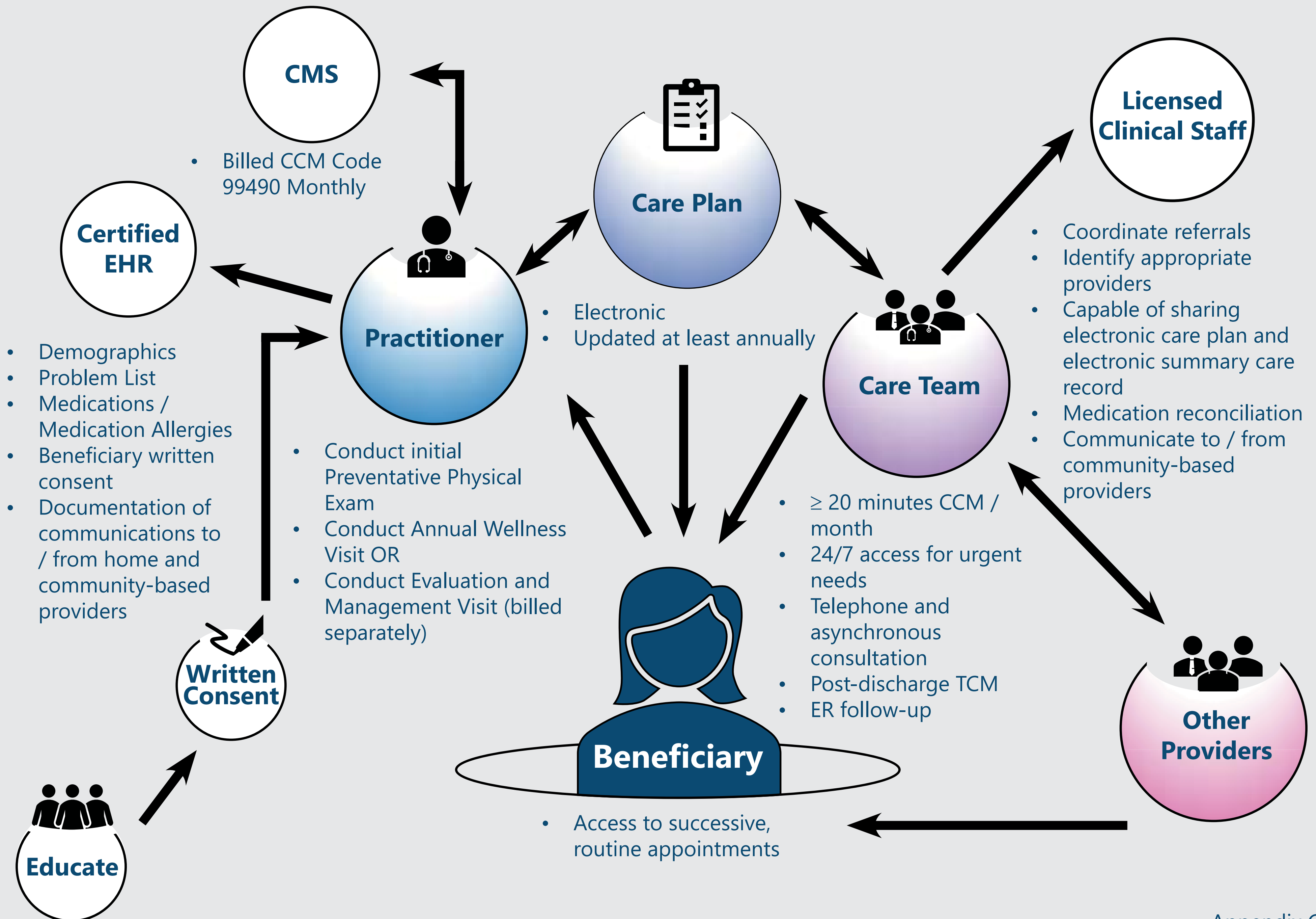
- MD to provide initial labs, referrals and monitoring lipid levels
- Pharmacy to initiate and maintain regular monthly contact with patient
- Pharmacy to track monitoring vitals, BG levels, annual eye exam, and the importance of foot exams
- Pharmacy to refer or provide diabetes self-management training opportunities for the patient
- Closing referral loops provided by pharmacy
- Preparation for medical appointments provided by pharmacy
- MD to review/edit care plan every six months based on outcomes and patient needs

