



Coverage to Care Partner Webinar

February 6, 2024



Accessibility

Closed Captions

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ASL Interpretation

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Medicaid and CHIP Renewals



Medicaid and CHIP Renewals

Following the COVID-19 PHE states will redetermine eligibility for each person covered by Medicaid or CHIP within 12 months and then complete renewals within 14 months, between **April 1, 2023**, and **July 31, 2024**.



Visit your state's [Medicaid website](#) to learn more!

Coverage to Care (C2C) Overview



What is C2C?

C2C aims to help individuals understand their health coverage and connect to primary care and the preventive services that are right for them, so they can live a long and healthy life.



How to Use C2C Resources

Using C2C Resources

- 1 Start the Conversation.** Use the *Roadmap to Better Care* as a tool to help people understand their new coverage and understand the importance of getting the right preventive services.
- 2 Help Consumers Understand.** The *Roadmap to Better Care* has a lot of information for consumers. You can help them use it as a resource to refer to as they journey to better health and well-being.
- 3 Personalize It.** You know your community. Consider adding local resources and information.



Who in your community is using C2C resources?

- Congressional Offices
- Voter Rights Organizations
- Legal Aid Societies
- Colleges and Universities
- United Way
- State Health Insurance Assistance Program Counselors
- Primary Care Associations
- Dialysis Facilities
- Ryan White Providers
- Libraries
- Justice System
- Community Health Centers
- Hospitals
- Insurance Companies
- State and County Health Departments
- Area Agencies on Aging
- Tribal Organizations
- Assistors and Brokers
- Faith-Based Organizations

C2C Resource Updates



New Community Connections Tour Video



<https://www.youtube.com/watch?v=TwTclvKAdD8&t=12s>

Prescription Resource

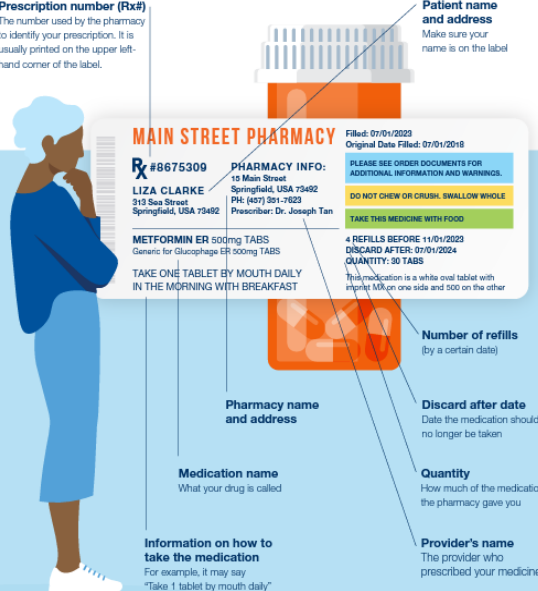


TIPS FOR UNDERSTANDING YOUR DRUG COVERAGE & PRESCRIPTIONS





READ YOUR PRESCRIPTION LABELS CLOSELY.

Your prescription label has information from your provider and pharmacy about safely taking your medication. The label will include:



- Prescription number (Rx#)**
The number used by the pharmacy to identify your prescription. It is usually printed on the upper left-hand corner of the label.
- Patient name and address**
Make sure your name is on the label.
- Pharmacy name and address**
- Medication name**
What your drug is called.
- Information on how to take the medication**
For example, it may say "Take 1 tablet by mouth daily."
- Number of refills**
(by a certain date)
- Discard after date**
Date the medication should no longer be taken.
- Quantity**
How much of the medication the pharmacy gave you.
- Provider's name**
The provider who prescribed your medicine.



Chronic Care Management (CCM) Resources




WHAT IS CHRONIC CARE MANAGEMENT?




