



HCCITM
HOME CENTERED CARE
INSTITUTE

Monitoring, Evaluating, and Measuring Success in CCM Implementation

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Agenda

1. Opening Discussion & CCM Program Recap
2. Monitoring CCM Program Performance & Why it Matters
3. Patient Engagement & Satisfaction
4. Team Roles & Responsibilities
5. Quality Improvement Cycles & Common Challenges
6. Tools for Staff Education & Implementation
7. Case Study
8. Q&A | Next Steps

Objectives

- Identify Quality Improvement (QI) metrics aligned with CMS goals.
- Outline roles and responsibilities of care team members involved in CCM delivery.
- Identify challenges of CCM implementation.
- Demonstrate how to document and bill for CCM services accurately under CMS guidelines.



Opening Discussion

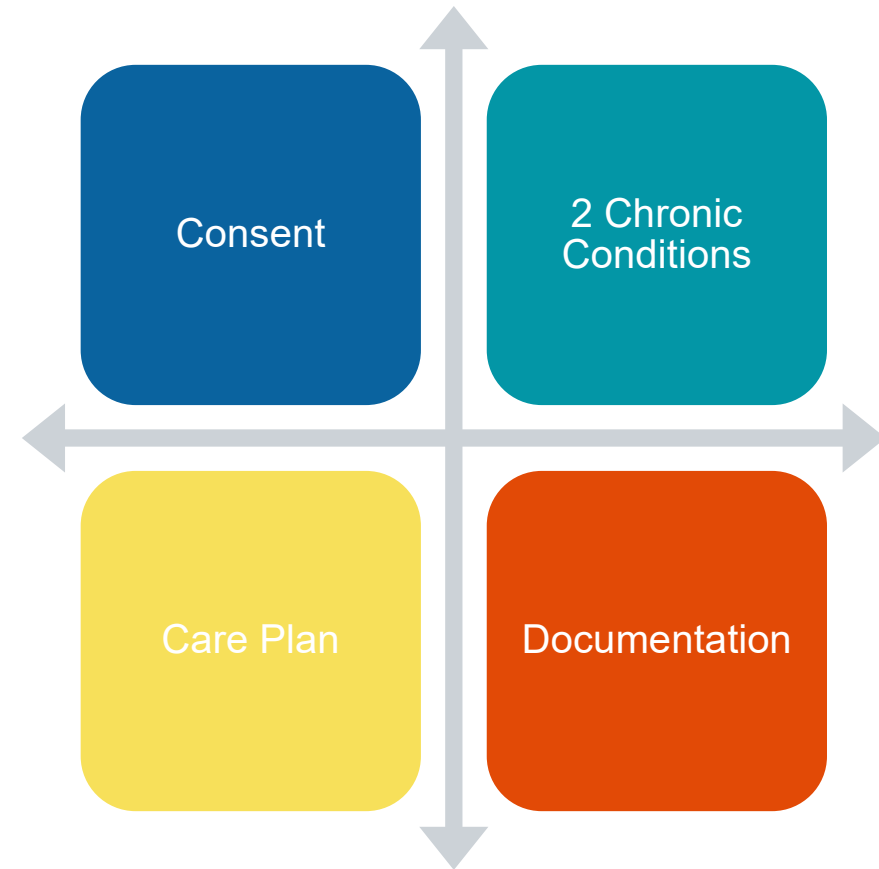
Imagine your CCM program has been fully implemented and running smoothly for a year.

How would you define success in this context? What specific outcomes, experiences, or transformations would indicate that your program is truly making a meaningful impact for patients, providers, and your organization?