Provider Signature: ______________________________

Sample CCM Workflow



Appendix B



Sample CCM Care Team Flow
CMS
Billed CCM Code 99490 Monthly
Certified EHR
Demographics
Problem List
Medications / Medication Allergies
Beneficiary written consent
Documentation of communications to / from home and community-based providers
Practitioner
Conduct initial Preventative Physical Exam
Conduct Annual Wellness Visit OR
Conduct Evaluation and Management Visit (billed separately)
Care Plan
Electronic
Updated at least annually
Care Team
≥ 20 minutes CCM / month
24/7 access for urgent needs
Telephone and asynchronous consultation
Post-discharge TCM
ER follow-up
Licensed Clinical Staff
Coordinate referrals
Identify appropriate providers
Capable of sharing electronic care plan and electronic summary care record
Medication reconciliation
Communicate to / from community-based providers
Other Providers
Written Consent
Educate
Beneficiary
Access to successive, routine appointments
Appendix C

General CCM Benefits

Improved Patient-Centered Care

- Assist in the development and updating of the comprehensive care plan
- Provide care management and coordination services to patients
- Ensure an accurate comprehensive medication review and reconciliation
- Provide 24/7 access to chronic care management services

Increased Revenue

- Provider billing for initial comprehensive assessment
- Increased timely follow up when appointments are due
- Improved practice reputation, new patient draw
- Improved quality metrics can lead to incentive payments (e.g., MACRA/ MIPS)

Improved Quality Measures

- Collect and record/relay structured data for documentation in the EHR
- Potential to improve key quality metrics and patient outcomes

Saving Provider Time

- Home health collaboration - supplies, feedback
- Referral follow-through
- Reduce phone calls/refill requests to practice
- Screen/triage less serious patient issues

Considerations prior to implementation – **Refer to Appendix J**

Pharmacy Partnership Checklist

Use this checklist to facilitate pharmacy partner collaboration.

Identify a potential partner (community pharmacy or primary care practice).

- If a local pharmacist is not available, schools of pharmacies may be able to assist.
- Pharmacists can also provide services remotely.

Discuss a partnership opportunity to offer CCM.

Agree to implement a four-month trial. Execute any necessary agreements. See **Appendix F** for a sample CCM Trial Agreement.

Select the chronic condition of focus for the trial (i.e., diabetes for dual eligible patients).

Identify eligible patients and create a referral process for the pharmacist or clinician.

- Providers can simply write a prescription for CCM services to the pharmacist.

Decide what patient outcomes you will measure.

- Note: The outcomes may align with the practice quality and/or improvement measures for the Medicare Quality Payment Program.

Collaborate to develop a basic care plan that can be individualized, if necessary, and reevaluated at the end of the trial. See **Appendix A** for a sample care plan.

Clarify provider/practice responsibilities including:

- Identifying eligible patients, obtaining/documenting patient consent.
- Setting up the initial appointment with the pharmacist/pharmacy.
- Billing for the service and paying the pharmacist a pre-arranged consultant fee.

The pharmacist responsibilities can include:

- Meeting with the patient monthly either in-person or by phone.
- Documenting a minimum of 20 minutes.
- Implementing the agreed-upon care plan.
- Providing monthly reports and invoices to the practice.

Pharmacy Partnership Checklist (cont.)

Use this checklist to facilitate pharmacy partner collaboration.

Develop a communication process for the provider and the pharmacist. For example, use a secure fax line or grant the pharmacist access to the patient chart, portal or EHR.

Decide how often you will communicate during the trial and evaluate areas for improvement.

Decide on a start/end date, and the number of patients that will be referred each month.

Establish Community Partner HIPAA agreement between practice and community partner. See **Appendix G** for a sample agreement.
Partner with the Health Quality Innovation Network (HQIN) for assistance with data analysis and outcomes reporting or use a basic data collection template.

Evaluate the outcomes and discuss how to expand, change, or end the program.