If you have Medicare or are dually eligible (Medicare and Medicaid) and live with two or more chronic conditions that worsen your quality of life and put your health at risk, chronic care management (CCM) services can help connect the dots so you can spend more time doing what you love. Examples of these chronic conditions include—but are not limited to—arthritis, cancer, depression, diabetes, and high blood pressure. Services may include:

-  **At least 20 minutes a month** of care coordination from a health care professional outside of in-person office visits, such as phone check-ins and access to a secure electronic patient portal
-  **Personalized assistance** from a dedicated health care professional who will work with you to create your care plan
-  **Coordination of care** between your pharmacy, specialists, testing centers, hospitals, and more
-  **24/7 emergency access** to a qualified health care professional and expert assistance with setting and meeting your health goals


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CCM Factsheet




CHRONIC CARE MANAGEMENT PROVIDER(S) CHECKLIST




-  **Identify patient eligibility for CCM services.**
 - Eligible CCM patients will **have multiple (2 or more) chronic conditions expected to last at least 12 months** or until the patient's death.
 - Identify patients who require CCM services by **using criteria suggested in CPT guidance** (like number of illnesses, number of medications, repeat admissions, or emergency department visits) or the **typical patient profile in the CPT prefatory language.**
-  **Initiate a face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) as an initiating visit** for new patients or patients who the billing practitioner hasn't seen within 1 year before CCM services start.
 - Assess the patient's medical, functional, and psychosocial needs.
 - Make sure the patient receives timely recommended preventive services.
 - Oversee the patient's medication self-management.
-  **Provide informed consent and inform patient(s) that:**
 - CCM services are available.
 - They may have cost sharing responsibilities.
 - Only one practitioner can furnish and bill CCM services during a calendar month.
 - They can stop the CCM services at any time (effective the end of calendar month).


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CCM Checklist




WHAT IS CHRONIC CARE MANAGEMENT (CCM)?




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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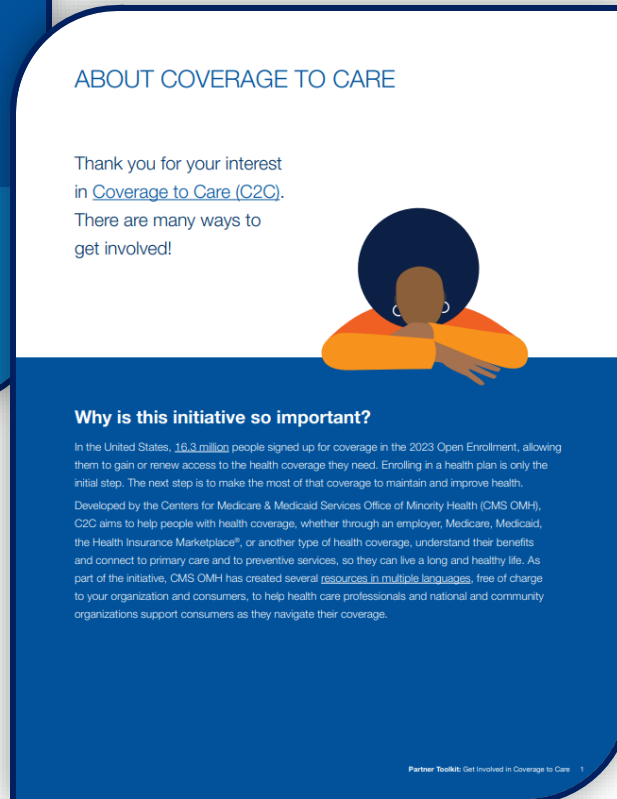


CCM At-A-Glance Checklist

Partnering with C2C



Partner Toolkit



- High-level document offering prospective and current partners information on how to share C2C materials
- Includes:
 - Significance of the C2C initiative
 - How to collaborate
 - Downloadable and printable resources
 - How to plan a C2C-based event
 - Guide on how to draft written content
- English and Spanish content
- [Partner Toolkit PDF](#)

Partner Toolkit (continued)

WAYS TO COLLABORATE



Become a Partner

Your support is vital to help new enrollees and other patients make the most of their coverage and access preventive services to support their health goals. Getting involved is simple. If you have any questions, email us at coveragetocare@cms.hhs.gov.



