NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Elevate *Learning Forum*

Care Management

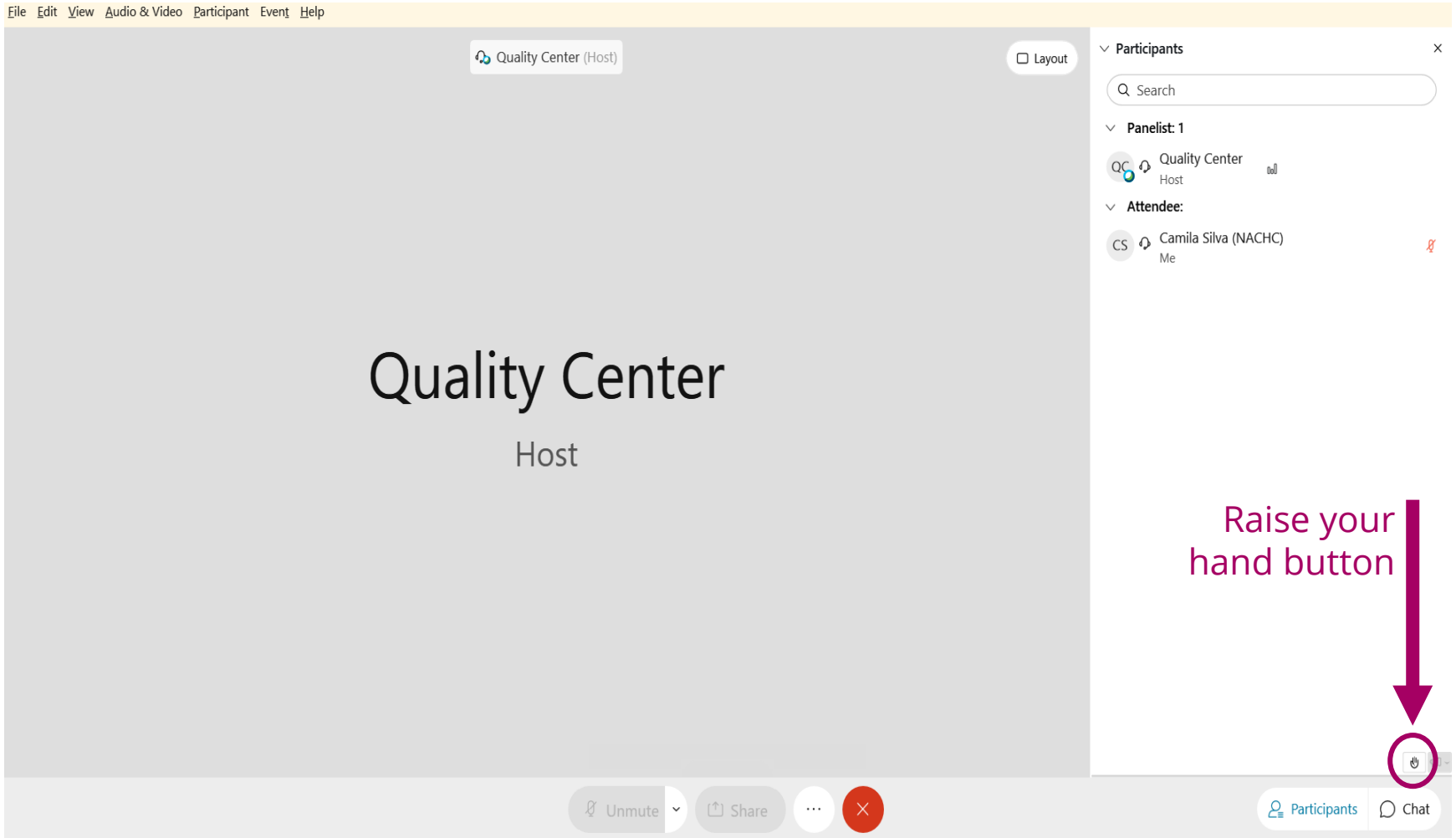
May 10, 2022

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®



Chat: When using the chat, please send the message to "Everyone"

During today's session:

- **Questions:** Send to the chat as you have them; there will be a Q&A and discussion at the end.
- **Resources:** If there is a topic where you have a tool/resource to share, let us know in the chat!

Packaging and implementing evidence-based transformational strategies for safety-net providers

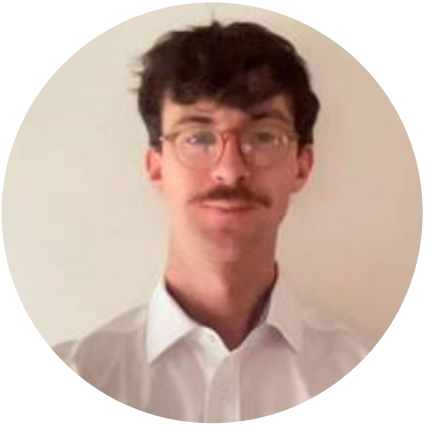
Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

Deputy Director,
Quality Center



Addison Gwinner

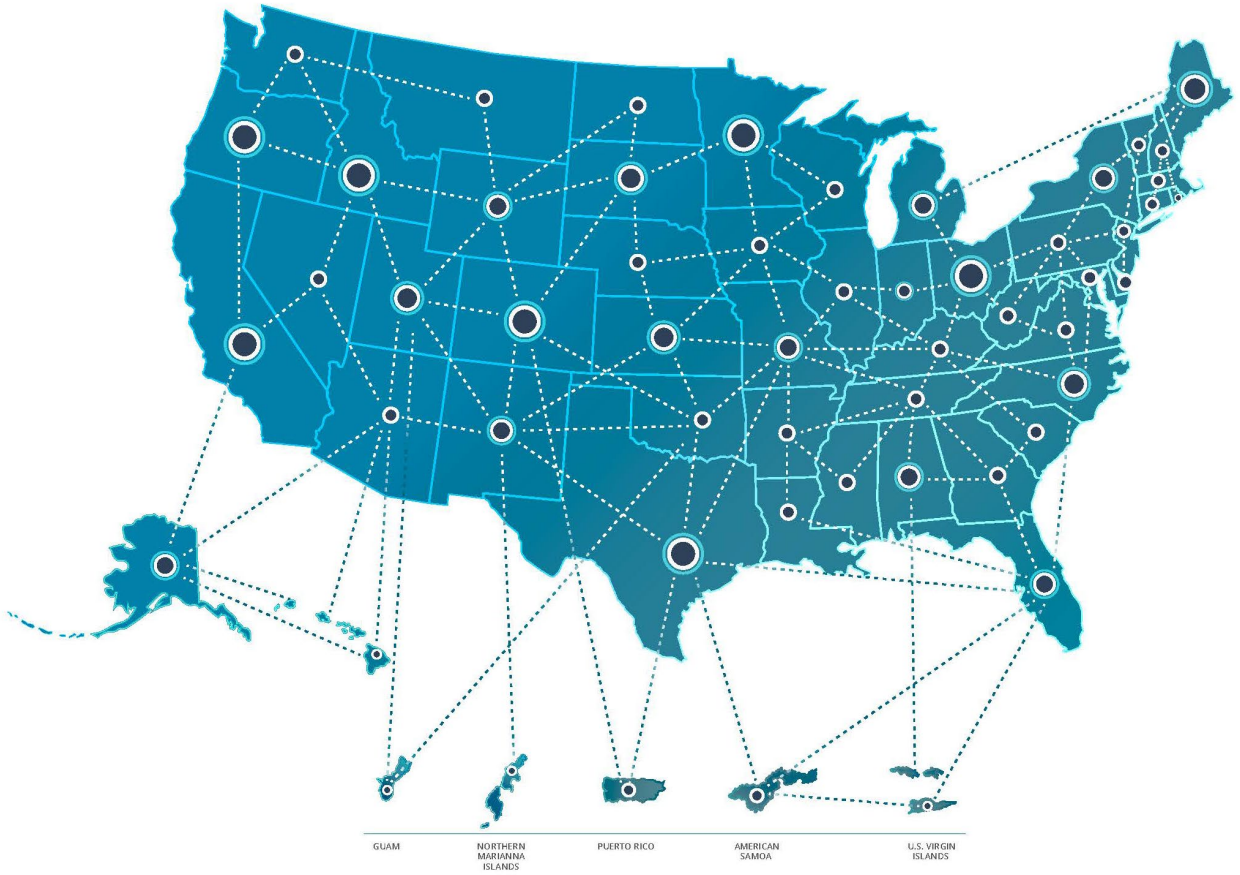
Specialist,
Quality Center

Joining Today's Call

Kristie Bennardi
Chief Executive Officer
& Chief Financial Officer
Keystone Rural Health Consortia