Chronic Care Management Trial

(Sample Agreement)

Start Date: ______________________________

End Date: ______________________________

Description of Trial: Patients from the practice who would benefit from Chronic Care Management and meet the trial inclusion criteria will be identified/consented by

Patients would then be referred to who will act as clinical extenders for the practice implementing the patient care plan from

Pharmacy will:

1. Provide monthly data reports via the EMR (or other process as defined by the practice) as well as invoices to detailing those trial patients who have received Chronic Care Management by the pharmacists.
2. Provide services in person or by phone at or at or at an agreed location that better suits the patient.

Practice will:

1. Consent and refer patients.
2. Bill Medicare for Chronic Care Management services.

At the conclusion of the trial, analysis of the program will be discussed, and next steps decided.

Financial Terms for Trial: would be compensated for of the billable services for Chronic Care Management.

______________________________ ______________________________

Practice Representative **Pharmacist Representative**

Business Associate Agreement

Sample

This Agreement is made effective the ________ day of ____________, 20__ by and between ____ _____, hereinafter referred to as "Covered Entity, and ________________________ ____, hereinafter referred to as "Business Associate" or "Vendor", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law I 04-191, known as "the Administrative Simplification provisions;" direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Security and Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined in the HIPAA Security and Privacy Rule (the agreement evidencing such arrangement is entitled Legal Services Agreement, dated _____________________, and is hereby referred to as the " Arrangement Agreement"); and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

I. DEFINITIONS

a. Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Security and Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Security and Privacy Rule, as amended, the HIPAA Security and Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security and Privacy Rule but are nonetheless permitted by the HIPAA Security and Privacy Rule, the provisions of this Agreement shall control.

b. The term "Protected Health Information"(PHI) means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation. Demographic, medical, and financial information that relates to the past, present, or future physical or mental health or condition of an individual: the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual: and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. "Protected Health Information " includes without limitation "'Electronic Protected Health Information" as defined below.

c. The term " Electronic Protected Health Information"' means Protected Health Information which is transmitted by Electronic Media (as defined in the HIPAA Security and Privacy Rule) or maintained in Electronic Media.

d. Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic dis p lay by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.

II. RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PROTECTIVE HEALTH INFORMATION

a. Business Associate agrees:

   i. to use or disclose any Protected Health Information solely: (I) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship, or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Security and Privacy Rule), or the HIPAA Security and Privacy Rule, and (3) as would be permitted by the HIPAA Security and Privacy Rule if such use or disclosure were made by Covered Entity:
   ii. at termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and
   iii. to ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information, and agrees to implement reasonable and appropriate safeguards to protect any of such information which is Electronic Protected Health Information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.

b. Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:

   i. if necessary, for the proper management and administration of

Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:

A. the disclosure is required by law; or
B. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached; for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services mean the combining of Protected Health Information by Business Associate with the protected health information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.
C. Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by the HIPAA Security and Privacy Rule.

c. Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware. For purposes of this Agreement, “security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health

Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to make available all records, books, agreements, policies and procedures related to the use and /o r disclosure of protected health information to the Secretary of HHS for purposes of determining Covered Entity's compliance with the Privacy Rule.

e. Covered Entity agrees:

   i. to obtain any patient consent or authorization that may be required by the Privacy rule or applicable state law prior to furnishing Vendor protected health information pertaining to an individual.
   ii. that it will not furnish Vendor protected health information that violates any restrictions on use and/or disclosure as provided for in 45 C.F.R. §164.522 and agreed to by Covered Entity:
   iii. to notify Vendor, in writing, of any protected health information in Vendor's possession that Covered Entity seeks to make available to a patient pursuant to 45 C.F.R. §164.524 and agree with Vendor as to the time, manner and form in which Vendor shall provide such access; and
   iv. to notify Vendor, in writing, of any amendment(s) to the protected health information in the possession of Vendor that Covered Entity believes are necessary because of its belief that the protected health information that is the subject of the amendment(s) has been or could be relied upon by Vendor or others to the detriment of the individual who is the subject of the protected health information.

