Care Management
Field Example:

Su Clinica

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Care Management at Su Clinica

CMS Care Management Services Su Clinica offers:

Chronic Care Management

Transitional Care Management

- Began care management services in 2010
- Currently work with a variety of payers who require and/or reimburse the health center for care management services
- Staffed by 7 care managers: 2 RNs; 5 LVNs

How Su Clinica Identifies Patients for Care Management

- ✓ Risk Stratification

  Risk Adjustment Factor (RAF) – a risk score is assigned to each patient using a risk adjustment payment model

  - 1 Hospitalization or 1 ED visit and/or
  - 1 or > SDOH

  Lists of patient with high RAF scores

- ✓ Provider referral through a flag to care managers in the EMR (Athena Health)
- ✓ Payer referrals
- ✓ RN and LVN
- ✓ Hand-off form
- ✓ Consent

Care Manager & Care Team Coordination and Training

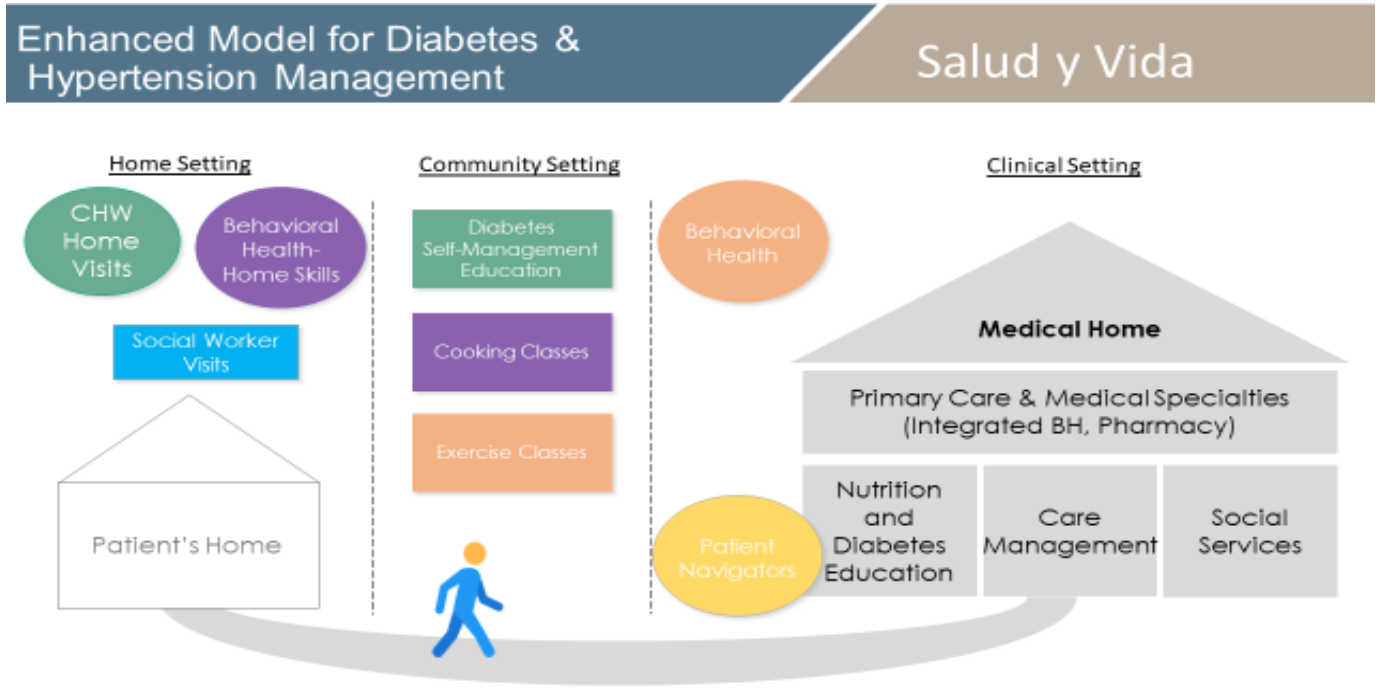
- Care Management Huddles
- Clinical Huddles
- Interdisciplinary Team (IDT) monthly meetings
- Social Risk (PRAPARE) Screening Tool
- Coordination of office visits
- Training on motivation interviewing and coaching