CCM Program Recap

Requirements

1. Consent (explain possible copay)
2. Active Patient with 2 or more chronic conditions
3. Care Plan (separate from other visit notes) & available to patient
4. Documented minutes for non F2F care related to chronic conditions cumulating over 20 minutes/calendar month



CCM Coding and Reimbursement

CPT Code	2025 CMS National Non-Facility Payment	Description
99490	\$61.49	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
99439	\$45.93	Add-on code, can only be billed in conjunction with traditional CCM (99490). CCM each additional 20 minutes of clinical staff time directed by a provider per calendar month.
99491	\$82.16	Provider CCM, 30 minutes per calendar month by the billing provider
99437 (add on for 99491)	\$57.58	Provider CCM Add-on Code: Each additional 30 minutes of CCM time personally spent by the billing practitioner.
99487	\$131.65	Complex chronic care management services, at least 60 minutes of clinical staff time as directed by a physician or qualified health care professional per calendar month.
99489 (add on for 99487)	\$70.52	Complex CCM Add-on Code; Each additional 30 minutes of clinical staff time as directed by the physician or other qualified health care professional
G0506 CCM Initiating Visit	\$60.81	Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services. Billed separately from monthly care management services. * This is only used for new patients or patients not seen within the past 12 months that require an initiating visit to enroll in CCM services

Examples of Billable Activities

1. Medication Review
2. Patient/Caregiver Education
3. Coordination with Specialists
4. Care Plan Updates

Documentation Example

This provider spent 16 minutes reviewing blood sugar log with patient, discussing appropriate testing times and techniques, discussing dietary restrictions and suggestions related to E11.22 DM with CKD. Patient and caregiver were present and expressed improved understanding following education.

Monitoring CCM Program Performance

Quality Improvement (QI) Metrics aligned with CMS Goals:

- Hospitalization & ER Visit rates
- Medication Adherence
- Functional Status scores (ADL, iADL)
- Patient Reported Outcomes, QoL
- Emergency Department visits (ED)
- Control of chronic disease indicators: A1C, BP, LDL, etc.
- Financial Metrics: CCM revenue, cost savings
- Compliance: documentation completeness

Pro-tip: Develop a dashboard for internal review and revisit regularly

Why Evaluate Key Metrics?

Hospitalizations & ER Visits

- Indicator of poor chronic disease control
- Costly and preventable in many cases
- Goal: reduce avoidable utilization

Medication Adherence

- Tied to disease progression, avoidable complications
- Identify barriers: cost, understanding, access

Functional Status

- Loss of function predicts hospitalization, mortality
- Track via validated tools (e.g., Katz Index, PROMIS)

Quality of Life:

- Essential in palliative care
- PROM tools: PHQ-9, Edmonton Symptom Assessment, EQ-5D

Compliance

- Audit readiness (chart audit pass rates)

Financial

- Return on investment (ROI) for the program

Patient Engagement & Satisfaction

Improved Access to Care

- Patients appreciate having a care manager or clinical team member they can contact between visits.

Better Coordination

- Patients often feel less overwhelmed when their providers are communicating and working together.
- Fewer duplicated services and errors in medication or follow-ups improve trust.

Timely Interventions

- Issues are caught early (before an ER visit or hospitalization is needed), which boosts satisfaction and reduces fear.

Personalized Care Plans

- Patients appreciate a plan tailored to their unique health needs and preferences

HCCI Resource Reference:
[Patient Caregiver Satisfaction Survey Form](#)

Team Roles & Responsibilities



RN/LPN/MA: Care coordination, education, follow-up



NP/MD: Clinical oversight, care plan updates, initial visit



Billing Staff: Time log review, claim submission



Admin Support: Consent forms, tracking participation

Quality Improvement Cycles



PDSA cycles: Plan – Do – Study – Act



Collect, analyze, and act on data monthly or quarterly

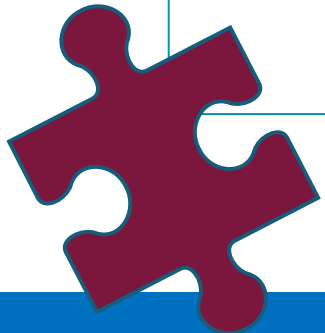


EXAMPLE: High ER use → root cause analysis → pharmacist-led med review → track outcome

Challenges & Solutions



Challenge		Solution	
Staff resistance to new documentation	→	Provide time-saving templates, reinforce ROI	
Patient confusion about CCM	→	Simplified handouts, consent discussions	
Tracking time	→	Real-time logs in EHR, mobile apps	
Limited patient adherence	→	“Check-in” calls, handouts, NP/PA explaining services in detail on initial visit	
Lack of real-time analytics	→	Interdisciplinary team approach-communication regarding hospitalizations, missed visits, etc.	



