NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Care Management & Payment
April 9, 2024

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®

NACHC Quality Center

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Director,
Quality Center

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Manager,
Quality Center

Rachel Barnes
Specialist,
Quality Center

Agenda

Welcome

Elevate Journey

Care Management

- Implementing a Care Management program *WHAT, WHY, HOW*
- Featured Health Center: OneWorld Community Health Centers, Inc.

Payment

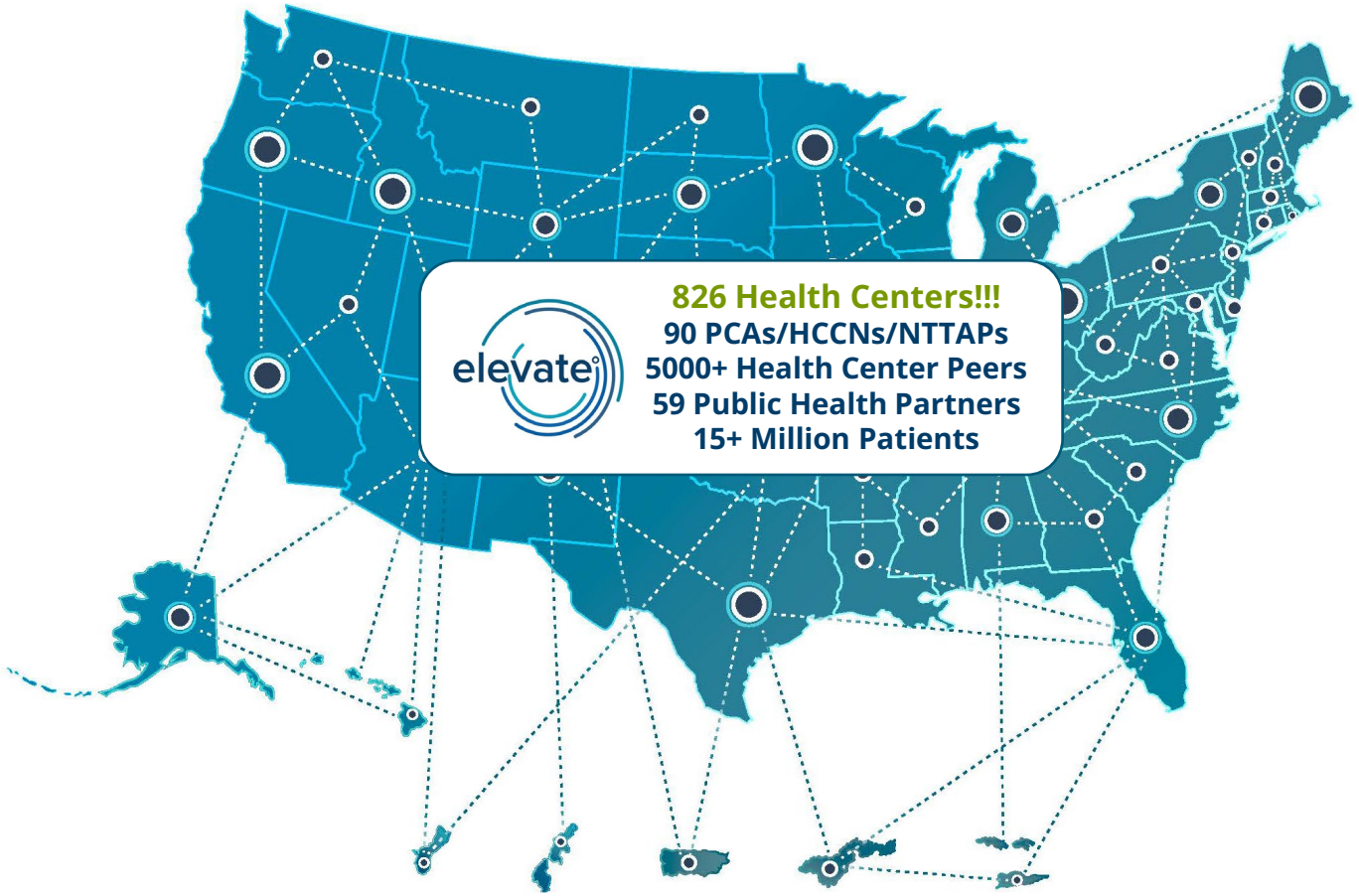
- Care Management Reimbursement Opportunities

Q&A and Discussion

- With Billing & Coding SME, Lisa Messina

Closing

Welcome!



Elevate **provides guided application of the Value Transformation Framework**

National learning forum and peer exchange

Collaborate * Learn * Share * Create * Innovate

Elevate Featured Health Centers: 2023 Health Center Quality Leaders!

ESPERANZA health centers

mainlinehealth systems, inc.

SOUTHSIDE Your Community Health Services

VCC

MVHC

St. Croix Regional Family Health Center

care resource
Your Community's Source for Healthcare

NORTHWEST MICHIGAN HEALTH SERVICES INC

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

RHG
RURAL HEALTH GROUP
healthcare that fits your family

CAMILLUS HEALTH CONCERN

StayWell Health Center
Growing a healthier community one person at a time.

HEARTLAND HEALTH SERVICES

WAIMĀNALO HEALTH CENTER

URBAN HEALTH PLAN
Providing Care for Healthier Lives

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

AudubonArea
Community Care Clinic, Inc.

CHARLES B. WANG COMMUNITY HEALTH CENTER

GPW Health Center
Dedicated to Your Health

OneWorld
Community Health Centers, Inc.

SFCHC
SAN FERNANDO COMMUNITY HEALTH CENTER

FIRSTMED
Health + Wellness
Your Healthcare Home

UMC
UNCOMPAHGRE MEDICAL CENTER

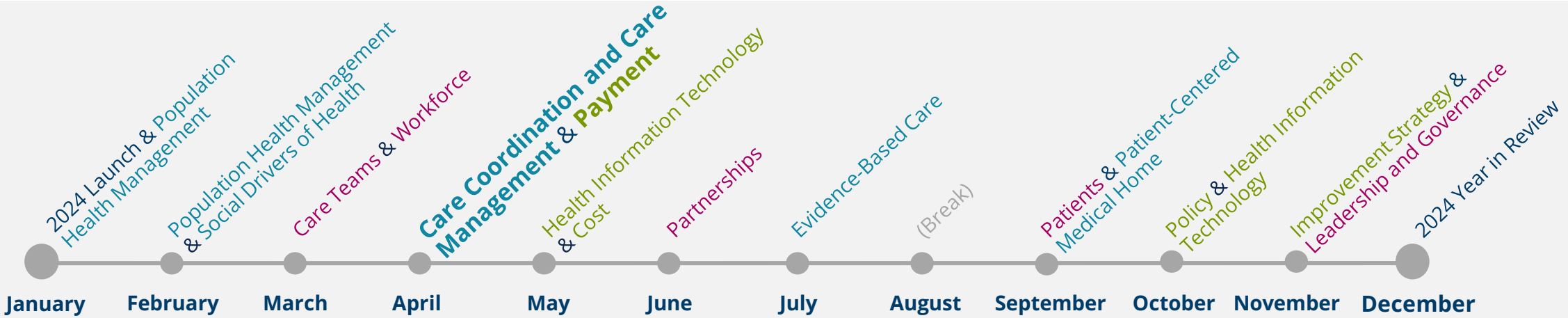
sunrise
COMMUNITY HEALTH

LAMPREY HEALTH CARE
SINCE 1971

Elevate 2024

15 Change Areas covered over 2024 calendar year

Monthly Learning Forums:



Supplemental Sessions:

- Value-Based Care Series – Coming soon! May/June 2024
- Clinical Quality Measures & Addressing Care Gaps – Summer 2024

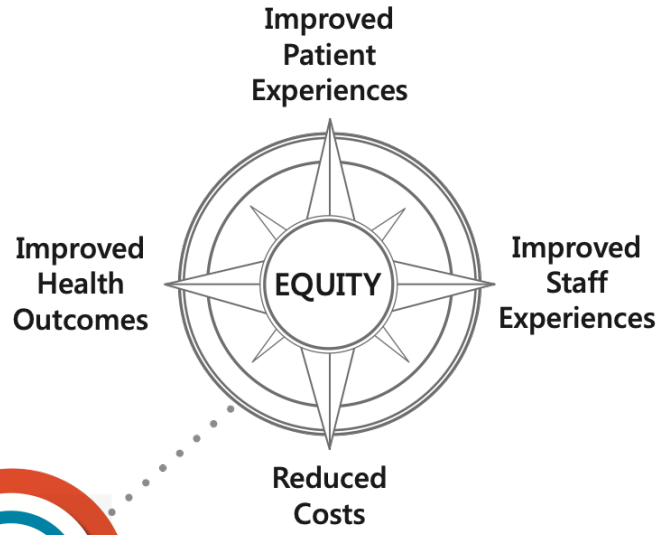
Professional Development Courses:

- **Clinical Staff & Health Coaches:** Lifestyle Coaching for the CDC's National Diabetes Prevention Program – **Applications due 4/12!**
- **Clinical Staff & Health Coaches:** Person-Centered Care for Individuals with Higher Weight – **Applications due 4/12!**
- **Quality Improvement Staff** – Summer/Fall 2024

*Schedule may be adjusted by the Quality Center as needed.

Elevate Journey

Your transformation journey begins here!



STEP 1 - ENGAGE
Register for Elevate and participate in the **FREE** health center learning community. Invite others

STEP 2 – ASSESS
Measure transformation progress using the Value Transformation Framework (VTF) Assessment

STEP 3 – PLAN
Incorporate transformation efforts into your Improvement Strategy

STEP 4 – TRANSFORM
Apply the VTF and suite of transformation tools and resources

STEP 5 – REASSESS
Measure transformation progress over time using the VTF Assessment; monitor, adjust, and improve

Complete VTF Assessments ➡ Access FREE OSV Tool

Complete 3+ VTF Assessments:

Health centers can receive a 6-month trial membership to an online document management platform to support health center Operational Site Visit (OSV) preparation and ongoing compliance!

Trial offer - $6,000 value

Missed the information session on the free Trial Subscription?
Email support@reglantern.com to express interest

REGLANTERN

RegLantern Continuous Compliance Tool

- Cloud-based platform that helps health centers move toward continuous HRSA compliance
- FTCA Application Tool
- Allows health centers to compile and organize all documents demonstrating compliance in one place
- Embedded with checklists, alerts, and reminders
- Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV) through Citrix ShareFile integration
- Access to exclusive discounts for health centers interested in continuing subscription after trial period.
- Free Form 5A Review

Data Dashboard

VTF Assessments (2019-current)

504 Health Centers
1809 Assessments

Average VTF Assessment Scores by Change Area

Health Information Technology 2.89	Improvement Strategy 3.11	Policy 2.97	Payment 2.83	Cost 2.75
Population Health Management 3.08	Patient-Centered Medical Home 3.59	Evidence-Based Care 3.28	Care Coordination and Care Management 3.19	Social Drivers of Health 3.09
Patients 3.14	Care Teams 2.98	Leadership 3.01	Workforce 2.85	Partnerships 3.42

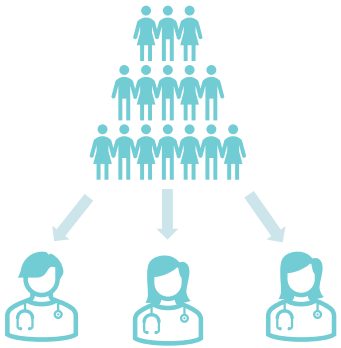
Leverage data to drive improvement!

- **National level:** Guides NACHC in program and resource development.
- **State level:** Guides PCAs & HCCNs in training and technical assistance offerings.
- **Health center level:** Guides health centers in transformation & QI opportunities.

Foundational Steps to Care Management

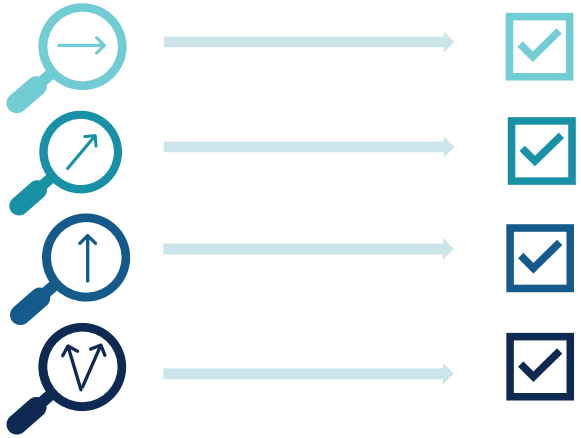
Empanelment

Matching every patient to a primary care provider and care team.



Risk Stratification

Segmenting patients into groups of similar complexity and care needs.

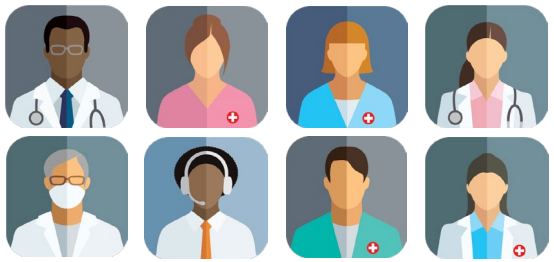


Models of Care

Care models based on risk for patients to be paired with more appropriate care team members and services.

Care Teams

Care teams and tasks are based on the needs of the patient population and the availability of personnel, services, and other resources.



Care Management

Intensive one-on-one services to individuals with complex health and social needs.

The Business Case for Care Management

Care Management Services	CPT & HCPCS Codes	Code FQHC Bills to CMS	CMS Pays (Physician Fee Schedule)
Chronic Care Management	See NACHC Payment Action Guide or the NACHC Reimbursement Tip Sheet for the corresponding service	G0511	$71.70
Complex Chronic Care Management		G0511	$71.70
Principal Care Management		G0511	$71.70
Chronic Pain Management		G0511	$71.70
Transitional Care Management		G0467	$195.99 $95.27, if telehealth (bill using G2025)
Behavioral Health Integration		G0511	$71.70
Psychiatric Collaborative Care Management		G0512	$144.05
Community Health Integration		G0511	$71.70
Principal Illness Navigation		G0511	$71.70
Remote Physiologic Monitoring		G0511	$71.70
Remote Therapeutic Monitoring		G0511	$71.70

The End Goal...

A care management program that **meets the needs of patients** while also meeting requirements for **CMS reimbursement**.

Opportunity for **additional revenue streams** as many payors model reimbursement after CMS requirements.

Get paid for your patient care coordination and management efforts!

Generate revenue to support transformation.

