# 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

WHAT?

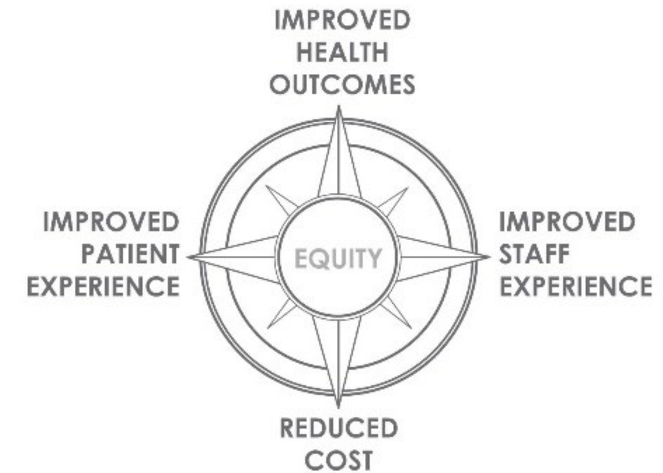
WHY?

HOW?

# *WHY*
# Use CMS requirements to frame a care management program?

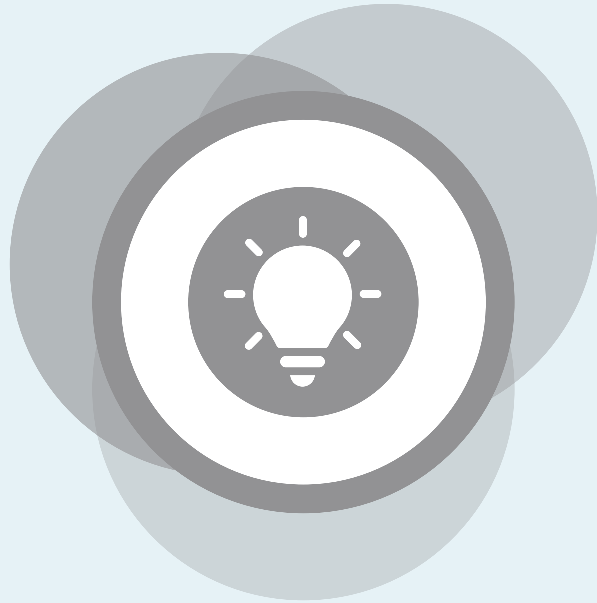
Using CMS care management requirements can help ensure a care management program is designed to:

- 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



WHAT?

WHY?

HOW?

# HOW
## to develop/optimize a care management program

## Action Guide

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### 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].

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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
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## 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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## 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.

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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*

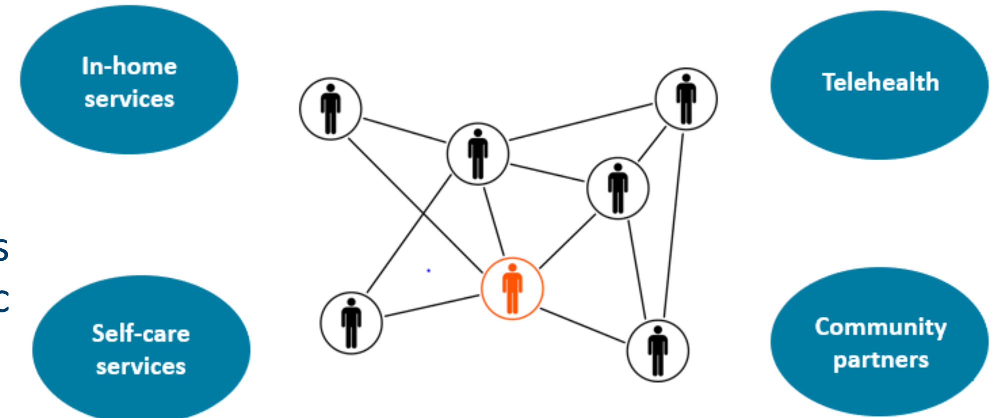
**Highly complex**. Require intensive, pro-active care management.

**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.

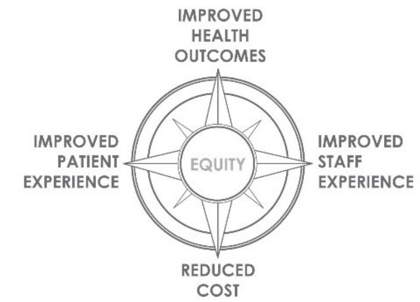
# *Step 7:*
# Enhance and Expand Partnerships




**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<br>$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:

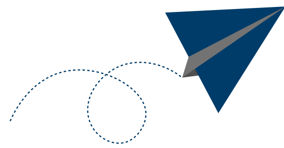
## CMS/Medicare Care Management

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?



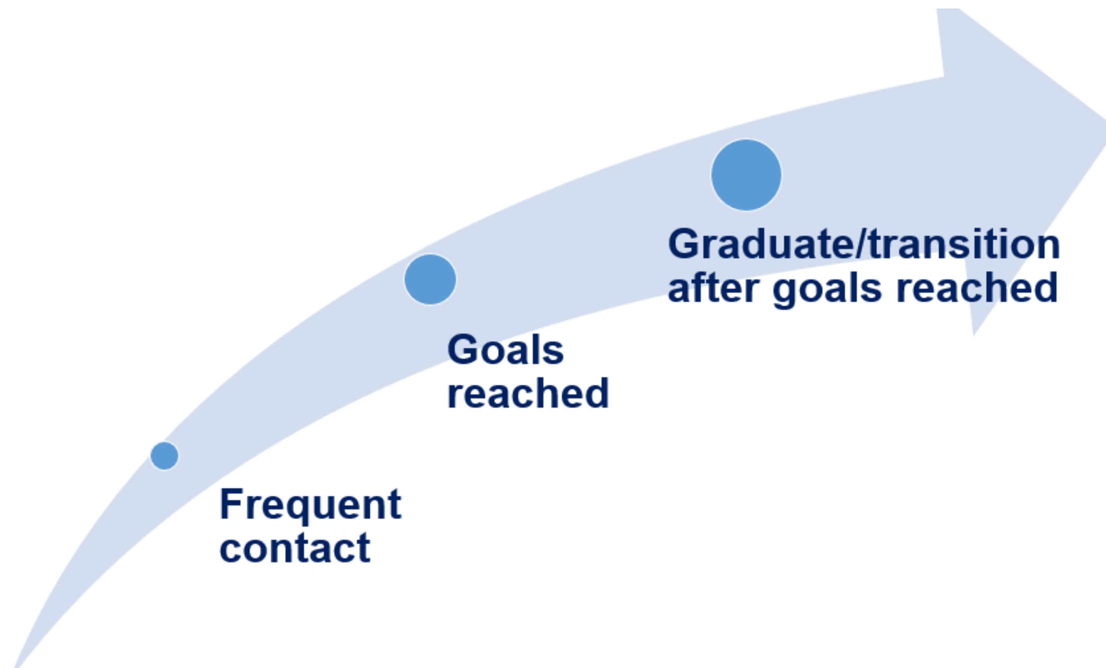
- While health centers are required to impose Medicare coinsurance for CMS/Medicare care management services, **the coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center**.

- 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

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## Actions

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**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