Tools for Staff Education & Implementation

Staff Training Topics

CCM eligibility criteria

Time tracking & billing compliance

Motivational interviewing

Recognizing clinical deterioration

Reimbursement complexity (CTP codes & CMS requirements)

Tools for Implementation

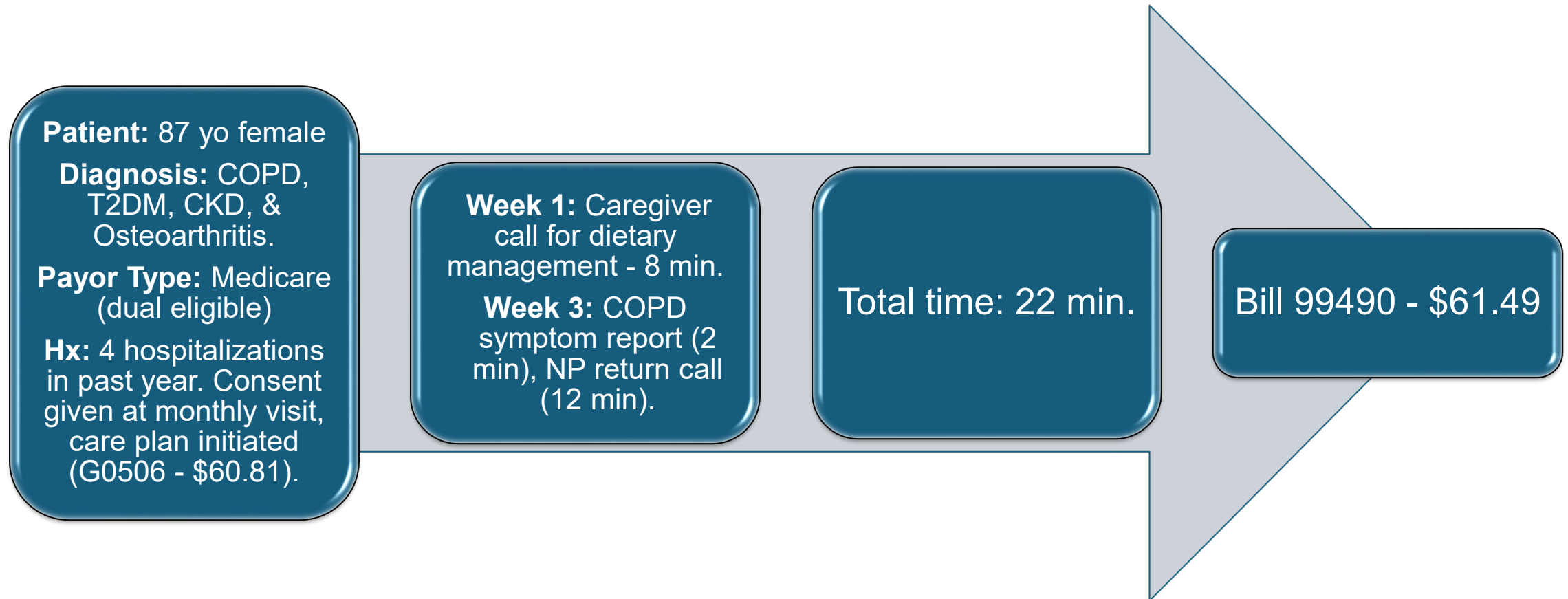
Charting quick phrases

Sample documentation templates

EHR alerts or ticklers for monthly touchpoints

Recorded meeting/PPT on CCM distributed to CCM team

Case Study: CCM Billing



Case Study: Operational Efficiency

- A large medical group implemented CCM utilizing EMR CCM template with current staff.
- Workflows were adjusted to account for CCM minutes and CCM team lead identified.
- Despite not hiring extra staff, they achieved better patient engagement and reduced ER visits.
- The practice saw improved A1C levels among diabetic patients and fewer hospital readmissions.