Lisa Messina
Messina Consulting, MPH, CPC

Our Community: ELEVATE 2022



All
States & Territories

600+
Health Centers

70+
PCAs/HCCNs/NTTAPs

35+
CDC Grantees

6,000+
Peers

Millions
Patients

2022 Featured Health Centers

Su Clínica

ESPERANZA health centers

Charles B. Wang Community Health Center
王嘉廉社區醫療中心

evara HEALTH

PARK DUVALLE COMMUNITY HEALTH CENTER

Mountain People's Health Councils Inc.

NEW HEALTH
North End • Charlestown

Fish River Rural Health

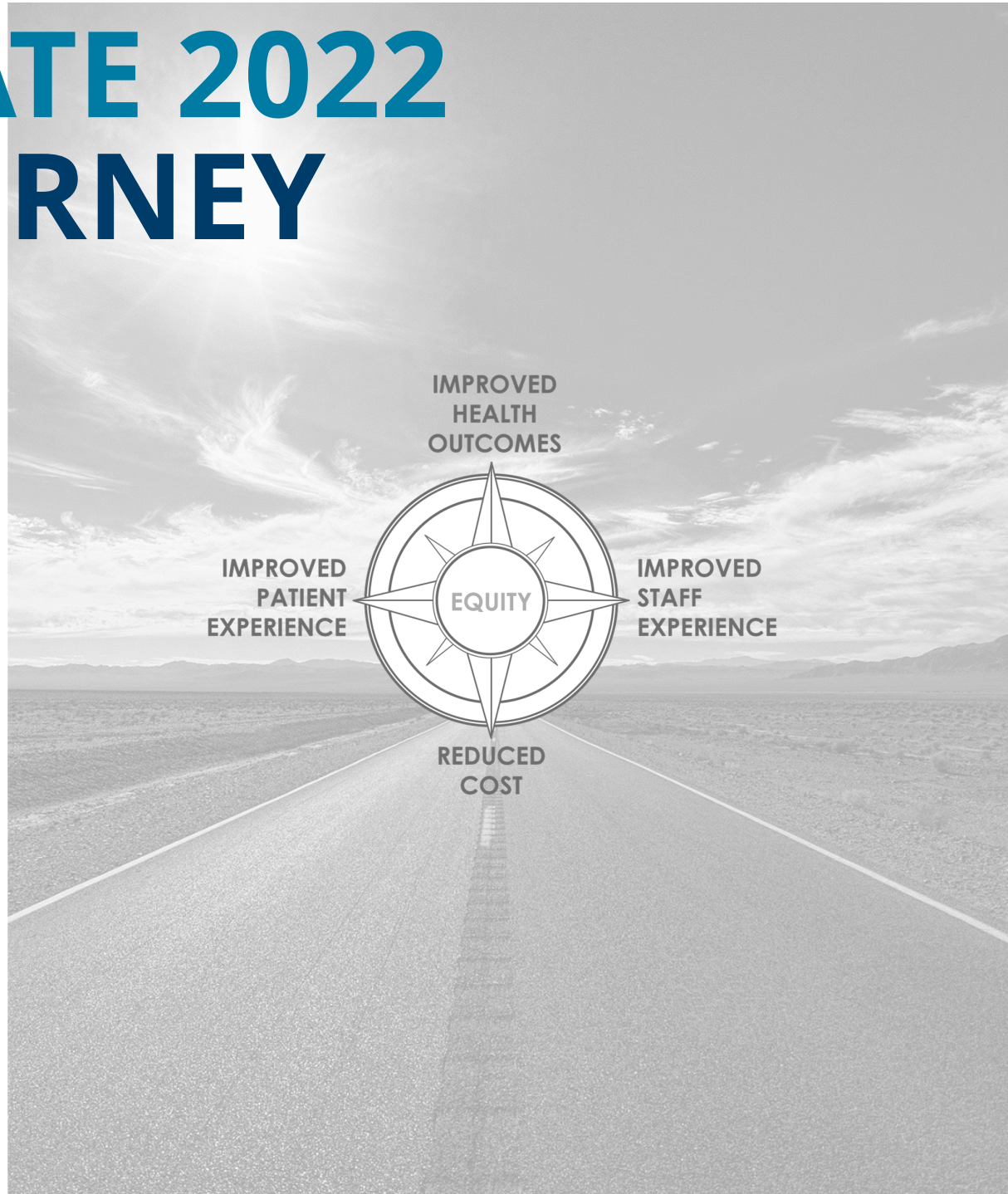
Keystone Rural Health Consortia, Inc.
One Team Working Together For Better Community Health Care

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

In the top 20 health centers nationally when looking at composite performance across measures for prevention and/or control of six high-cost, high burden conditions (2019 UDS): colorectal cancer, cervical cancer, HTN, diabetes, depression, & obesity

ELEVATE 2022 JOURNEY

- Leadership
- Empanelment
- Population Health: Risk Stratification
- Payment
- Care Teams
- Care Management
- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home



Today's Learning Forum

- ✓ Leadership
- ✓ Empanelment
- ✓ Population Health: Risk Stratification
- ✓ Payment
- ✓ Care Teams
- **Care Management**
- Evidence-Based Care
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home

Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

Centers for Medicaid and Medicare Services (CMS) Care Management Services

NATIONAL ASSOCIATION OF Community Health Centers®

May 10, 2022

CMS Care Management Services

What?

Why?

How?

WHAT are CMS Care Management Services?

WHY use CMS Care Management Requirements to Guide Care Management Model?

HOW to provide Care Management Services?

- **STEP 1** Identify or Hire a Care Manager
- **STEP 2** Identify High-Risk Patients
- **STEP 3** Define Care Manager – Care Team Interface
- **STEP 4** Define the Services Provided as Part of Care Management
- **STEP 5** Enroll Patients in Care Management
- **STEP 6** Create Individualized Care Plans
- **STEP 7** Enhance and Expand Partnerships
- **STEP 8** Document and Bill for Chronic Care Management
- **STEP 9** Graduate Patients from Care Management
- **STEP 10** Measure Outcomes

NACHC Care Management Action Guide

Care Management

WHAT?

WHY?

HOW?

WHAT
are CMS* Care Management services?

Intensive, one-on-one services, provided by one or multiple members of the care team, to individuals with often complex health and social needs.

Key components of care management may include:

- Identifying and engaging high-risk individuals
- Providing a comprehensive assessment
- Creating an individual care plan
- Engaging in patient education
- Monitoring clinical conditions
- Coordinating needed services

*Centers for Medicare and Medicaid Services (CMS)

Medicare Care Management Programs

Patient Eligibility

CCM

Chronic Care Management

Multiple **(two or more) chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

CCCM

Complex Chronic Care Management

Multiple **(two or more) complex chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. **Complex CCM patient is at a moderate or high MDM.**

PCM

Principal Care Management

A qualifying condition that is expected to last at least 3 months and places the patient at **significant risk of hospitalization**, acute exacerbation/ decompensation, functional decline or death.
PCM patient is at a moderate or high MDM.

BHI

Behavioral Health Integration

Integrated behavioral health and primary care services that does not require, but may use, services of psychiatric consultation or designated behavioral health manager.

CoCM

Psychiatric Collaborative Care Model

Integrated behavioral health and primary care services but with two additional service components beyond general BHI: **a dedicated care manager and psychiatric consult**.

