Chronic Care Management

NATIONAL ASSOCIATION OF Community Health Centers®

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Chronic Care Management

What?

Why?

How?

WHAT is Chronic Care Management?

WHY provide Chronic Care Management?

HOW to provide Chronic Care Management?

- **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
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- **STEP 9** Graduate Patients from Care Management
- **STEP 10** Measure Outcomes

NACHC Care Management Action Guide

Chronic Care Management

WHAT?

WHY?

HOW?

WHAT
Is Chronic Care Management?

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

Key components of care management may include:

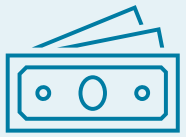
- Identifying and engaging high-risk individuals
- Providing a comprehensive assessment
- Creating an individual care plan
- Engaging in patient education
- Monitoring clinical conditions
- Coordinating needed services

WHAT
Is Chronic Care Management?

Medicare's Suite of Chronic Care Management Programs Include:

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

There are additional Medicare programs for Behavioral Health Care Management and Virtual Care Services.



The Centers for Medicare and Medicaid Services (CMS) will separately reimburse health centers for services under this suite of care management programs.

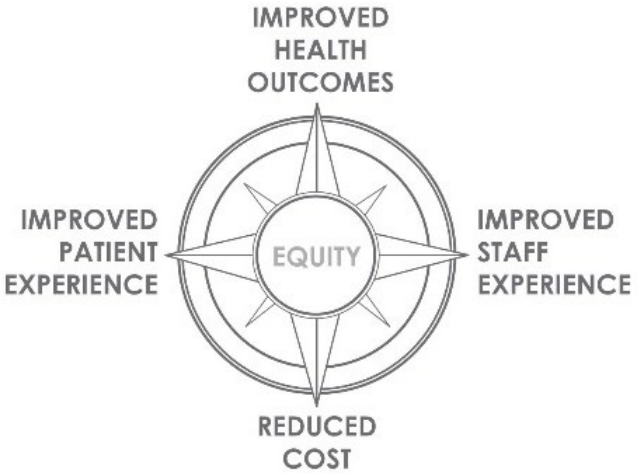
CCM, CCCM, and PCM services are typically provided outside of face-to-face visits.

Care Management

WHY
Provide Chronic Care Management?

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

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



Quintuple Aim

Chronic Care Management

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 the lead role but other members of the care team (MA, CHW, etc.) can perform many of the care management services within state/license requirements.

When determining the number of care managers needed and which care teams to add them to, consider the volume and care needs of the patient population:

- Empanelment
- Risk Stratification

Tools & Resources

Sample Care Manager Job Description

Provide care managers with training on care management and patient self-management. Review national or state training programs available.

Step 2:
Identify High Risk Patients

For Chronic Care Management Programs, consider eligibility criteria:

CCM

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

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 medical decision making.**

PCM

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 medical decision making.**

Step 2:
Identify High Risk Patients

Pull condition count reports by payor from your EHR or Population Health Management system using conditions included in UDS Table 6A.

Assess whether the patients on the reports have had a qualifying Initiating Visit, including:

- Initial Preventive Physical Examination (IPPE)
- Annual Wellness Visit (AWV)
- Evaluation and Management service (E/M)
- The face-to-face visit included in Transitional Care Management (TCM)

Review lists of identified patients with other care team members and the Primary Care Provider (PCP) to confirm eligibility and the level of medical decision making required.

Diagnostic Category	Applicable ICD-10-CM Code
Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-
Chronic lower respiratory diseases	J40 (count only when code U07.1 is not present), J41- through J44-, J47-
Asthma	J45-
Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)
Hypertension	I10- through I16-, O10-, O11-
Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)

Step 2:
Identify High Risk Patients

The target caseload for an RN care manager varies depending on several factors and is likely to be in the range of **50-150** high-risk patients.

Factors affecting caseload size and complexity include:

- Health center environment
- The care manager's experience
- The clinical and social complexity of patients
- Available social supports
- Target care management outcomes

Evaluate caseload size and manageability on an ongoing basis.

Tools & Resources

NACHC Risk Stratification Action Guide

NACHC Models of Care Action Guide

Step 3:
Define Care Manager-Care Team Interface

In addition to the care manager, each patient is assigned to a care team. This includes a designated provider (PCP) who works with the care manager and patient to carry out the patient's individualized care plan.

Determine how, and in what ways, the care manager and care team will work together. Including:

- How often they meet to discuss patient care details
- How they communicate in between face-to-face meetings
- Documentation expectations
- Follow up

Tools & Resources

NACHC Care Teams Action Guide

Checklist, Integrated Care Management

Step 4:

Define Services Provided as Part of Care Management

A care management program for high-risk patients should ensure comprehensive care plans support chronic disease and prevention needs, as well as mental, social, and environmental factors.

CCM, CCCM, and PCM services focus on the time and resources used to manage patients' health between face-to-face visits

Documentation requirements include:

- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care
- Medication management
- Comprehensive care plan
- Continuity of care
- Coordination with home-health and community-based providers
- 24/7 access to providers or clinical staff

Tools & Resources

Care Management Protocol for High-Risk Patients

Step 5:
Enroll Patients in Care Management

Consider enrolling eligible patients in Chronic Care Management, through any of the following methods:

- Warm handoffs from the PCP (or other designated care team member) to the care manager
- The care manager can call, email, or mail a letter indicating that their provider has recommended them for chronic care management.

Consent is obtained during or after the initiating visit and before care management services are provided. Consent can be written or verbal but must be documented in the medical record and:

- Include the availability of care coordination services and applicable cost-sharing.
- Inform the patient that only one practitioner can furnish and be paid for care coordination services during a calendar month.
- Communicate the patient's right to stop care coordination services at any time (effective at the end of the calendar month).
- Provide the patient with permission to consult with relevant specialists.