CCM Calculator

Discover your practice's potential for financial sustainability and practice growth with the HCCI Chronic Care Management (CCM) Calculator



CCM Revenue Calculator

Total number of PCPs in practice:	5
Patients per PCP (Typically 250):	150
% with two or more chronic conditions (Typically 90%):	90
% covered by Medicare (Typically 90%):	90
% patients billed 20+ minutes rate:	80
% patients billed 40+ minutes rate:	15
% patients billed 60+ minutes rate:	20
Administrative Time Cost (%):	20
20+ minutes rate (Medicare average) (CPT 99490):	\$64.02
40+ minutes rate (Medicare average) (CPT 99490+99439):	\$112.47
60+ minutes rate (Medicare average) (CPT 99490+99439+99439):	\$160.92
Total number of monthly hours of full-time clinical staff:	160

Results

Total Monthly CCM Revenue Potential:	\$60,914.33
Total Monthly Staff Time:	2.58 FTE

Questions or Comments?

How Did We Do?

Scan QR Code to complete a short evaluation.



Takes 1–2 minutes

Thank you for your time and insights!

Innovation Award: Webinar #4

Exploring Service Solutions in Managing Complex Illness for Palliative Care

Tuesday, October 21, 2025
10 – 11AM CST

Enrolled

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Elea Innovation Award: Webinar Series

After the completion of each module, please join HCCI subject matter experts for a 90-minute webinar to discuss any questions you may have regarding the course material. See below for a link to register for each webinar.

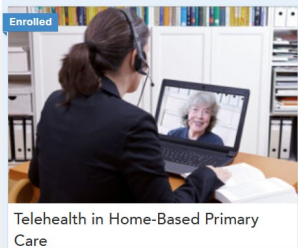
LAUNCH COURSE

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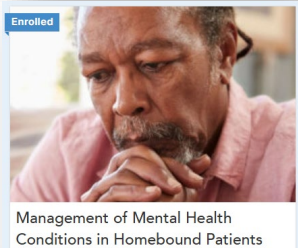
[REGISTER HERE](#)

Additional Resources

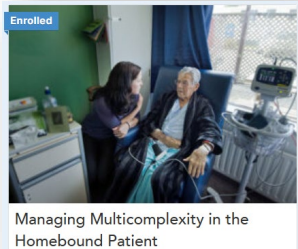
Course Offerings



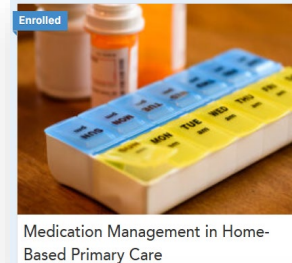
Telehealth in Home-Based Primary Care



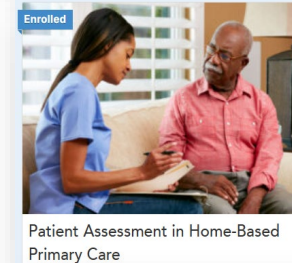
Management of Mental Health Conditions in Homebound Patients



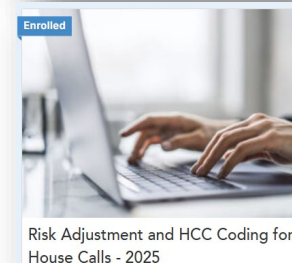
Managing Multicomplexity in the Homebound Patient



Medication Management in Home-Based Primary Care



Patient Assessment in Home-Based Primary Care



Risk Adjustment and HCC Coding for House Calls

Additional Resources (cont'd)

[Remote Patient Monitoring](#)

[Risk Adjustment Factors \(RAF\) for House Calls: Hierarchical Condition Categories \(HCC\) Coding Guide](#)

[Social Determinants of Health \(SDoH\) Screening and Coding Requirements](#)

[HBPC: An Essential Lifeline for Caregivers](#)

[HBPC: A Powerful Solution for Home-Limited, Medically Complex Patients](#)

[Patient Caregiver Satisfaction Survey Form](#)

[CCM Toolkit](#)

[Media Toolkit & Marketing Toolkit](#)

[HCCI Learning Hub™](#)



Next Steps

- ☐ Attend Monthly Consult Meeting
- ☐ Review New Resources
- ☐ Attend Webinar #3 – October 21, 2025 from 10-11AM