III. AVAILABILITY OF PHI

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security and Privacy Rule. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164 .526 of the HIPAA Security and Privacy Rule. In addition, Business Associate agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by Section 16 4.5 28 of the HIPAA Security and Privacy Rule.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, either party shall have the right to terminate this Agreement and the Arrangement Agreement immediately if that party determines that the other party has violated any material term of this Agreement. Alternatively, either party may choose to provide the other with ten (I0) days written notice of the existence of an alleged material breached and afford the breaching party an opportunity to cure. Nonetheless, in the event a mutually agreeable terms cannot be achieved; the breaching party must cure said breach or the agreement shall be terminated. If either party reasonably believes that the other will violate a material term of this Agreement in the future, and where practicable, gives written notice to the other party of such belief, and the other party fails to provide adequate written assurances that it will not breach this agreement, then the party believing that a breach will occur shall have the right to terminate this agreement and the Arrangement Agreement as provided here in.

V. MISCELLANEOUS

a. Except as expressly stated herein or the HIPAA Security and Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents. Employees, contractors, successors, and assigns as set forth herein.

b. This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the state of ___________________. No change, waiver or discharge of any liability or obligation here under on any one or more occasions shall be

deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

c. The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associates use and disclosure of Protected Health Information.

d. In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a party believes in good faith that any provision of this Agreement fails to comply, with the then-current requirements of the HIPAA Security and Privacy Rule, such party shall notify the other party in writing. For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period. the Agreement fails to comply with the HIPAA Security and Privacy Rule, then either party has the right to terminate upon written notice to the other party.

e. The parties agree to negotiate in good faith mutually acceptable and appropriate amendment(s) to this Agreement to give effect to any amendment to any provision of HIPAA, or its implementing regulations set forth at 45 C.F.R. parts 160 through 16 4, or any new privacy or security requirements imposed under state or federal law, which materially alters either Party's or both Parties '·obligations under this Agreement; provided, however, that if the Parties are unable to agree on mutually acceptable amendment(s) within thirty (30) days of the relevant change of law, either party may terminate this Agreement consistent with section IV.

WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

Covered Entity

Name: ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Telephone: ______________________________
Facsimile: ______________________________
Email: ______________________________
By: ______________________________

Business Associate

Name: ______________________________
Address: ______________________________
City/State/Zip: ______________________________
Telephone: ______________________________
Facsimile: ______________________________
Email: ______________________________
By: ______________________________

CCM Coding and Billing Details

CCM Type	CPT Code	Time	Oversight/ Delivery of Care	Billing Limitations	Required Elements	Transitional Care Mgt	Approx. Reimbursement
Non-Complex	**99490**	At least **20** minutes	Directed by a physician or other qualified healthcare professional	**Once** per calendar month	Two or more chronic conditions expected to last at least 12 months or until death Patient at significant risk of death, acute exacerbation / decompensation, or functional decline Comprehensive care plan established, implemented, revised or monitored	Can bill directly	**$42.00**
	99439* (add on code for 99490)	Each additional **20** minutes	Directed by a physician or other qualified healthcare professional	**Up to twice** per calendar month			**$38.00**
	99491	At least **30** minutes	**Provided directly** by a physician or other qualified healthcare professional	**Once** per calendar month			**$84.00**
Complex	**99487**	At least **60** minutes	Directed by a physician or other qualified healthcare professional	**Once** per calendar month	Two or more chronic conditions expected to last at least 12 months or until death Patient at significant risk of death, acute exacerbation / decompensation, or functional decline Establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making	**Cannot** bill directly	**$92.00**
	99489 (add on code for 99487)	Each additional **30** minutes	Directed by a physician or other qualified healthcare professional	**Once** per calendar month			**$45.00**

*as of 1/1/21 99439 replaced G2058. For most current rates, refer to the National Physician Fee Schedule Tool here: https://www.cms.gov/medicare/physician-fee-schedule/search/license-agreement?destination=/medicare/physician-fee-schedule/search%3F

Participating CCM Patient Log Template

(Example of recommended tracking components. A similar log may be part of your existing EHR modules.)