VCS*

Virtual Communication Services

Communications-based technology or remote evaluation services (e.g., telephone audio/video, store & forward, secure text messaging, email, portal), including online digital evaluation and management, by a provider within 24 hours of a request by an established patient for conditions not related to a visit within the past seven (7) days and that does not result in an appointment in the next 24 hours or next available appointment.

*VCS is not a care management service but can billed in the same month as care management services as long as the requirements of both are met.

Authorized Provider/Staff

See Reimbursement Tips for additional details.

CCM

Chronic Care Management

Staff directed by a qualified health professional (QHP): MD, DO, NP, PA, & CNM.

CCCM

Complex Chronic Care Management

Staff directed by a QHP: MD, DO, NP, PA, & CNM.

PCM

Principal Care Management

Staff directed by a QHP: MD, DO, NP, PA, & CNM.

BHI

Behavioral Health Integration

QHP or clinical staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM.

Other services by the care management team are permitted under general supervision (under billing practitioner direction and control but physical presence not required).

CoCM

Psychiatric Collaborative Care Model

QHP or staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM.

Other services by the care management team are permitted under general supervision (under billing practitioner direction and control but physical presence not required).

VCS

Virtual Communication Services

Must be performed personally by a qualified FQHC practitioner: MD, DO, NP, PA, CP, CNM, CSW.

Timeframe and Services

See Reimbursement Tips for additional details.

CCM

Chronic Care Management

Non-complex CCM:
Minimum of **20** minutes.
20-minute add-ons up to 60 mins.

Provider only:
Minimum of 30 mins provided personally by a physician or qualified health professional.
New in 2022: 30 minute add-ons.

CCCM

Complex Chronic Care Management

Complex CCM:
Minimum of **60** minutes.
30-minute add-ons.

No provider only codes: If a physician or QHP furnishes any of the clinical staff services, that time may be counted toward total required clinical staff time.

PCM

Principal Care Management

Minimum of 30 minutes of clinical or staff time directed by, or personally provided by a physician or QHP.

All new codes in 2022:

BHI

Behavioral Health Integration

Minimum of 20 minutes.

CoCM

Psychiatric Collaborative Care Model

Initial:
Minimum of 70 minutes.

Subsequent:
Minimum of 60 minutes of services.
30-minute add-ons.

VCS

Virtual Communication Services

Minimum of 5 mins.

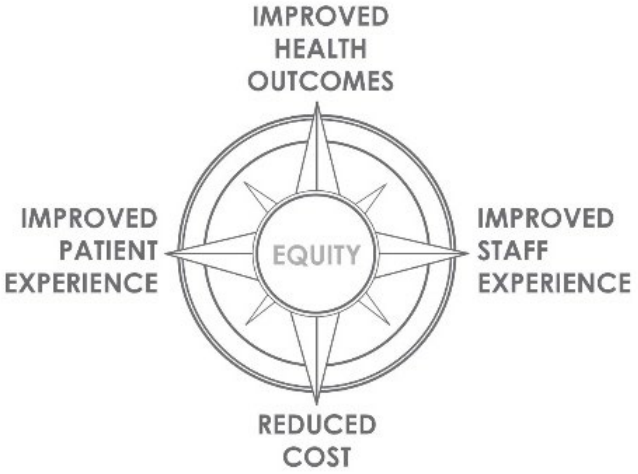
Care Management

WHY

Use CMS requirements to frame a care management program?

Using CMS care management requirements can help ensure a care management program is designed to:

- Improve patient care
- Improve patient outcomes
- Address important population health activity
- Engage in value-based care payment models
- Deliver on the Quintuple Aim



Quintuple Aim

Care Management

HOW
to develop/optimize a care management program

Action Guide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CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE MANAGEMENT

WHY

Use Care Management with High-Risk Patients?

Value-based care requires health care organizations to better control the clinical and financial risk associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes[1,2,3]. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs [4,5,6]. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim (better care, better patient and provider experiences, and lower costs)[7].

This Action Guide provides the steps to start a health center care management program for high-risk patients. The outlined recommendations meet the requirements of Chronic Care Management (CCM) services defined by CMS and, therefore, are eligible for reimbursement.

CARE MANAGEMENT

The Value Transformation Framework addresses how health centers can effectively deliver and coordinate care and manage high-risk and other subgroups of patients with more targeted services. This Action Guide outlines steps health centers can take to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

WHAT

Does a High-Risk Care Management Model Look Like?

High-risk care management involves intensive, one-on-one services, provided by a nurse or other health worker, to individuals with complex health and social needs. The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. The model discussed in this Action Guide is based on a nurse in the role of care manager. Other staffing models can be employed with some modification. Key components of care management include: identifying and engaging high-risk individuals, providing a comprehensive assessment, creating an individual care plan, engaging in patient education, monitoring clinical conditions, and coordinating needed services[8,9,10].

https://bit.ly/VTF_CareMngt

CMS Requirements

CMS requirements for Chronic Care Management (CCM) can be used to frame a care management program targeting high risk patients.

Use CMS CCM guidelines to design a care management program focused on quality and improved outcomes while also generating revenue.

Actions

STEP 1 Identify or Hire a Care Manager

STEP 2 Identify High-Risk Patients

STEP 3 Define Care Manager – Care Team Interface

STEP 4 Define Services Provided as Part of Care Management

STEP 5 Enroll Patients in Care Management

STEP 6 Create Individualized Care Plans

STEP 7 Enhance and Expand Partnerships

STEP 8 Document and Bill for Chronic Care Management

STEP 9 Graduate Patients from Care Management

STEP 10 Measure Outcomes

Steps 3-10
Care Management

Action Steps

- **STEP 1** Hire a Care Manager
- **STEP 2** Identify Care Management Patients
- **STEP 3** Define Care Manager – Care Team Interface
- **STEP 4** Define Services Provided as Part of Care Management
- **STEP 5** Enroll Patients in Care Management
- **STEP 6** Create Individualized Care Plans
- **STEP 7** Enhance and Expand Partnerships
- **STEP 8** Document and Bill for Care Management
- **STEP 9** Graduate Patients from Care Management
- **STEP 10** Measure Outcomes

Tools & Resources

- Sample Care Manager Job Description
- Risk Stratification Action Guide
- Sample Internal Referral to CM Form
- Sample Consent Form
- Sample Closeout Form

Step 1:
Identify or Hire a Care Manager

Identify staff to serve as the central point of contact for a panel of high-risk patients. These professionals provide one-on-one services to individuals with complex health and often social needs. An RN often serves in this role.

Care Management services include:

- Identifying and engaging high-risk individuals
- Comprehensive assessment
- Clinical monitoring
- Coordination of services
- Individual care planning
- Patient education

Tools & Resources

Sample Care Manager Job Description

Expanded Care Team Roles: Care Team Worksheet

Step 2:
Identify High Risk Patients


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CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT

MODELS OF CARE

WHY

Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs to direct care and target resources (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

WHAT

are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.
- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.
- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.

POPULATION HEALTH MANAGEMENT

within the Value Transformation Framework speaks to the systematic process of utilizing data on patient populations to target interventions for better health outcomes at lower cost, with a better care experience. This Action Guide outlines a framework for the design of unique models of care to subgroups of the population identified through risk stratification.

https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Pop-Health_Models-of-Care-AG_November-2019.pdf

Complete Risk Stratification
Create Models of Care

Highly complex. Require intensive, pro-active care management.