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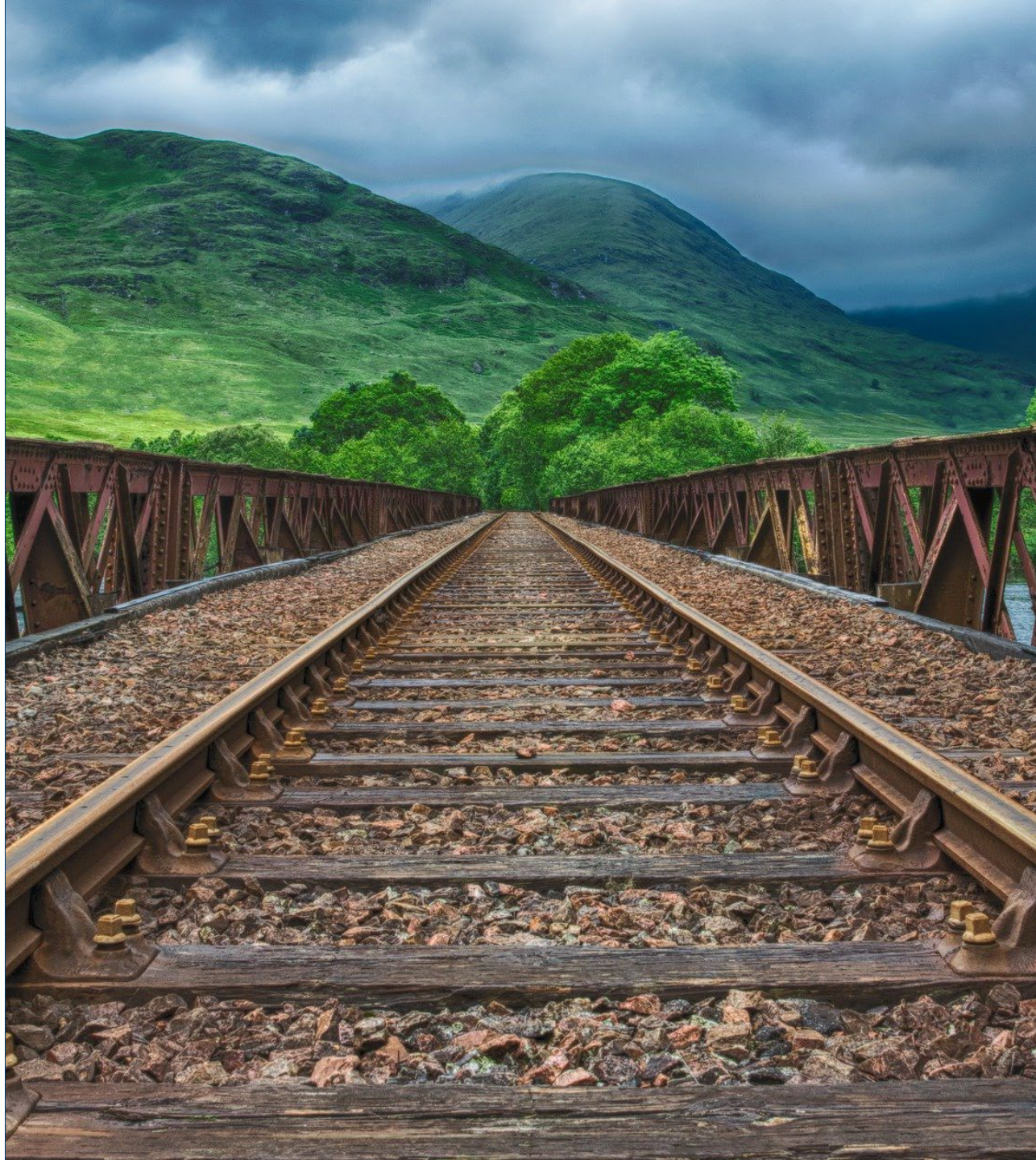

Implementing a Care Mangement Program

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VTF Assessment: Care Coordination & Care Management

VTF Change Area: Care Coordination & Care Management

Facilitate the delivery and coordination of care for high-risk and other patient segments through targeted services, provided when and how needed.

	1 – Learning	2 – Basic	3 – Applied	4 – Skilled	5 – Expert
Care Coordination & Referrals				*Health center's referral and tracking process includes goals for referral management that are incorporated into health center improvement strategies…*	
Transitions of Care				*Health center operates a transitional care management program that meets Transitional Care Management (TCM) billing requirements of the Centers for Medicare and Medicaid Services (CMS), though health center may not be billing for services…*	
Care Management				*Health center operates a care management system for high-risk patients that meets billing requirements for the Centers for Medicare and Medicaid Services (CMS) care management services (e.g., Chronic Care Management (CCM)…*	

WHAT services does a care management program provide?

Care management involves intensive, one-on-one services, provided by one or more care team members, to individuals with complex health and social needs.

Medicare care management services *(reimbursable outside of PPS!)* include:

- Chronic Care Management
- Complex Chronic Care Management
- Principal Care Management
- Transitional Care Management
- Behavioral Health Integration
- Psychiatric Collaborative Care Management
- Community Health Integration
- Principal Illness Navigation
- Chronic Pain Management
- Remote Physiologic Monitoring
- Remote Therapeutic Monitoring

Programs differ in ***eligible patients***, ***staff who may provide/bill for services,*** and ***service elements*** but **ALL** involve providing individualized support to patients outside of typical office visits.

In this learning forum, we will focus on how to implement a **Chronic Care Management** Program.

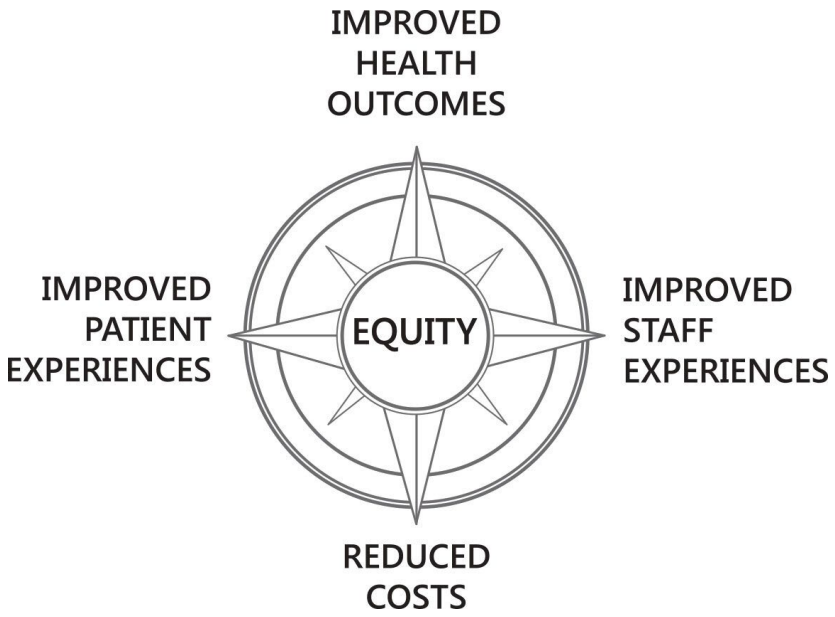
WHAT services does a care management program provide?

Key components of Chronic Care Management include:

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

WHY implement a care management program?