Time spent on care management services is captured in the Care Plan

Partnerships that Support Care Management

- ✓Payers
- ✓Health Information Exchange
- ✓TACHC
- ✓NACHC

- ✓Salud Y Vida



Measuring Success

Su Clinica tracks:

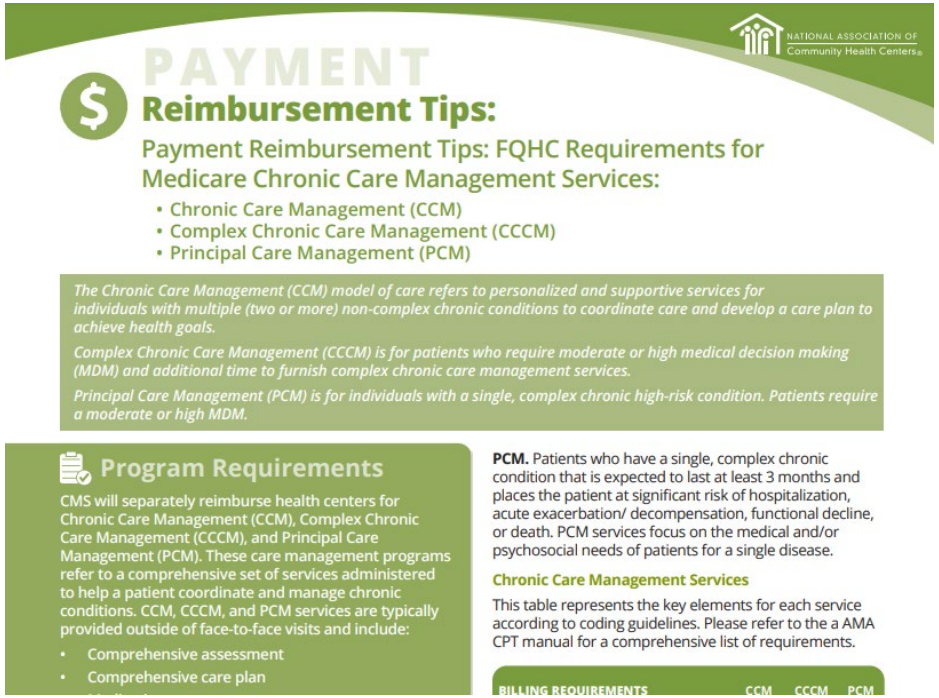
Quality Measures

Readmission Rates

Access

- Patients graduate from care management when they meet their goals and are stable
- Follow-up call at the third and sixth month after program completion

NACHC Reimbursement Tip Sheets


PAYMENT

Reimbursement Tips:

Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) non-complex chronic conditions to coordinate care and develop a care plan to achieve health goals.

Complex Chronic Care Management (CCCM) is for patients who require moderate or high medical decision making (MDM) and additional time to furnish complex chronic care management services.

Principal Care Management (PCM) is for individuals with a single, complex chronic high-risk condition. Patients require a moderate or high MDM.

Program Requirements

CMS will separately reimburse health centers for Chronic Care Management (CCM), Complex Chronic Care Management (CCCM), and Principal Care Management (PCM). These care management programs refer to a comprehensive set of services administered to help a patient coordinate and manage chronic conditions. CCM, CCCM, and PCM services are typically provided outside of face-to-face visits and include:

- Comprehensive assessment
- Comprehensive care plan

PCM. Patients who have a single, complex chronic 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 services focus on the medical and/or psychosocial needs of patients for a single disease.

Chronic Care Management Services

This table represents the key elements for each service according to coding guidelines. Please refer to the a AMA CPT manual for a comprehensive list of requirements.

Newly updated to reflect 2022 guidance!

- ★ NACHC Reimbursement Tip Sheet - Behavioral Health Integration
- ★ NACHC Reimbursement Tip Sheet - CCM, CCCM, PCM
- ★ NACHC Reimbursement Tip Sheet - IPPE & AWV

NACHC Reimbursement Tip Sheet - Telehealth

- ★ NACHC Reimbursement Tip Sheet - Psych CoCM

NACHC Reimbursement Tip Sheet - RPM-SMBP

- ★ NACHC Reimbursement Tip Sheet - Tobacco Cessation
- ★ NACHC Reimbursement Tip Sheet - TCM
- ★ NACHC Reimbursement Tip Sheet - VCS

NACHC Guidance - Sliding Coinsurance for CMS Care Management

VTF

Available free of charge on NACHC's Elevate platform