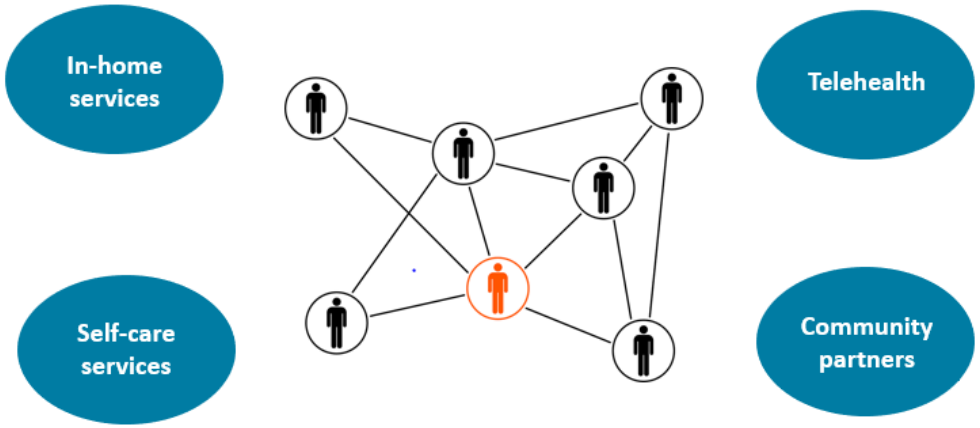
Care Management Action Guide

High-risk. Engage in care management to provide one-on-one support for medical, social and care coordination needs.

Rising-risk. Manage within PCMH model; support in managing risk factors (e.g., obesity, smoking, blood pressure, cholesterol).

Low-risk. Manage using more remote, group, and technological solutions; focus on keeping patients healthy and engaged.

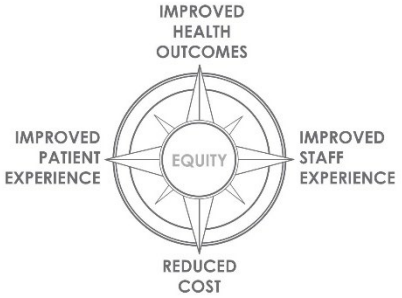
Step 7:
Enhance and Expand Partnerships



Sample Resources

- **AUNT BERTHA -** A free website (www.auntbertha.com) that provides access to comprehensive, localized listings of community-based resourc every zip code.
- **211 -** A free, online resource directory in every state that connects individuals to local resources. To find the phone number to call for local resources and services, visit www.211.org and enter your zip code or city and state, and then identify area of need (e.g., food, health, jobs).
- **The EveryONE Project™ -** The American Academy of Family Physicians' public-facing Neighborhood Navigator offers information on community resources for food, housing, transit, legal, and other areas.

Step 8:
Document and Bill for Chronic Care Management



Care Management Services	Reimbursement*
Chronic Care Management (CCM)	$79.25
Complex Chronic Care Management (CCCM)	$79.25
Principal Care Management (PCM)	$79.25
Transitional Care Management (TCM)	$180.16 $97.24 (telehealth)
Psychiatric Collaborative Care Model (CoCM)	$151.23
General Behavioral Health Integration (BHI)	$79.25
Virtual Communication Services	$23.88

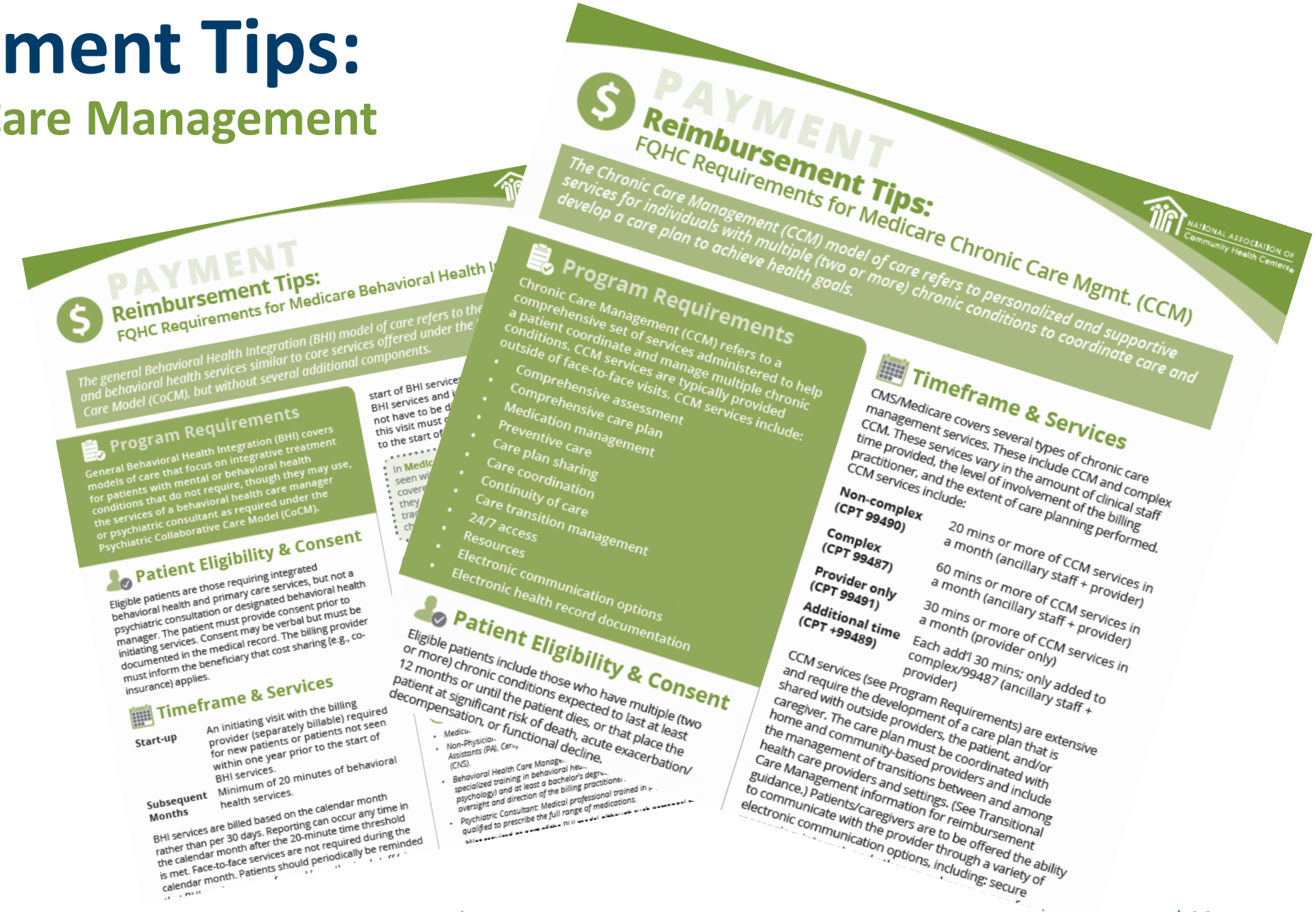
*Above intended to provide a general picture of reimbursement potential using 2022 CMS reimbursement guidance. See Reimbursement Tips for more details.

Reimbursement Tips:

CMS/Medicare Care Management

This compendium of care management tools is available free of charge on NACHC's Elevate platform

VTF logo appears on slides where a tool is available on the Elevate platform



CMS/Medicare Care Management Services

Can Coinsurance be Slid?