Quintuple Aim Goals:



Improved health outcomes

- Chronic condition management
- Care plans designed to meet patient health goals
- Support with preventive services and social risk factors
- Education and self-management support

Improved patient experience

- Increased time and attention from care providers

Improved staff experience

- Skill development and career advancement pathway
- Contributes to optimized care team functioning

Reduced cost

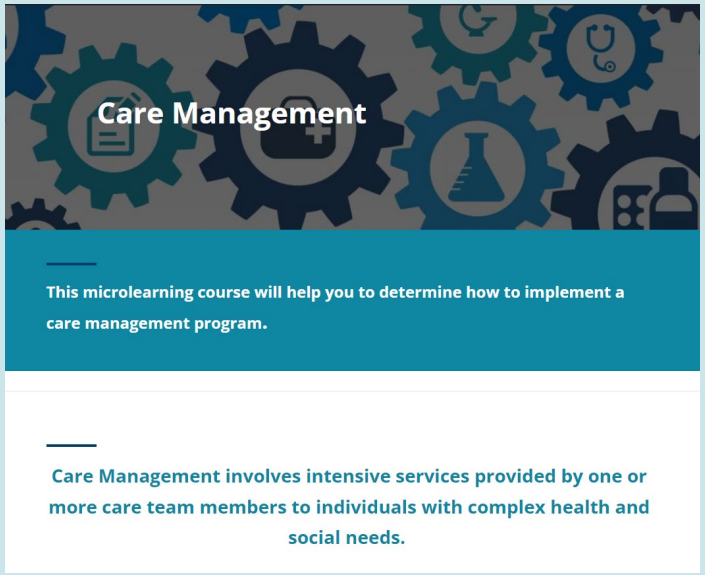
- Better control financial risks/high cost of care associated with complex patients

Advanced equity

- Individualized support to patients experiencing health disparities and social needs

HOW to implement a care management program

NEW!



Care Management Microlearning

STEP 1 Ensure leadership support of initiative

STEP 2 Define care management services to be provided

STEP 3 Identify or hire a care manager

STEP 4 Announce initiative to all health center staff

STEP 5 Identify eligible patients through data

STEP 6 Provide training specific to job role

STEP 7 Design workflow and prepare HIT systems to support program

STEP 8 Enroll patients

STEP 9 Provide and document care management services

STEP 10 Ensure regular communication with provider, care team

STEP 11 Code and bill for services

STEP 12 Monitor program outcomes as part of health center quality improvement plan

STEP 1 *Ensure Leadership Support of Initiative*

Engage health center leadership, Board members, and other stakeholders to support the implementation of a care management program. Highlight the ways this work aligns with existing organizational priorities and adds value to patients, the health center, and the community.

State the business imperative for care management, including serving as a foundation for value-based care.

All organizational transformation, including the implementation of a care management program, requires that leaders invest in and train health center staff as well as provide staff with protected time to work toward program goals.

Leadership must also invest in the tools and infrastructure needed to support activities, including health information technology that can support the delivery of care management services.

Tools & Resources: NACHC Leadership Action Guide

STEP 2

Define Care Management Services to be Provided

Care management programs can differ across health centers as well as across payor and state initiatives.

DIFFERS BY PROGRAM

- Patients eligible to participate (demographics, insurance type, clinical conditions, social risk factors)
- Staff roles who provide services
- Services provided through the care management program
- Coding and billing opportunities

Define the care management services your health center will provide based on:

- Patient population needs
- Health center priorities, resources, and staffing
- Reimbursement opportunities

After defining services, identify a pilot site, provider champion, and patient panel where services will be initially implemented. This enables process improvement to occur before services are expanded to additional sites, providers, and patients.

STEP 3 *Identify or Hire a Care Manager*

DIFFERS BY PROGRAM

For a Chronic Care Management (CCM) Program, this is most commonly a Nurse (CNS, RN, LPN), may also be a Social Worker.

The care manager is member of the expanded care team and works closely with the Provider, Medical Assistants, Nurses, patient-facing administrative staff, and other care team members who are working together to support a panel of patients.

The identified care manager is responsible for providing the one-on-one care management services to a sub-panel of patients with complex health and social needs. (See *Step 9* for a description of CCM service elements.)

Define the roles and responsibilities of the care manager with a clear job description.

Tools & Resources:
- NACHC Care Teams Action Guide
- Sample Job Description

STEP 4

Announce Initiative to all Health Center Staff

Successful initiatives start with communication! Inform health center staff about the organization's plans to implement a care management program and explain its impact on staff and patients.

Be sure to acknowledge the care manager leading the program and recognize other staff (e.g., provider champion, members of the care team, IT staff, and others) who will be needed to support program activities.

STEP 5 *Identify Eligible Patients Through Data*

DIFFERS BY PROGRAM

Work together with IT/data staff to pull reports of patients who meet eligibility criteria to be used in *Step 8, Enroll Patients.* Consider the pilot site, provider champion, and patient panel identified in *Step 2.*

CCM: Medicare patients who have multiple (two or more) chronic continuous or episodic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

NCQA PCMH:

- The practice systematically identifies patients who may benefit from care management
- Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management:
  - ✓ Behavioral health conditions
  - ✓ High cost/high utilization
  - ✓ Poorly controlled or complex conditions
  - ✓ Social determinants of health
  - ✓ Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver
- Applies a comprehensive risk-stratification process for the entire patient panel to identify and direct resources appropriately (elective)

Tools & Resources: NACHC Risk Stratification Action Guide

STEP 6

Provide Training Specific to Job Role

Care Manager

- ✓ Required service elements of program (see *Step 9*)
- ✓ Documentation requirements for coding & billing
- ✓ Empathic inquiry
- ✓ Motivational interviewing
- ✓ Patient case studies
- ✓ Technology that will be utilized

Leadership & Board

- ✓ General understanding of program to support goal setting, strategic planning, ensuring the program has necessary resources

All Health Center Staff

- ✓ General understanding of program to support patients and administrative functions

Provider Champion, Care Team, Care Manager

- ✓ Required service elements of program (provides clarity on care team member roles)
- ✓ Communication (see *Step 10*)

QI & Data Staff

- ✓ General understanding of program to support process improvement and reporting on program metrics

Coding & Billing Staff

- ✓ Documentation requirements, codes

STEP 7

Design Workflow and Prepare Health Information Technology (HIT) Systems to Support Program

Consider processes & HIT functionality for:

- Panel management
- Documenting a care management encounter/'visit'
- Service elements (see *Step 9*)
  - Care plan template
- Time spent providing services
- Billing & coding
- Care team communication (see *Step 10*)

NCQA PCMH:

- The care plan is integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement (elective)

STEP 8 *Enroll Patients*

Determine which method, or combination of methods, will be most effective in enrolling patients:

Outreach
- Phone calls
- Letters
- Text/portal messages

Warm handoffs

Referrals

Provide information on what care management services include, whether the patient will be responsible for any copays/coinsurance, and why their PCP is recommending them for care management services.

Receive patient consent for care management services.

A full panel size for a care manager is likely to be in the range of 50-150 high-risk patients. Factors affecting panel size include health center processes, the care manager's experience, the clinical and social complexity of patients, available social supports, and desired care management outcomes. Evaluate caseload size and manageability on an ongoing basis.

Keep in mind when setting goals or calculating potential revenue for care management, it takes time to build a patient panel!

STEP 9

Provide and Document Care Management Services

DIFFERS BY PROGRAM

CCM Service Elements

- ✓ 24/7 access to clinical support staff
- ✓ Continuity of care with designated care team member
- ✓ Comprehensive assessment of medical, functional, and psychosocial needs
- ✓ Preventive care
- ✓ Medication management
- ✓ A comprehensive ***care plan*** created, monitored, revised, and shared with the patient/caregiver and other internal/external members of the patient's care team.
- ✓ Patient education and resources
- ✓ Care coordination

STEP 9

Provide and Document Care Management Services

DIFFERS BY PROGRAM

What is included in a care plan?