Share the Tools

Whether you represent an organization or are an individual community advocate, you can be part of the important effort to improve the health of our nation. We encourage you to share C2C resources in churches, clinics, health systems, and your community settings.



Download and Share C2C Resources

5 Ways to Make the Most of Your Health Coverage – English (PDF)

This checklist is a quick reference on how to make the most of your health coverage.

- [Spanish/Español \(PDF\)](#)

Partner Toolkit: Get Involved in Coverage to Care 2

Download and Share C2C Resources

Roadmap to Better Care – English (PDF)

This roadmap explains what health coverage is, and how to use it to get the primary care and preventive services to help you and your family live long, healthy lives.

- [Arabic / العربية \(PDF\)](#)
- [Chinese / 中文 \(PDF\)](#)
- [Haitian Creole / Kreyòl Ayisyen \(PDF\)](#)
- [Korean / 한국어 \(PDF\)](#)
- [Russian / Русский \(PDF\)](#)
- [Spanish / Español \(PDF\)](#)
- [Tribal Version \(PDF\)](#)
- [Ukrainian / Українська \(PDF\)](#)
- [Vietnamese / Tiếng Việt \(PDF\)](#)



Enrollment Toolkit – English (PDF)

This is a tool to help consumers choose the health plan that's right for them.

- [Spanish/Español \(PDF\)](#)



Telehealth for Providers: What You Need to Know (PDF)

Help providers learn how and when to use telehealth, including how to set up telehealth services, how to conduct a successful visit, and how to keep up to date on telehealth payment (particularly for Medicare and Medicaid).



Partner Toolkit: Get Involved in Coverage to Care 3

Use the Partner Toolkit

- Ideas on how to get involved: C2C-based events to host in your community, sample text to use in a blog, newsletter, social media posts and graphics, and a web badge
- Available in English and Spanish

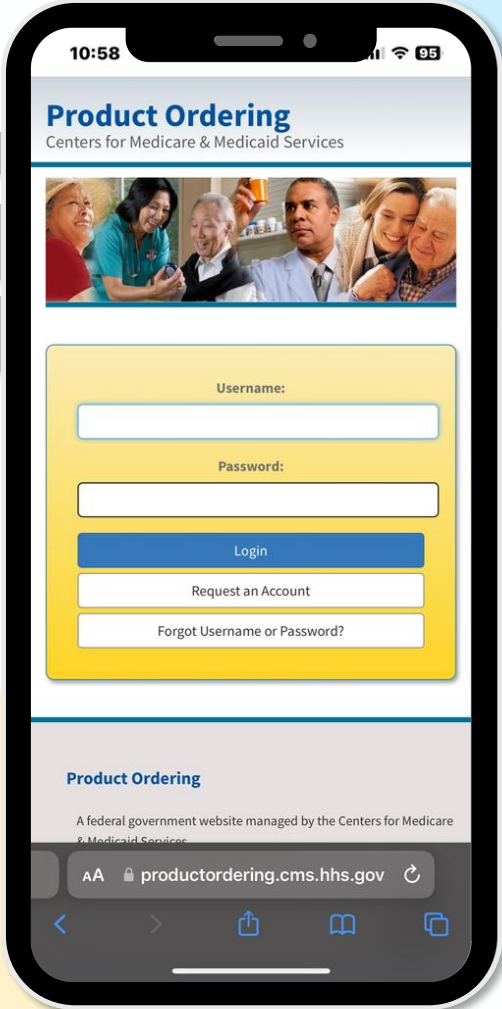
Use the C2C Community Presentation

- Overview of the *Roadmap to Better Care* with all eight steps, including slides, script, and a handout
- Available in English and Spanish

Order and share C2C resources at no cost to your organization.