Track enrolled patients, and their assigned care manager, in the EHR where other care team members can view it

Tools & Resources

Sample Internal Referral to CM Form

Sample Consent Form

Step 6:

Create Individualized Care Plans

Working with the patient and PCP, care managers create an individualized, patient-centered care plan for each patient enrolled in care management. Each care plan goal should have explicit action items and interventions formulated with the patient and should include steps for patient engagement in self-care.

The comprehensive care plan covers all health issues with particular focus on the chronic conditions being managed. It includes the following elements:

- ✓ Problem list
- ✓ Expected outcome and prognosis
- ✓ Cognitive and functional assessments
- ✓ Measurable treatment goals
- ✓ Symptom management
- ✓ Planned interventions, including responsible individuals
- ✓ Medication management
- ✓ Caregiver assessment
- ✓ Summary of advance directives
- ✓ Community/social services ordered
- ✓ A description of how outside services/agencies are directed/coordinated
- ✓ Schedule for periodic review and, where appropriate, revision of the care plan

A copy of the care plan is shared with the patient and PCP.

Tools & Resources

Create EHR templates to aid care managers in the documentation of required care plan elements

Care Plan Tracking Tool

Step 7:
Enhance and Expand Partnerships

Connect care management patients to needed community and social resources to address social drivers of health (SDOH)

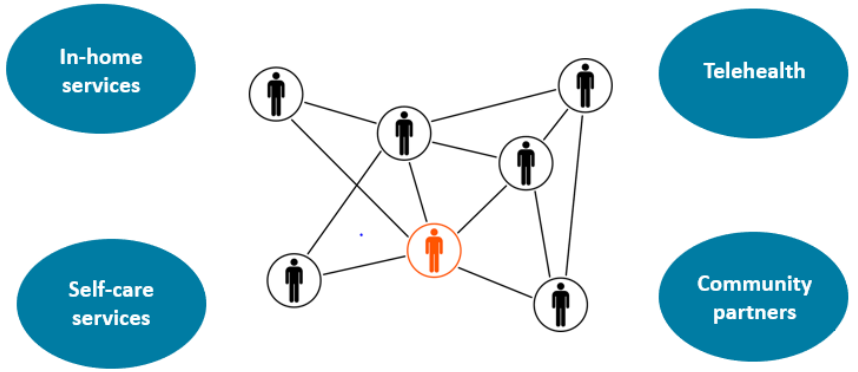
May be necessary to enhance and expand local, state, or national partnerships to have resources identified and readily available to meet patient needs.

Sample Resources:

AUNT BERTHA - A free website (www.auntbertha.com) that provides access to comprehensive, localized listings of community-based resources in 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

CCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2022 Fees*
Non-complex (CPT® 99490)	First 20 mins of CCM clinical staff time directed by a physician or QHP.	G0511	$ 79.25
Non-complex additional time (CPT® +99439)	Each add'l 20 mins of clinical staff time directed by physician or QHP; added to 99490 (clinical staff time).		
Provider only (CPT® 99491)	30 mins or more of CCM services in a month provided personally by a physician or QHP.		
Provider only (CPT® +99437) New!	Each add'l 30 mins of CCM services provided personally by a physician or QHP; added to 99491.		

CCCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2022 Fees*
Complex (CPT® 99487)	First 60 mins of CCCM clinical staff time directed by a physician or QHP.	G0511	$ 79.25
Complex additional time (CPT® +99489)	Each add'l 30 mins of clinical staff time directed by physician or QHP; added to 99487.		

PCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2022 Fees*
CPT® 99424 New!	Comprehensive care management services for a single high-risk disease; first 30 mins of PCM personally provided by a physician or QHP.	G0511	$79.25
CPT® +99425 New!	Each add'l 30 mins of PCM services provided personally by a physician or QHP; added to 99424.		
CPT® 99426 New!	First 30 mins of PCM clinical staff time directed by a physician or QHP.		
CPT® 99427 New!	Each add'l 30 mins of PCM clinical staff time directed by physician or QHP; added to 99426.		

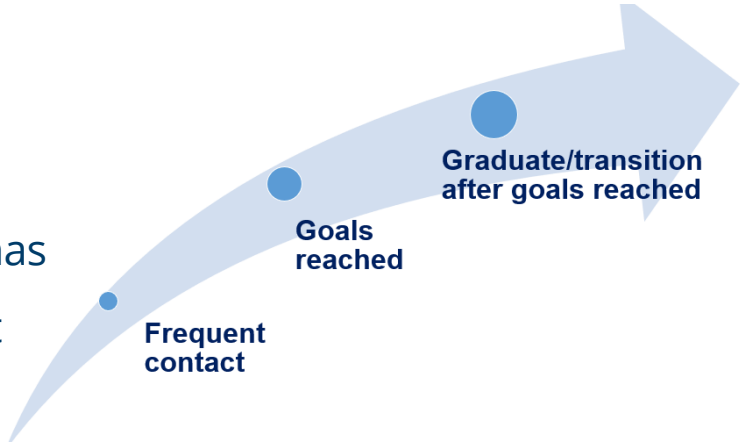
Tools & Resources

NACHC Reimbursement Tip Sheet - CCM, CCCM, PCM

Checklist of FQHC Requirements to Bill CMS for Care Management

Step 9:
Graduate Patients

Provide care management services to patients until the patients' health goals have been reached, or until the patient has opted out of receiving care management services.



[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: _____

Tools & Resources

Sample Closeout Form

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