Following NCQA PCMH, a care plan includes:

- ✓ Problem list
- ✓ Expected outcome/prognosis
- ✓ Treatment goals
- ✓ Medication management
- ✓ Community and/or social services
- ✓ A schedule to review and revise the plan, as needed

When developing a care plan:

- Involve the patient, including discussions about goals (e.g., patient function/lifestyle goals, goal feasibility and barriers) and consider patient preferences
- Write the care plan at a health literacy level accessible to the patient (i.e., does not contain medical jargon, abbreviations/acronyms or billing codes)
- Use motivational interviewing to assess patient readiness to change and self-management abilities through patient questionnaires and self-assessment forms.
- Provide the patient with a copy of the care plan

STEP 10

Ensure Regular Communication with Provider, Care Team

Consider how the care plan will be shared with members of the care team (see *Step 7*):

- Internal care team (PCP and others)
- External care team members (outside of the health center)
- Patient/caregiver

Use huddles to share key updates regarding Care Management patients who have a scheduled appointment that day.

Implement meetings with key care team members dedicated to discussing high risk patients.

STEP 11 *Code and Bill for Services*

DIFFERS BY PROGRAM

Services may be billed once per calendar month:

What the Provider Codes (CCM)	Services (CCM)	Code FQHC Bills to CMS	CMS Pays (Physician Fee Schedule)
CPT 99490	At least **20 minutes** of services provided by auxiliary personnel.	G0511	$71.70
CPT 99491	At least **30 minutes** of services provided by the authorized billing provider.	G0511	$71.70

Once a minimum CPT service time threshold is reached, FQHCs are expected to continue furnishing services, as applicable, during the calendar month and are not permitted to bill for any additional time via add-on service codes.

G0511 can be billed multiple times per month for separately identifiable services, co-insurance applies. Certain services cannot be billed together.

STEP 12

Monitor Program Outcomes as Part of Health Center Quality Improvement Plan

Incorporate measures into your health center's QI Plan, and use data to scale your care management program, meet the needs of your patient population, and balance staffing/care team responsibilities.

Consider measuring:

- The number of patients in each care manager's panel
- Each care manager's panel size over time to view 'net' changes
- Patient enrollments and disenrollments by month
- Patient disenrollments by reason
- The number of CCM eligible patients enrolled in care management
- The number of completed Care Management encounters
- The number of billed CCM encounters
- The impact on UDS quality measures
- Progress on patient care management goals

NCQA PCMH: Monitor the percentage of the total patient population identified for Care Management through its process and criteria.

Tools & Resources:

- NACHC Improvement Strategy Action Guide
- Monitoring Care Management Program Outcomes

Featured Health Center

Michele Labs, MSN-E, RN, CCM
Associate Director Value Based Care
OneWorld Community Health Centers, Inc.

- *Nurse > 25 Years*
  - *BSN Clarkson College 1998*
  - *MSN-Education Walden University 2007*
- *MCO/VBC > 10 Years*
- *Certified in Case Management since 2014*
- *OneWorld > 5 Years*
  - *Nurse Manager TOC/VBC 2018-2022*
  - *AD VBC 2023-Present*
- *Specialty: Quality Improvement & Revenue Sourcing through VBC*

William Ostdiek, MD
CMO
OneWorld Community Health Centers, Inc.

- *Family Physician >20 years*
- *FQHC leadership >6 years*
- *Special interests: population health and medical care for individuals experiencing homelessness*
- *MD University of Nebraska Medical Center*

Featured Health Center

- Located in Omaha, Nebraska
- 22 Sites: Medical/Quick Sick/Behavioral Health/Dental/Immigration/Learning Center/Teens & Young Adults/School-based Health Centers/Mobile Clinics/Homeless shelter/WIC
- Served 51, 913 patients and had 181,702 visits in 2023
- 2023 Awards/Achievements

- Engaged in 4 VBC contracts, 2 of which are Shared Savings
- Unique aspect: resourced VBC contracts to account for over 5% of budgeted revenue

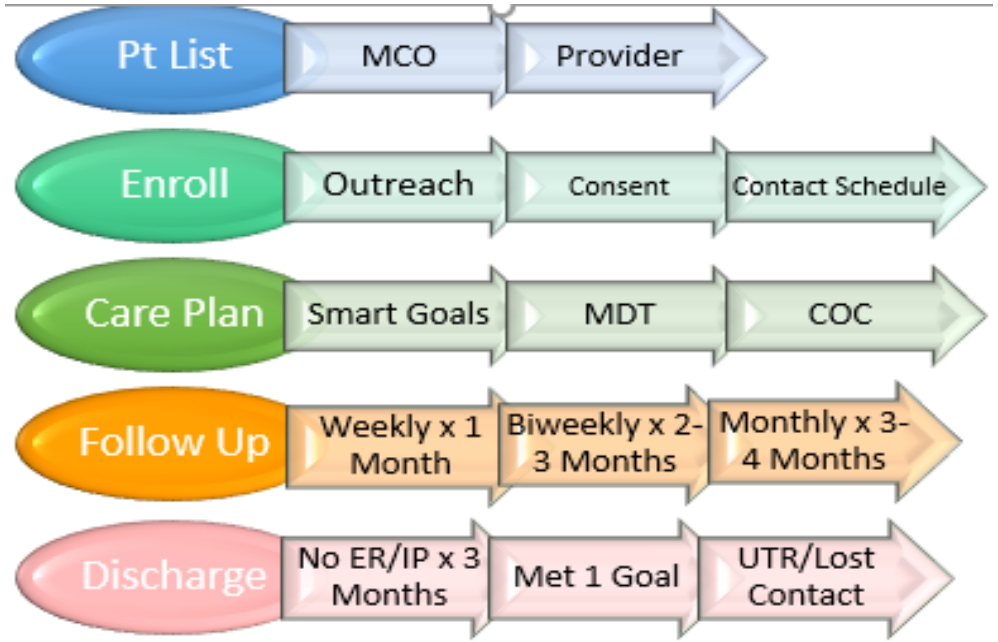
Featured Health Center

OneWorld developed Multidisciplinary (MDT) meetings, Care Coordination meetings, and templates to enhance our patient care:

- **People:**
  - We have 3 Care Managers (2.5 FTE): 1LPN, 2RN who share the workload for our Transitions of Care (TOC), High Utilizers, High Risk, Complex Pts. We have figured the salary of a 1.0 FTE into our VBC contracts.
  - Ongoing communication is essential between provider, patient, care manager, pharmacy, and Managed Care Organization (MCO). We have 2 monthly meetings (MDT: Provider/CM/SW from MCO/Pharm) and a Care Coordination Meeting (MCO/CM)
- **Infrastructure:**
  - NextGen EMR SDOH risk score
  - MCO Report with usage in dollars and a predictive risk score
  - Templates for documentation and meetings
  - Secure File Transfer Protocol (SFTP) sites with the MCOs
  - State database for hospitalizations/ER usage

Featured Health Center

- **Care Delivery:**
  - Process



  - Impact on Care
    - Care is focused on a holistic patient centered approach
    - Meaningful provider visits often with CM/patient
    - More communication has decreased no-show rate as well as noncompliance

Featured Health Center

OneWorld Community Health Centers, Inc.