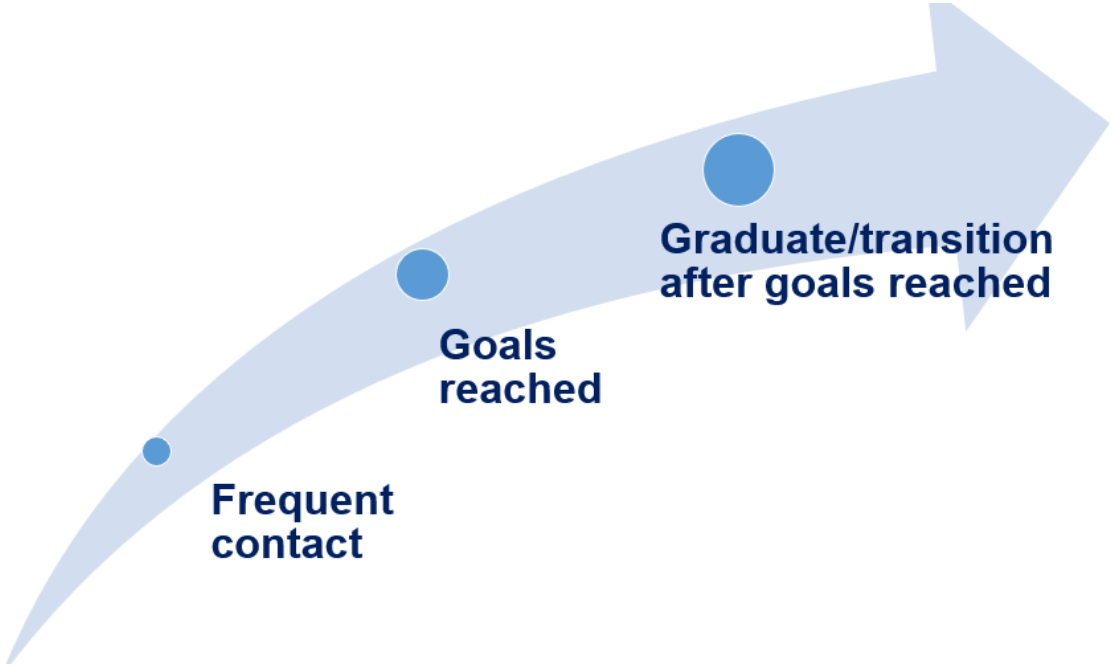
- While health centers are required to impose Medicare coinsurance for CMS/Medicare care management services, **the coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center**.

- Federal anti-kickback statutes and beneficiary inducement prohibitions include exceptions allowing health centers to discount coinsurance for patients who are eligible for the health center's sliding fee discount program without violating Medicare rules.

- HRSA's guidance (Compliance Manual, Chapter 9, Element K) **allows health centers to discount coinsurance for their SFDP eligible patients** to an amount no more than what the patient would have paid under his/her applicable SFDS payment level.

Guidance per Feldesman Tucker Leifer Fidell LLP, April 2020

Step 9:
Graduate Patients



[HEALTH CENTER LOGO]

Care Management Closeout

[HEALTH CENTER NAME] thanks you for participating in our care management program. Our goal has been to help you manage your health and to support you when, and in a way, that works for you. Patients may end care management services when this help is no longer needed or you no longer want to receive this help.

Some reasons patients stop care management are:

- The goals you set with your care manager and provider have been met.
- Your health has changed and care management is no longer needed.
- You choose not to participate in care management any longer.

If you decide to end care management today, please know that you can restart these services at any time – just let your provider, care team, or a care manager know that you want to start again.

For now, we ask you to confirm that you want to stop care management services today.

_____ Yes, I choose to stop care management services today.

_____ No, I want to continue care management services.

Patient Name: _____

Patient Signature: _____

Date: _____

Care Manager Name: _____

Care Manager Signature: _____

Date:

- Consent in effect unless services closed out or patient opts out
- If patient wishes to resume services after opting out, new consent required

Step 10:
Measure Outcomes

The effectiveness of care management can be measured by the degree to which patients achieve care plan goals. Performance should also be measured against key clinical and quality indicators, such as:

- Performance on relevant Uniform Data Systems (UDS) measures
- Enrollment rates
- Percent of patients that reach care plan goals
- Graduation rates
- Hospital readmission rates
- Patient experience surveys
- Care Manager panel size, by program
- Enrollments and disenrollments
- Care manager completed encounters
- Percent of billed encounters

Care Management Highlights

Action Guide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CARE MANAGEMENT

WHY

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CARE MANAGEMENT

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Does a High-Risk Care Management Model Look Like?

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https://bit.ly/VTF_CareMngt

Actions

CMS requirements for Chronic Care Management (CCM) can be used to frame a care management program targeting high risk patients.

Use CMS CCM guidelines to design a care management program focused on quality and improved outcomes while also generating revenue.

Resources

- Scheduling Virtual Care Management Services
- Scheduling Virtual Communication Services
- Website/Email Message
- Sample Care Manager Job Description
- Care Management Protocol for High-Risk Patients
- Checklist of FQHC Requirements to Bill CMS for Care Management
- Checklist, Integrated Care Management
- Sample Referral Form
- Sample Informed Consent
- Sample Closeout Form
- Tracking Form
- Patient Waiver of Fees Application

Transitional Care Management

NATIONAL ASSOCIATION OF Community Health Centers®

May 10, 2022

Microlearning:
Transitional Care Management

What?

Why?

How?

STEP 1 Identify/Hire Care Coordination/Care Management Staff

STEP 2 Identify Patients For Care Coordination/Care Management

Prior Steps: Empanelment, Risk Stratification, Models of Care

STEP 3 Define Care Manager-Care Team Interface

STEP 4 Define Services Provided as Part of Care Management

STEP 5 Enroll Patients in Care Management

STEP 6 Create Individualized Care Plans

STEP 7 Enhance and Expand Partnerships

STEP 8 Document and Bill for Care Management

STEP 9 Graduate (Transition) Patients from Care Management

STEP 10 Measure Outcomes

Transitional Care Management

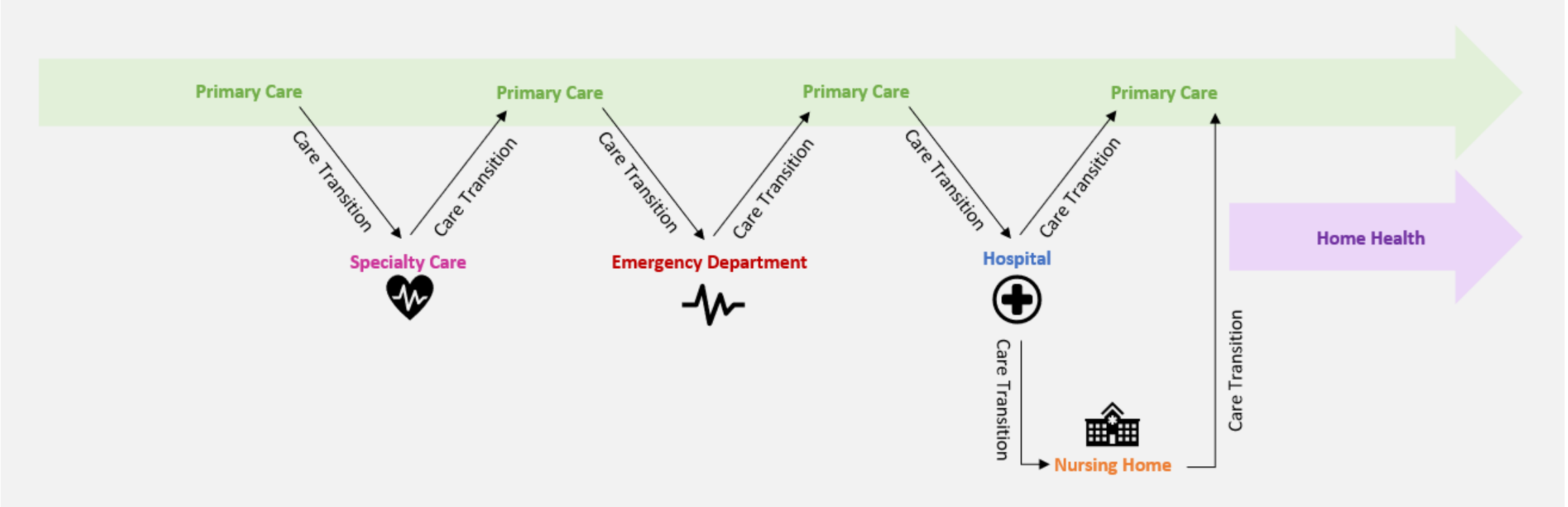
WHAT?

WHY?

HOW?