Send stories to coveragetocare@cms.hhs.gov.

Order From Coverage to Care Materials



Visit productordering.cms.hhs.gov

Partner Presentation



PathStone Corporation

PathStone Corporation is a non-profit community development and human services organization. Dedicated to eliminating poverty and strengthening families since 1969. Primarily serves low-income families and economically distressed communities in multiple states.

PathStone Management Corporation is an affiliate of PathStone Corporation and a leader in affordable housing, an equal housing opportunity provider. We manage 2,400 homes within New York State.

Resident Services is a department under PathStone Management. This department is dedicated to assisting over 1000 residents by providing various tools, resources, and programs. The services offered by Resident Services include health insurance assistance, lease support, financial guidance, health fairs, social/educational events, community gardens, and referrals. As part of PathStone Management, Resident Services plays a crucial role in supporting and enhancing the overall well-being and quality of life for the residents.



HEALTH DISPARITIES



- **Access to Healthcare:** Limited access to quality healthcare and barriers to insurance coverage.
- **Chronic Diseases:** Higher prevalence of diseases (e.g., diabetes, hypertension) and increased risk factors like obesity and poor nutrition.
- **Mental Health:** Elevated rates of depression and anxiety, along with limited access to mental health services.
- **Social & Economic Determinants of Health:** Disparities in social and economic factors contribute to health inequalities, addressing environmental justice issues.
- **Health Literacy:** Varied levels impacting the understanding of healthcare information. Overcoming language barriers for improved communication and comprehension.



Partnership



Positive Impact

- ✓ Residents empowered with information
- ✓ Workshop materials incorporated into monthly newsletters.
- ✓ Distribution to homes for those unable to attend events.

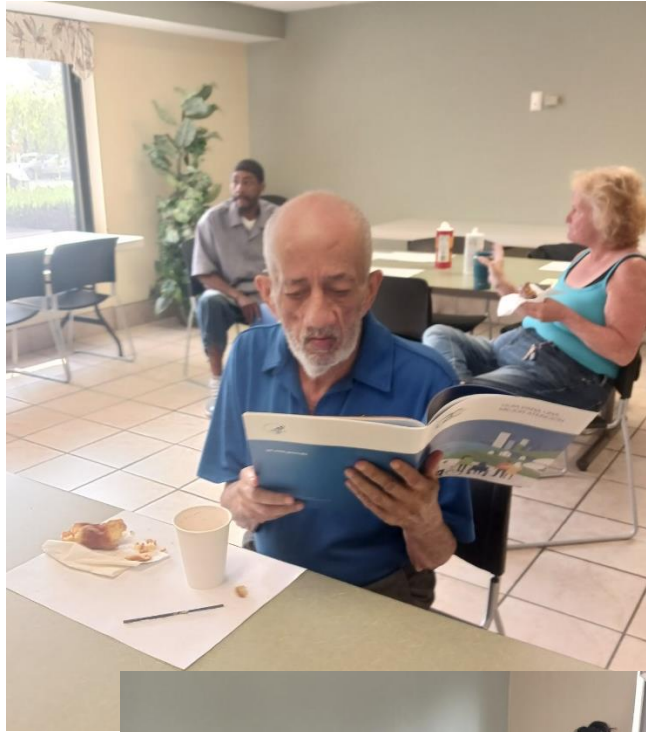
Resident Services & CMS OMH Coverage to Care

- Collaborative efforts with Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH).
- Clear and accessible C2C materials in multiple languages.