Case Management Documentation Template

Screening/Assessment

- Pt Info (Number called/name of person/etc.)
- Medical/Behavioral Conditions
- Affect
- ER/IP
- Recent specialty appointments
- Recent medication refills/changes
- ADLS
- SDOH
    - Housing
    - Transportation
    - Food
    - Other

Planning

- Goal (SMART)
- Goal Progress

Care Coordination

Subjective

Next Appointment/Follow Up

NextGen Care Plan Template

Area	Responses	Dates
Supportive Services		
Chronic Problem Details		
Community Supports/Self Help Groups		
Living Will/ Health Care Proxies		
Durable Medical Equipment		
Healthcare Providers		
Self Management Goals (SMART)		
Allergies & Medication Reactions		
Care Team & Patient Contact Info for Questions		
Details for Patient Care Plan Document		
Follow up & Pending Appts		
Next CM Contact Date & Preference		

MDT Template

Person #/MRN	Last Name	First Name	DOB	Age	Insurance	PMH (3-5)	Top Barriers 1-2	Meds	Plan	Progress	ED	IP	MDT Dates	MDT Notes

Tools & Resources: OneWorld's Templates

Featured Health Center

Outcomes

- Decreased ER
  - Decreased cost by 28% for MCO contract
- Improved patient/provider relationship
- Increased patient satisfaction

Lessons Learned

- Provider Paloozas
- Accurate attribution is essential
- Utilizing both BH and medical for MDT
- Referral criteria
- Acuity score

Payment for Care Mangement Services

VTF Assessment: Payment

VTF Change Area: Payment

Utilize value-based and sustainable payment methods and models to facilitate care transformation.

	1 – Learning	2 – Basic	3 – Applied	4 – Skilled	5 – Expert
Payment Strategy				*Health center leaders have outlined a strategy for payment reform which includes transforming care and services. Health center has secured appropriate legal and compliance expertise for proposed alternative payment methods…*	
Financial Models				*Health center leaders use financial modeling to support negotiations with various payers and understand financial requirements to support the transition to value-based care.*	
Engagement in Value-Based Contracts				*Health center has entered into a risk-based value-based contract (e.g., through an independent practice association, accountable care organization, etc.) and is actively working to optimize payments.*	
CIN Participation				*Health center is actively engaged in a clinically integrated network (CIN), and through the CIN, is engaged in negotiations to enter into an alternative payment model (APM) or risk-based contract.*	

Payment for Care Management Services

Health centers can obtain revenue above and beyond their federally-qualified all-inclusive Prospective Payment System (PPS) encounter rate for medically necessary, allowable care management services.

This additional revenue can help fund systems transformation as well as be an important part of a health center's value-based care model.

Medicare care management services include:

- Chronic Care Management
- Complex Chronic Care Management
- Principal Care Management
- Transitional Care Management
- Behavioral Health Integration
- Psychiatric Collaborative Care Management
- Community Health Integration
- Principal Illness Navigation
- Chronic Pain Management
- Remote Physiologic Monitoring
- Remote Therapeutic Monitoring

Payment for Care Management Services

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Remote Physiologic Monitoring		G0511	$71.70
Remote Therapeutic Monitoring		G0511	$71.70

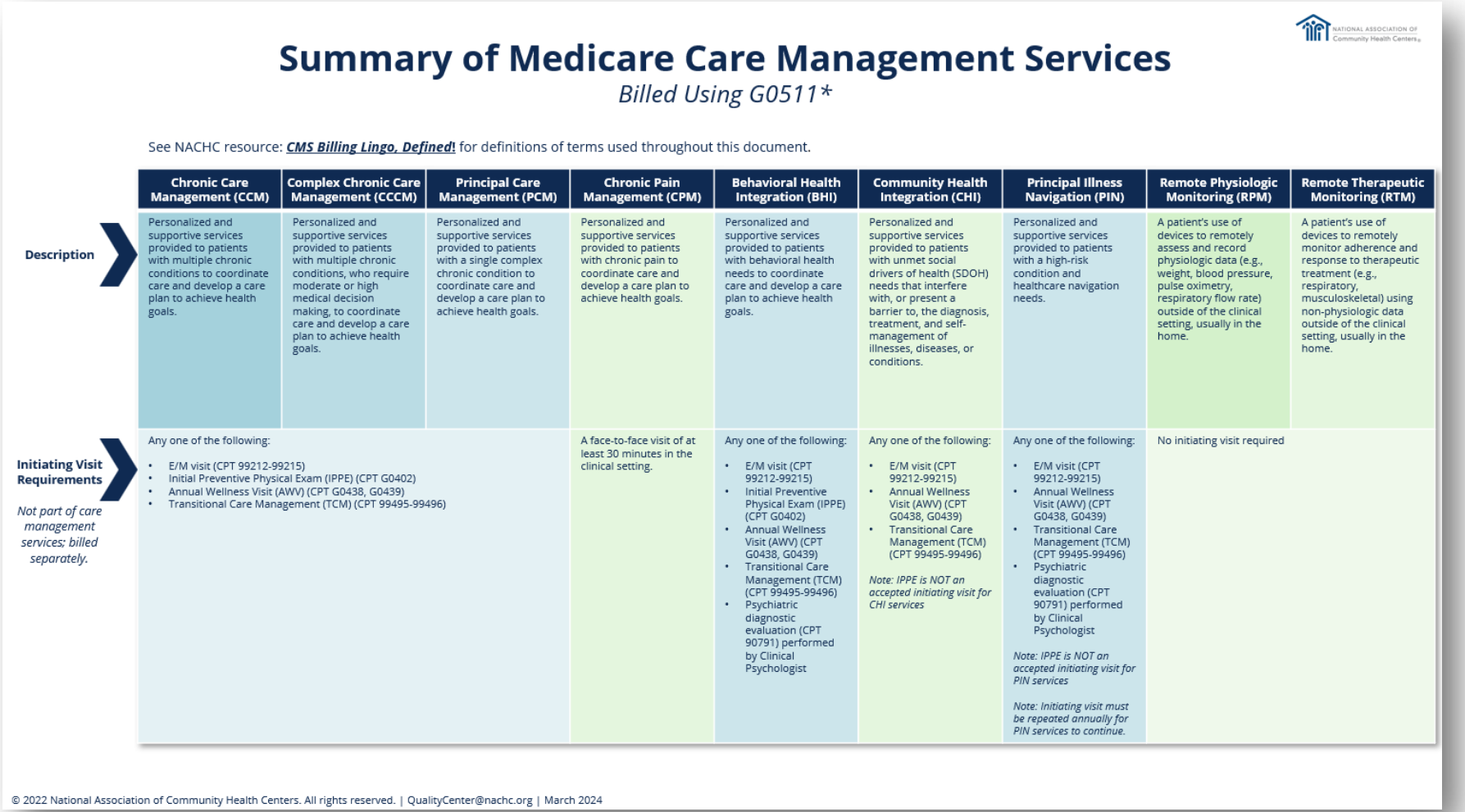
NEW Resource!

Summary of Medicare G0511 Care Management Services:

- ✓ Chronic Care Management
- ✓ Complex Chronic Care Management
- ✓ Principal Care Management
- ✓ Chronic Pain Management
- ✓ Behavioral Health Integration
- ✓ Community Health Integration
- ✓ Principal Illness Navigation
- ✓ Remote Physiologic Monitoring
- ✓ Remote Therapeutic Monitoring

Summary Includes:

- ✓ Description
- ✓ Initiating visit requirements
- ✓ Eligible patients
- ✓ Authorized billing providers
- ✓ Examples of auxiliary personnel
- ✓ Service elements
- ✓ CPT & HCPCS codes
- ✓ Examples of co-occurring services



Summary of Medicare Care Management Services

*Billed Using G0511**

See NACHC resource: ***CMS Billing Lingo, Defined!*** for definitions of terms used throughout this document.