WHAT
Is Transitional Care Management (TCM)

Examples of Care Transitions Along the Patient Continuum of Care

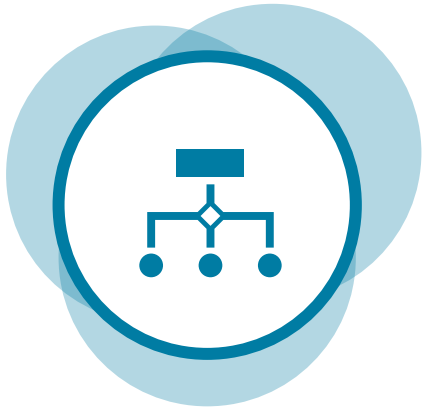


WHAT
Is Transitional Care Management (TCM)

Transitional Care Management (TCM) supports the transition and coordination of services from an **inpatient/acute care setting** to a **community care setting** by establishing a coordinated plan with the patient's Primary Care Provider (PCP).

Transitional Care Management

Why Transitional Care Management?



Essential population health activity

Improve health outcomes

Revenue potential

Transitional Care Management

Step 1:
Identify/Hire Care Coordination/Care Management Staff

Consider the volume and care needs of the patient population

- Empanelment
- Risk Stratification

Consider the responsibilities the Care Manager may have in addition to TCM

- Chronic Care Management, nursing responsibilities, other care coordination duties

Coming Soon: Care Team Planning Worksheet – Care Coordination and Care Management

Expanded Care Roles

Job descriptions reflect staff roles and broad responsibilities that are allowable under state laws and licensure.

Job descriptions outline staff responsibilities that can be accomplished remotely.

Step 2:
Identify Patients For Care Coordination/Care Management

Patient eligible for TCM services are those who, within the past 2 business days, have been discharged from an **inpatient/acute care setting** and transitioned to a **community care setting.**

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation/partial hospitalization
- Partial hospitalization at a community mental health center

Step 3:
Define Care Manager-Care Team Interface

- Utilize state or local Health Information Exchanges (HIEs) to review Admit, Discharge, Transfer (ADT) data
- Form or strengthen relationships with local care systems (hospitals, EDs, nursing homes, etc.)
- Document a process for how care transition data will be received and reviewed, and follow up services provided as needed

Demonstrate HRSA OSV Compliance

Continuity of Care and Hospital Admitting

The health center has internal operating procedures and, if applicable, related provisions in its formal arrangements with non-health center provider(s) or entity(ies) that address the following areas for patients who are hospitalized as inpatients or who visit a hospital's emergency department (ED):

1. Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
2. Follow-up actions by health center staff, when appropriate.

Step 4:
Define Services Provided as Part of Care Management

Three components in 30 days:

1. Initial Interactive Contact
2. Face-to-Face Visit
3. Non-Face-to-Face Services

All three components are required to bill Medicare for TCM services.

This process is best practice and can be applied for all patients moving through transitions of care, though reimbursement may vary by state or payer.

Step 5:

Enroll Patients in Care Management

Initial Interactive Contact

Within 2 business days of discharge date, the Care Manager (under the supervision of the billing provider) initiates direct and interactive communication with the patient (phone, in-person, electronic)

- Contact should address:
  - Type of services the patient had during admission
  - The discharge diagnosis
  - Follow up services that may be needed
  - Scheduling a face-to-face follow up appointment with the provider (PCP)

- It may also be beneficial (though not required) to address:
  - Medication reconciliation (required on or before the date of the face-to-face visit)
  - Social Drivers of Health (SDOH)
  - ADLs (Activities of Daily Living)

Step 5:

Enroll Patients in Care Management

Face-to-Face Visit

Following discharge, a face-to-face visit with a provider (PCP) is required.

- A patient whose condition warrants medical decision making of **high complexity** must be seen within **7** days of discharge.
- A patient whose condition warrants medical decision making of **moderate complexity** must be seen within **14** days of discharge.

Telehealth Visits

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service. As it is on the CMS list of telehealth services, the current guidance is that it would be billed for using G2025 for the duration of the PHE when provided as an audiovisual telehealth service.

Step 6:

Create Individualized Care Plans

Face-to-Face Visit

The face-to-face visit does not have to meet typical Evaluation and Management documentation requirements. In addition to minimum documentation requirements, clinical notes may include:

- Medication reconciliation (required on or before the date of the face-to-face visit)
- Referrals made to other providers
- Identification of community resources available to the patient
- Any contacts made with other providers to coordinate care
- Continuing care instructions for family members who may be present
- Patient education materials given to the patient
- Labs and/or diagnostic tests performed
- DME ordered or discontinued

Step 6:

Create Individualized Care Plans

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, additional care coordination services may be needed by the patient. These “Non-Face-to-Face Services” by the **Provider** may include:

- Reviewing the discharge information
- Reviewing the need for, or following up on, pending diagnostic tests and treatments
- Interacting with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems
- Educating patient, family, guardian, and/or caregiver(s)
- Establishing or reestablishing referrals and arranging for needed community resources

Step 6:

Create Individualized Care Plans

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, additional care coordination services may be needed by the patient. These “Non-Face-to-Face Services” by the **Care Manager** or other care team members may include:

- Identify and facilitate access to, and communication with, community and health resources, including home health agencies, available to support patient and/or family service needs
- Provide assessment to support adherence and management of medication treatment regimen
- Educate patient and/or family/caretaker to support self-management, independent living, and ADLs
- Communicate aspects of care with the patient and any individuals involved in the care or decision-making process.

Step 7:
Enhance and Expand Partnerships

- Create or enhance partnerships with community agencies to connect patients moving through care transitions with needed social services and community support.

- Work with applicable Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), payors, or local health care systems to improve TCM processes and optimize communication.

Step 8:
Document and Bill for TCM

TCM Documentation Requirements

- ✓ Date the beneficiary was discharged
- ✓ Date of interactive contact with the beneficiary and/or caregiver
- ✓ Date of the face-to-face visit
- ✓ Complexity of medical decision making (moderate to high)
- ✓ Services provided during Face-to-Face Visit and Non-Face-to-Face components

FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays
99495 (Moderate Complexity) Communication with patient and/or caregiver within 2 days of discharge; **Moderate MDM** ; Face-to-face visit, **within 14 calendar days of discharge** **99496 (High Complexity)**Communication with patient and/or caregiver within 2 days of discharge; **High MDM**; Face-to-face visit, **within 7 calendar days of discharge**	**G0467**; established FQHC patient visit *TCM services are qualified visit codes under G0467*	**$180.16 (PPS)**
If services are provided via Telehealth During PHE, G2025 rate trumps non-PHE telehealth rate.	**G2025**	**$97.24**

Step 9:

Graduate (Transition) Patients from Care Management

- Provide care management services to high-risk patients on a routine basis to prevent readmissions and support management of chronic conditions.
- The face-to-face visit included in Transitional Care Management (TCM) services qualifies as a “comprehensive” visit for care management service initiation.
- Use TCM visit as an opportunity to enroll qualifying patients in Chronic Care Management programs.

Step 10:
Measure Outcomes

Track TCM process and outcome measures

- Completed TCM encounters
- Hospital/ED discharges
- Hospital admissions/readmissions
- ED visits
- Cost of care

Work with applicable Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), payors, or local health care systems to improve processes and track outcomes together!

Kristie Bennardi
Chief Executive Officer
& Chief Financial Officer

Care Management
Field Example:

Keystone Rural Health Consortia

Care Management

WHAT?

WHY?

HOW?

WHAT
is care management at Keystone Rural?

CMS Care Management Services Keystone offers:

- Complex Chronic Care Management
- Chronic Care Management (~180 patients/month)
- Principal Care Management
- Transitional Care Management (~20-30/month)
- Behavioral Health Integration

Other CMS reimbursable services

- Initial Preventive Physical Exams (IPPEs)/Annual Wellness Visits (AWVs)

WHAT
is care management team?