Integrated C2C Workshops

- Coffee Hours
- Birthday Parties
- Health Fairs

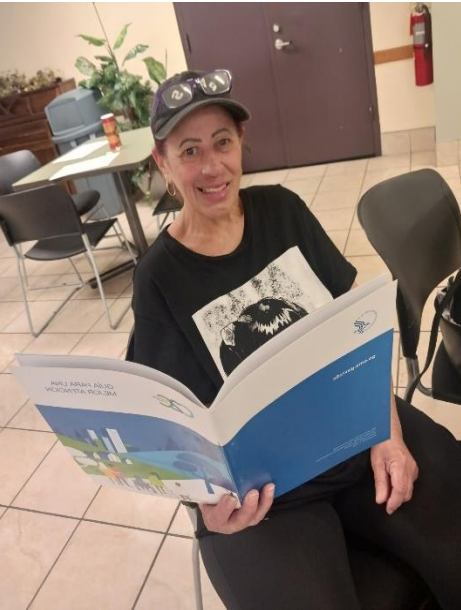




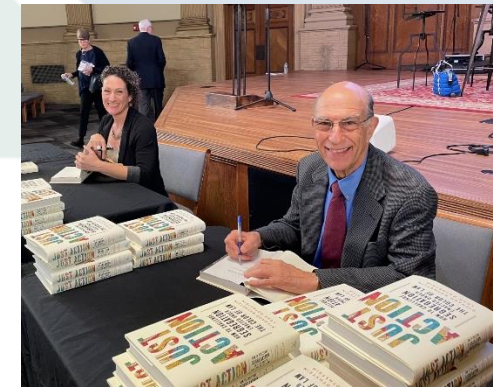
Incorporating C2C Workshops



Resident Services Events



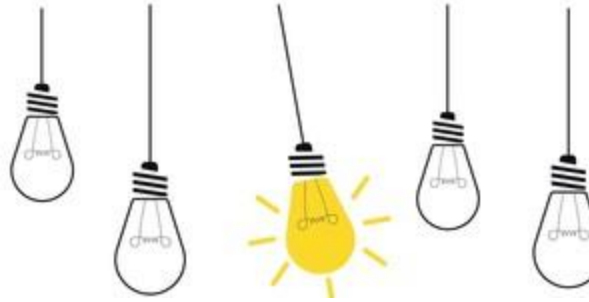
PathStone Presents Provok!ng Thought



- ❖ Opportunity for community builders to engage with thought leaders.
- ❖ Focus on racial segregation's impact and strategies for redress.
- ❖ 2023 Keynote speakers: Richard Rothstein and Leah Rothstein.

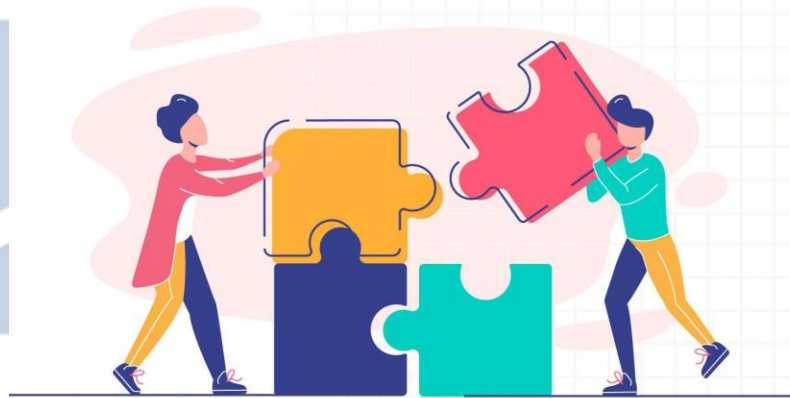


C2C's Community Impact



- Over 70 residents engaged.
- Positive feedback and questions about healthcare scenarios.
- Distribution of materials to homes and events.
- Outreach through 700 newsletters.
- Commitment to empowering residents for confident healthcare decisions.

PathStone's Commitment



- Continuing efforts to eliminate poverty and strengthen communities
- Empowering residents with knowledge and resources
- Grateful for community engagement and positive impact



Questions?





THANK YOU

Visit our website:

go.cms.gov/c2c

Contact us:

CoverageToCare@cms.hhs.gov

OMH@cms.hhs.gov

C2C Listserv:

<http://bit.ly/CMSOMH>