	Chronic Care Management (CCM)	Complex Chronic Care Management (CCCM)	Principal Care Management (PCM)	Chronic Pain Management (CPM)	Behavioral Health Integration (BHI)	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	Remote Physiologic Monitoring (RPM)	Remote Therapeutic Monitoring (RTM)
Description	Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with multiple chronic conditions, who require moderate or high medical decision making, to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with a single complex chronic condition to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with chronic pain to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with behavioral health needs to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.	Personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs.	A patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) outside of the clinical setting, usually in the home.	A patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data outside of the clinical setting, usually in the home.
Initiating Visit Requirements *Not part of care management services; billed separately.*	Any one of the following: • E/M visit (CPT 99212-99215) • Initial Preventive Physical Exam (IPPE) (CPT G0402) • Annual Wellness Visit (AWV) (CPT G0438, G0439) • Transitional Care Management (TCM) (CPT 99495-99496)			A face-to-face visit of at least 30 minutes in the clinical setting.	Any one of the following: • E/M visit (CPT 99212-99215) • Initial Preventive Physical Exam (IPPE) (CPT G0402) • Annual Wellness Visit (AWV) (CPT G0438, G0439) • Transitional Care Management (TCM) (CPT 99495-99496) • Psychiatric diagnostic evaluation (CPT 90791) performed by Clinical Psychologist	Any one of the following: • E/M visit (CPT 99212-99215) • Annual Wellness Visit (AWV) (CPT G0438, G0439) • Transitional Care Management (TCM) (CPT 99495-99496) *Note: IPPE is NOT an accepted initiating visit for CHI services*	Any one of the following: • E/M visit (CPT 99212-99215) • Annual Wellness Visit (AWV) (CPT G0438, G0439) • Transitional Care Management (TCM) (CPT 99495-99496) • Psychiatric diagnostic evaluation (CPT 90791) performed by Clinical Psychologist *Note: IPPE is NOT an accepted initiating visit for PIN services* *Note: Initiating visit must be repeated annually for PIN services to continue.*	No initiating visit required	

Summary of Medicare Care Management Services Billed Using G0511

Summary of Medicare Care Management Services *Billed Using G0511**

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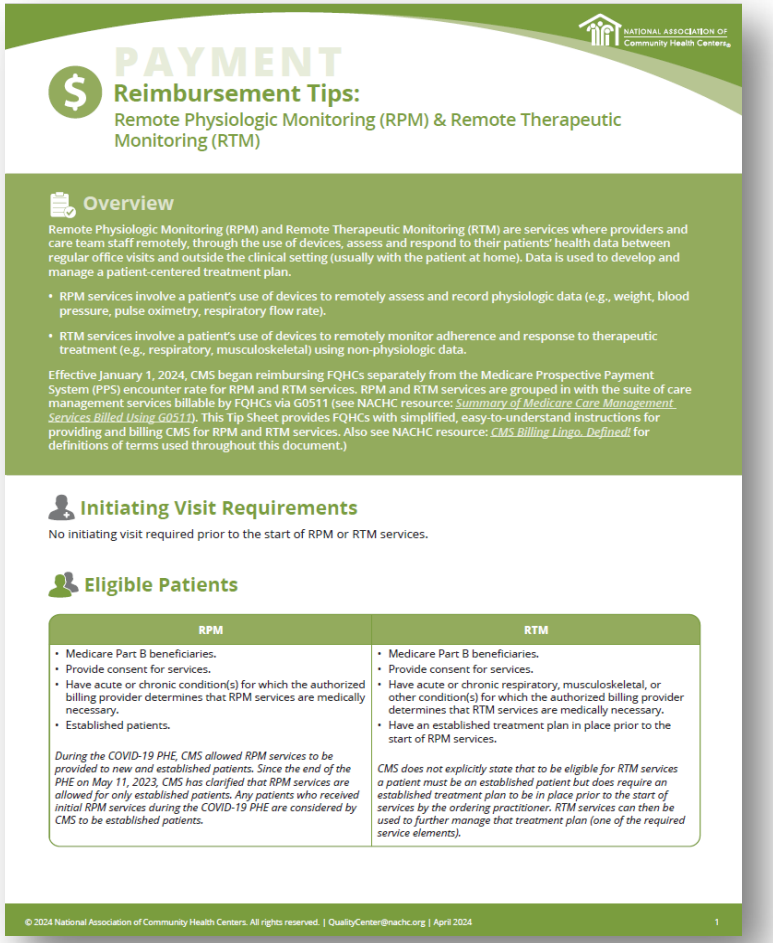
	Chronic Care Management (CCM)	Complex Chronic Care Management (CCCM)	Principal Care Management (PCM)	Chronic Pain Management (CPM)	Behavioral Health Integration (BHI)	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	Remote Physiologic Monitoring (RPM)	Remote Therapeutic Monitoring (RTM)
Service Elements	Services may be billed once per calendar month after: At least **20 minutes** of services provided by auxiliary personnel. Or At least **30 minutes** of services provided by the authorized billing provider.	Services may be billed once per calendar month after: At least **60 minutes** of services provided by auxiliary personnel and/or authorized billing provider per calendar month.	Services may be billed once per calendar month after: At least **30 minutes** of services provided by auxiliary personnel. Or At least **30 minutes** of services provided by the authorized billing provider.	Services may be billed once per calendar month after at least **30 minutes** of services provided by the authorized billing provider, including: • Administration of a validated pain rating scale or tool • Patient-centered care plan • Patient assessment and monitoring of their diagnosis and treatment • Medication management • Pain and health literacy counseling • Facilitation, coordination, and on-going communication with other necessary providers (e.g., behavioral health, physical and/or occupational therapy, home care) • Facilitation for crisis care for chronic pain	Services may be billed once per calendar month after at least **20 minutes** of services provided by the authorized billing provider or auxiliary personnel (CPT 99484) or by CP, CSW, MHC, or MFT (G0323), including: • Initial assessment and ongoing monitoring using validated clinical rating scales • Behavioral health care planning in relation to behavioral/psychiatric health problems, including time spent modifying plans for patients who are not progressing or whose status changes • Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation • Continuity of care with a designated member of the care team • Coordination with and/or referral to qualified providers for medication, E/M services, counseling and/or psychiatric consultation (G0323)	Services may be billed once per calendar month after at least **60 minutes** of services provided by certified or trained auxiliary personnel, including: • Patient-centered assessment • Coordination with home- and community-based resources • Health education • Developing self-advocacy skills • Health care access and navigation • Patient behavioral change facilitation • Facilitate and provide social and emotional patient support	Services may be billed once per calendar month after at least **60 minutes** of services provided by certified or trained auxiliary personnel, including: • Patient-centered assessment (PIN) or interview (PIN-PS) • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Health education • Developing self-advocacy skills • Health care access/health system navigation • Facilitating behavioral change as necessary for meeting diagnosis and treatment goals (PIN only) • Facilitating and providing social and emotional support	Services may be billed once per calendar month after at least **16 days of data** have been collected in a 30-day period. • Initial device set-up and patient education on the use of equipment. • Device supply with scheduled recording(s) and transmissions • The collection, analysis, and interpretation of digitally collected physiologic data. • Management of a patient-centered treatment plan. • CPT services 99457 and 99458 require at least one interactive communication with the patient during the calendar month, 20 minutes of authorized billing provider time. *Note: This is a summary of RPM service elements. Each RPM CPT code includes a unique set of service elements to be provided.*	Services may be billed once per calendar month after at least **16 days of data** have been collected in a 30-day period. • Initial device set-up and patient education on the use of equipment. • Device supply with scheduled recording(s) and transmissions • Review and monitoring of data related to signs, symptoms, and functions of respiratory or musculoskeletal system therapeutic response. • Non-physiologic and therapeutic data can be patient self-reported and/or digitally uploaded • Management of a patient-centered treatment plan. • CPT services 98980 and 98981 require at least one interactive communication with the patient during the calendar month, 20 minutes of authorized billing provider time. *Note: This is a summary of RTM service elements. Each RTM CPT code includes a unique set of service elements to be provided.*
	• 24/7 access to clinical support staff • Continuity of care with designated care team member • Comprehensive assessment of medical, functional, and psychosocial needs • Preventive care • Medication management • A comprehensive care plan created, monitored, revised, and shared with the patient/caregiver and other internal/external members of the patient's care team. • Patient education and resources • Care coordination								

UPDATED & NEW Resources!