RN Care Managers

- Caseloads = one case manager per site and discipline regardless of numbers
- Case manager in each primary care location, pediatric, behavioral health, and new dental care manager

Electronic Health Record is Athenahealth formerly known as GE Centricity
Population health software is I2i and will be using Azara as well
Care management services (e.g., what was done and time spent) is documented in EHR system

Key Areas of Focus for our Care Managers

- TCM visits
  - medication reconciliation before patient comes into the office
  - Making sure all discharge needs are met
- Medicare Annual Wellness Visits
  - Address preventive needs (e.g., colonoscopy screening) are addressed prior to provider contact
- Diabetic Eye Exams
- Hypertension Follow-up calls
- Other telephone communication and follow-up

Care Management

WHY
care management is essential to Keystone Rural and our patients

- **Quality Care**: offering care management services is the ‘right’ thing to do for our patients.
- **Value-based care**: offering care management services is an important condition of participation in value-based payment models; it is an expectation in the accountable care organization (ACO) we participate in.
- **Revenue**: care management services provide a critical revenue source outside of the FQHC Prospective Payment System (PPS)
- **Reduced Hospitalizations and Readmissions:** < 3% with our RN Case Managers, CCM, and internal 24/7 RN Triage on call system

Institutionalization of Quality as Culture

Care Managers - true champions of the Quality Team and the beating heart of the clinic

- **Start of Day**. Care Managers create huddle sheets, facilitate daily huddles, review quality metrics on huddle sheets
- **Throughout the Day**. Care Managers follow-up with providers and care team on items from the huddle sheet.

Care Management

WHAT?

WHY?

HOW?

Step 1
Hire Care Managers

- We made an important and impactful decision to hire Care Managers in 2016 in our efforts to transition to Value Base Care models.

- Currently employ 5 Care Managers
- Case manager in each primary care location, pediatric, behavioral health, and new dental care manager
- All of the Care Managers focus on TCM

Step 2
Identify Patients for Care Management

Patients identified for overall care management services through the following :

- Risk Stratification – Using I2i and Aledade App, we identify those that are high risk including those with recent hospitalization/ER visits, uncontrolled diabetes and hypertension, etc.

Patients identified for TCM via:

- Discharge data
  - Skilled nursing facility (SNF) or hospital fax
  - SNF or hospital email
  - Aledade App
- Care Manager reaches out to patient within 2 business days of discharge using patient script

Step 3
Define Care Manager – Care Team Interface

- Keystone Care Manager job description
- Keystone Nurse Care Manager TCM script

Care Managers connect regularly with the care team

- Prepare daily huddle sheets
- Lead daily huddles
- Review and monitor quality metrics

Step 4
Services Provided as Part of TCM:
Care Manager

Prior to TCM visit (via phone), Care Manager:

- Reviews discharge instructions and any outstanding questions
- Determines whether symptoms have improved or worsened
- Determine whether patient has started/stopped any medications.
- Assess whether patient has picked up any new medications at pharmacy.
- Address social risks that could prevent patient from attending TCM visit (e.g., financial, transportation, scheduling, etc.)
- Remind patient to bring all pill bottles and medications
- Provide instructions for seeking after-hours access and same day access, if needed, prior to appointment

Step 4 (cont'd)
Services Provided as Part of TCM:
CM/RN/Provider

During the TCM visit (in-person), Provider:

- Perform full medication reconciliation, pre-post hospitalization
- Discuss Advance Directives
- Document any hospital administered vaccines or any outstanding vaccines
- Review symptom response plan with patient including any emergent vs. primary-care treatable symptoms
- Provide instructions for seeking emergency care, same day access, and after-hours care
- Perform Fall Risk Assessment
- Assess for social needs including food, housing, and transportation
- Assess patient goals for visit and perceived factors leading to hospitalization
- Determine if medication adjustments needed or follow up on test results, imaging, or discharge instructions
- Determine need for referrals including Chronic Care Management and additional social support services
- If patient agrees to receive Chronic Care Management, it must be documented by the provider in the note and Case Management must be notified
- Determine follow up plan.

Pre-visit CM followed by provider in person
Rooming RN
Provider

Step 5
Enroll Patients in Care Management

During TCM Visit

- Determine need for referrals including Chronic Care Management and additional social support services.
    - If patient agrees to receive Chronic Care Management, informed consent must be documented by the provider in the note and Case Management must be notified
- Determine follow-up plan
- Enroll in Care Management – warm hand-off, if possible

Post TCM Visit

- Provide patient or patient representative with dated and reconciled active medication list and clinical visit summary
- Communicate follow up plan to patient/patient representative
- Ensure that any follow-up appointments are scheduled including care management

Step 6 - 10
Care Management

Care Managers take it from here…

- **STEP 6** Create Individualized Care Plans
- **STEP 7** Enhance and Expand Partnerships
- **STEP 8** Document and Bill for Care Management
- **STEP 9** Graduate Patients from Care Management
- **STEP 10** Measure Outcomes

FQHC Care Management Billing & Coding

Lisa Messina
Messina Consulting, MPH, CPC

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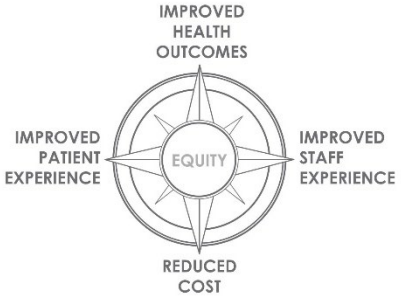
CARE MANAGEMENT

PAYMENT

Centers for Medicare and Medicaid Services (CMS) Care Management Services:
Reimbursement Opportunities



Care Management Services	Reimbursement*
Chronic Care Management (CCM)	$79.25
Complex Chronic Care Management (CCCM)	$79.25
Principal Care Management (PCM)	$79.25
Transitional Care Management (TCM)	$180.16 $97.24 (telehealth)
Psychiatric Collaborative Care Model (CoCM)	$151.23
General Behavioral Health Integration (BHI)	$79.25
Virtual Communication Services	$23.88

*Above intended to provide a general picture of reimbursement potential using 2022 CMS reimbursement guidance. See Reimbursement Tips for more details.

Care Management Services
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays (PFS)
Chronic Care Management (CCM)	**99490** (First 20 mins, ***non-complex***; clinical staff) **+ 99439** (each add'l 20 mins; clinical staff. Only added to ***non-complex***/99490) **99491** (30 mins; **physician or QHP only** (*not to be reported in same month as above clinical staff codes*) **+99437 (New!)** (each add'l 30 mins; physician or QHP. Only added to 99491)	**G0511** *General care management, 20 minutes or more of clinical staff time, directed by FQHC practitioner, per calendar month*	**$79.25**
Complex Chronic Care Management (CCCM)	**99487** (60+ mins, **complex**; clinical staff) **+99489** (each add'l 30 mins; clinical staff. Only added to **complex**/99487)		
Principal Care Management (PCM)	**99424 (New!) (F**irst 30 mins; physician or QHP) **+99425 (New!)** (each add'l 30 mins; physician or QHP. Added to 99424) **99426 (New!)** (First 30 mins; clinical staff) **+99427 (New!)** (each add'l 30 mins; clinical staff; added to 99426)		

Behavioral Health Care Management Services
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays (PFS)
Behavioral Health Integration (BHI)	**CPT 99484** (20 minutes of clinical staff time directed by physician or QHP, per calendar month)	**G0511** *General care management, 20 minutes or more of clinical staff time, directed by FQHC practitioner, per calendar month*	**$79.25**
Psychiatric Collaborative Care Model (CoCM)	**CPT 99492** (Initial CoCM, first 70 mins of BHC manager activities; first calendar month; in consultation with psychiatric consultant; directed by treating physician or QHP) **CPT 99493** (Subsequent CoCM; 60 mins; plus as above elements) **+99494** (each add'l 30 mins of either of the above in a calendar month. Add on to either 99492 or 99493.	**G0512** *Psychiatric CoCM, 60 minutes or more of clinical staff time, directed by FQHC practitioner, including BHC manager in consultation with psychiatric consultant, per calendar month*	**$151.23**