Patient Name Clinician	Primary	Date Enrolled	Care Plan Reviewed Date	Date Terminated	Notes
i.e., John Doe	Dr. Brown	01/07/2021	01/07/2021	05/01/2021	

Considerations Prior to CCM Implementation

(These items should be considered with or without Pharmacy Partner Collaboration)

Collaborative Care

- Who will be on the Chronic Care Management (CCM) care team?
- Who will be accountable for establishing, implementing, revising, or monitoring patients' Comprehensive Care Plan?
- What will be the role of each team member?
- How will team members communicate?
- How frequently will team members communicate?
- Who are the key points of contact for the team?
- Who are the key points of contact for the patient?
- How will non-clinical staff support care delivery in all settings?
- How will you structure the business relationship between the Qualified Health Provider (QHP) and clinical staff (e.g., leased, contracted, employed)?
- Will you create a collaborative practice agreement (required in some states) to facilitate efficiencies in care delivery?

EHR and Communication

- Is the QHP compliant with CCM's EHR requirements?
- How will CCM services be documented by the QHP to ensure all necessary information is available if audited?

Patient Enrollment and Consent

- Which patients will the care team target for CCM services?
  - Eligibility Requirements: Two or more chronic conditions expected to last at least 12 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.
  - Must have be seen within the past 12 months. Or schedule a required face-to-face office visit or Annual Wellness Visit (AWV.)
  - For trial, dually eligible Medicare/Medicaid beneficiaries with diabetes will almost always have a secondary eligible chronic condition and Medicare primary/Medicaid secondary.
- How do you obtain consent from the patient to participate?
- What is the process that will be used by each member of the care team after the patient gives consent (e.g., first person to contact the patient, routine questions to ask, process of care)?

Billing

- A minimum of 20 minutes of CCM services are required each month (see **Appendix H** for details).
- How will you ensure CCM is not billed in the same month as other CPT codes that are precluded from being billed concurrently with CCM’s 99490?
- How will all members of the care team ensure duplicate services are not being provided in the same month or that services are not being counted toward multiple CPT codes (e.g., for E/M visit and CCM)?

Miscellaneous

- Although a copay exists for Medicare beneficiaries, if they are dually eligible, the copayment will be covered by Medicaid.
- Patients not seen within one year of starting CCM must initiate a face-to-face visit with the billing provider another opportunity for billing additional CPT codes. PHE telehealth exceptions exist temporarily.
- Consider offering CCM enrollment during Medicare Annual Wellness Visits.
- CCM can be done in-house at practice, via partnership with pharmacist or pharmacy school or outsourced to a third party.

Supplemental CCM Resources

Connecting to Chronic Care Management Services Partner Webinar	Hosted by CMS Office of Minority Health and the Federal Office of Rural Health Policy (FORHP) this webinar provides information on the benefits of chronic care management services and the Connected Care campaign. (52 minutes)
Connected Care: Physician Testimonial about Chronic Care Management	This video features a physician sharing her experience with offering Chronic Care Management (CCM) services to her Medicare patients in a rural North Carolina community. (2 minutes)
Care Management Services in RHCs and FQHCs - FAQs	FAQ document from CMS outlining care management services billing, claims processing, payment, and program requirements for RHCs and FQHCs.
Chronic Care Management (CCM): An Overview for Pharmacists	This overview provides a summary of how pharmacists can form collaborative and contractual partnerships with qualified healthcare professionals (QHPs) to provide CCM services that are within their scope of practice.
CCM Patient Video: Connecting the Dots	This animated video provides chronic care management (CCM) services information for Medicare beneficiaries living with multiple chronic conditions. (30 seconds)
Chronic Care Management Toolkit	This toolkit developed by the American College of Physicians provides a summary of what practices need to do to implement and bill CCM codes.
Chronic Care Management Services	This booklet from CMS provides background on payable CCM service codes, identifies eligible practitioners and patients, and details the Medicare PFS billing requirements.
Patient Postcard English & Spanish	Informational postcard for patients about Connected Care, encouraging beneficiaries with chronic conditions to ask their doctor about CCM services.
Healthcare Provider Postcard	Informational postcard for healthcare providers about Connected Care and the benefits of CCM services.
Partnership in Chronic Care Management	Informational poster demonstrating the benefits and outcomes of a successful partnership in delivering Chronic Care Management services.

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