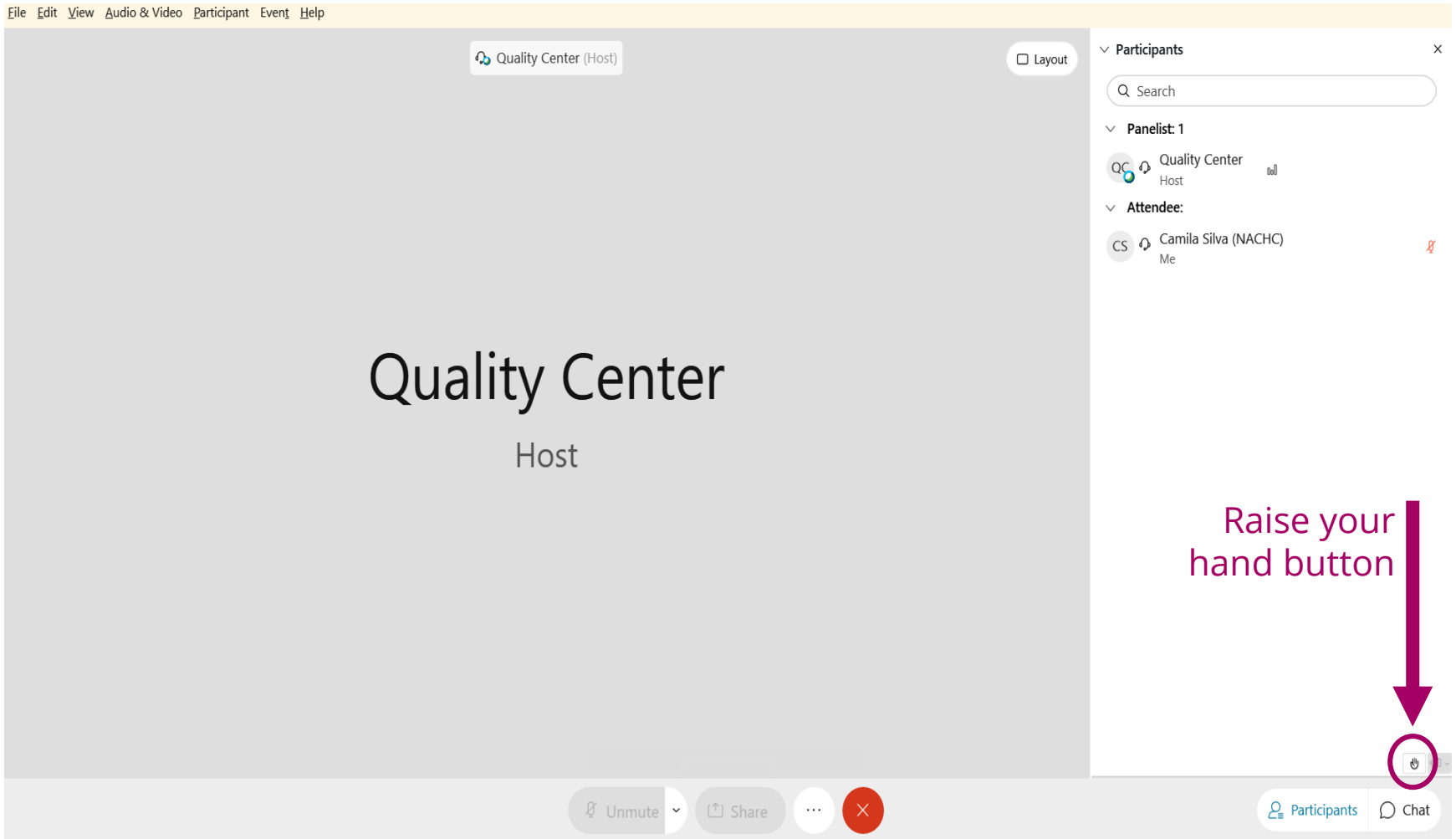
Transitional Care Management
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays
Transitional Care Management (TCM	**99495 (Moderate Complexity)** Communication with patient and/or caregiver within 2 days of discharge; **Moderate MDM** ; Face-to-face visit, **within 14 calendar days of discharge** **99496 (High Complexity)**Communication with patient and/or caregiver within 2 days of discharge; **High MDM**; Face-to-face visit, **within 7 calendar days of discharge**	**G0467**; established FQHC patient visit *TCM services are qualified visit codes under G0467*	**$180.16 (PPS)**
	If services are provided via Telehealth During PHE, G2025 rate trumps non-PHE telehealth rate.	**G2025**	**$97.24**

New! FQHCs may bill for TCM and care management services furnished "for the same beneficiary during the same service period, provided all requirements for each medically necessary service are separately met."

Virtual Communication Services
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays (PFS)
Virtual Communication Services	Visit is not related to E/M provided in previous 7 days and not leading to E/M within 24 hours or soonest avail. appt.: **G2010** (Remote evaluation of recorded video and/or images submitted by the patient, 24 hour follow-up by FQHC practitioner) **G2012** (Virtual check-in by FQHC practitioner; 5-10 minutes of medical discussion)	**G0071** *Communication technology-based services; 5 or more mins; non-face-to-face patient and FQHC practitioner; OR 5 or more mins or remote evaluation of recorded video and/or image by FQHC practitioner; in lieu of office visit.*	**$23.88**
Digital Assessment Services "E-Visits" (PHE Only)	Online digital E/M service, for an established patient for up to 7 days, cumulative time during the 7 days; **CPT 99421** (5-10 minutes) **CPT 99422** (11-20 minutes) **CPT 99423** (21 or more minutes)		



Q&A

- **Questions:**
  - Send questions to the chat
  - "Raise Hand" button; we will unmute your line.
- **Answers:**
  - "Raise Hand" button; we will unmute your line.
- **Resources:**
  - If you have a tool/resource to share, let us know in the chat!

Coming Next

- ✓ Leadership
- ✓ Empanelment
- ✓ Population Health: Risk Stratification
- ✓ Payment
- ✓ Care Teams
- ✓ Care Coordination & Care Management
- **Evidence-Based Care, Cancer Screening**
- Social Drivers of Health (SDOH)
- Improvement Strategy
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home

Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

Elevate 2022 Participants:

QI Professional Development Opportunity

Institute *for* Healthcare Improvement

One year of free access to the IHI's full catalog of online courses including:

- More than 35 continuing education credits for nurses, physicians, and pharmacists
- Basic Certificate in Quality and Safety

VTF

Open to registered participants who complete the VTF assessment

Submit interest here: https://bit.ly/Elevate_IHI
by May 18th to be eligible for a scholarship

UPCOMING EVENTS

May 2022

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June 2022

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May 26. Elevate Connect – Topic: FQHC Coding & HCC Coding

June 14. Learning Forum – Topic: Evidence-Based Care, Cancer Screening

June 23. Elevate Connect – Topic: Evidence-Based Care, Cancer Screening

Use this link to receive calendar invitations for all upcoming learning forums:
bit.ly/Webinars22

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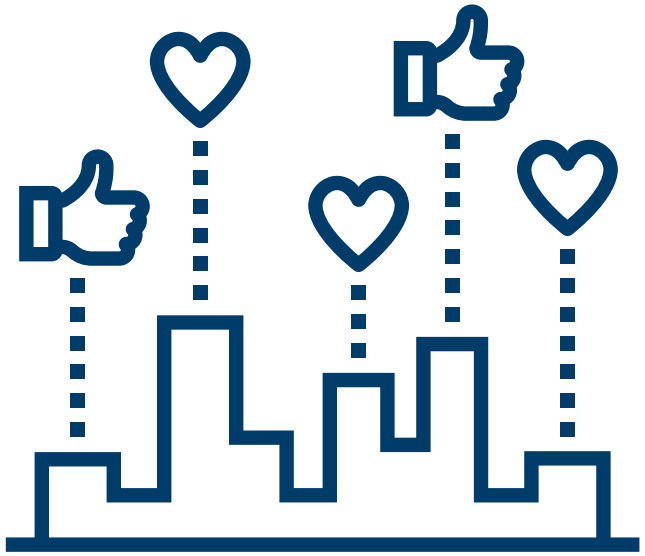

Provide Us Feedback

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

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Next *Connect* Call:

May 26, 2022
1-1:45 pm ET

Next Monthly Forum Call:

June 14, 2022
1-2 pm ET

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elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, & Addison Gwinner

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