PAYMENT

Reimbursement Tips:

Remote Physiologic Monitoring (RPM) & Remote Therapeutic Monitoring (RTM)

Overview

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) are services where providers and care team staff remotely, through the use of devices, assess and respond to their patients' health data between regular office visits and outside the clinical setting (usually with the patient at home). Data is used to develop and manage a patient-centered treatment plan.

- RPM services involve a patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate).
- RTM services involve a patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data.

Effective January 1, 2024, CMS began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for RPM and RTM services. RPM and RTM services are grouped in with the suite of care management services billable by FQHCs via G0511 (see NACHC resource: *Summary of Medicare Care Management Services Billed Using G0511*). This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing CMS for RPM and RTM services. Also see NACHC resource: *CMS Billing Lingo, Defined!* for definitions of terms used throughout this document.)

Initiating Visit Requirements

No initiating visit required prior to the start of RPM or RTM services.

Eligible Patients

RPM	RTM
• Medicare Part B beneficiaries. • Provide consent for services. • Have acute or chronic condition(s) for which the authorized billing provider determines that RPM services are medically necessary. • Established patients. *During the COVID-19 PHE, CMS allowed RPM services to be provided to new and established patients. Since the end of the PHE on May 11, 2023, CMS has clarified that RPM services are allowed for only established patients. Any patients who received initial RPM services during the COVID-19 PHE are considered by CMS to be established patients.*	• Medicare Part B beneficiaries. • Provide consent for services. • Have acute or chronic respiratory, musculoskeletal, or other condition(s) for which the authorized billing provider determines that RTM services are medically necessary. • Have an established treatment plan in place prior to the start of RPM services. *CMS does not explicitly state that to be eligible for RTM services a patient must be an established patient but does require an established treatment plan to be in place prior to the start of services by the ordering practitioner. RTM services can then be used to further manage that treatment plan (one of the required service elements).*

Reimbursement Tip Sheets:

Improved formatting

Simplified language (still detailed guidance)

Aligned with 2024 Medicare Physician Fee Schedule Final Rule

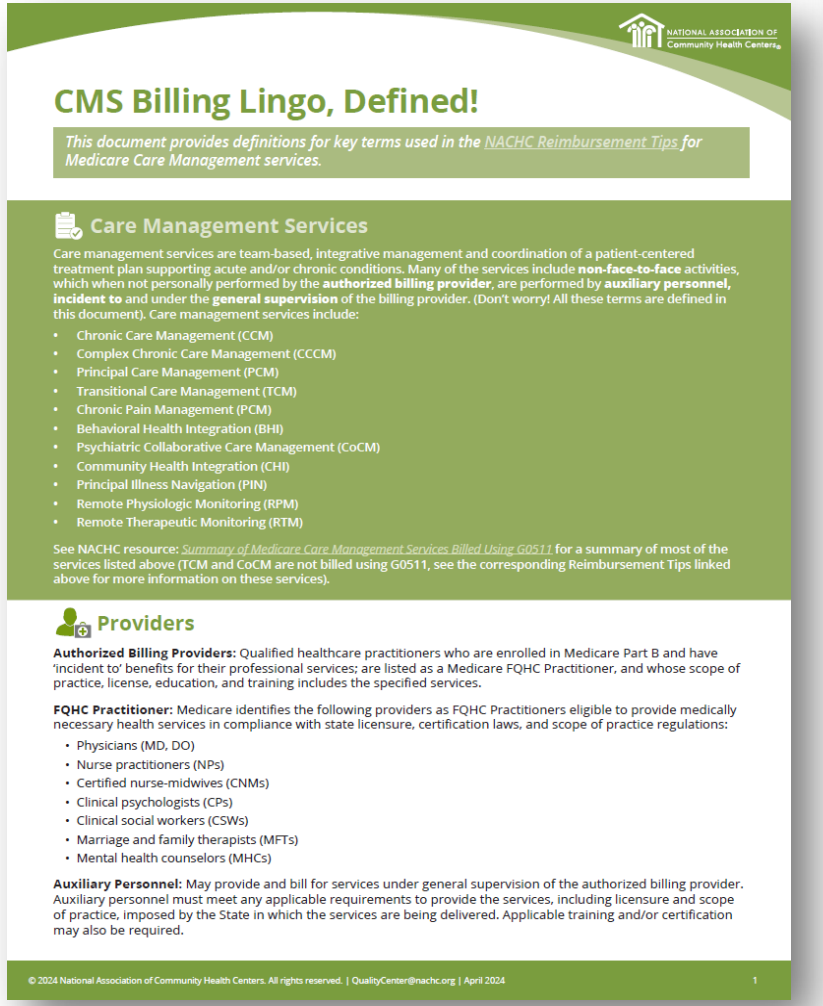
Available Now: Remote Physiologic Monitoring & Remote Therapeutic Monitoring **(New)**

Coming Soon:

- ✓ Community Health Integration **(New)**
- ✓ Principal Illness Navigation **(New)**
- ✓ Chronic Care Management, Complex Chronic Care Management & Principal Care Management **(Updated)**
- ✓ Transitional Care Management **(Updated)**
- ✓ Initial Preventive Physical Exam & Annual Wellness Visits **(Updated)**
- ✓ Behavioral Health Integration **(Updated)**
- ✓ Chronic Pain Management **(Updated)**
- ✓ Psychiatric Collaborative Care Management **(Updated)**
- ✓ Diabetes Self-Management Training & Medical Nutrition Therapy **(Updated)**
- ✓ Virtual Communication Services **(Updated)**
- ✓ Mental Health Telehealth **(Updated)**

NEW Resource!

CMS Billing Lingo, Defined!



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CMS Billing Lingo, Defined!

This document provides definitions for key terms used in the NACHC Reimbursement Tips for Medicare Care Management services.

Care Management Services

Care management services are team-based, integrative management and coordination of a patient-centered treatment plan supporting acute and/or chronic conditions. Many of the services include **non-face-to-face** activities, which when not personally performed by the **authorized billing provider**, are performed by **auxiliary personnel, incident to** and under the **general supervision** of the billing provider. (Don't worry! All these terms are defined in this document). Care management services include:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- Chronic Pain Management (PCM)
- Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Management (CoCM)
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)
- Remote Physiologic Monitoring (RPM)
- Remote Therapeutic Monitoring (RTM)

See NACHC resource: *Summary of Medicare Care Management Services Billed Using G0511* for a summary of most of the services listed above (TCM and CoCM are not billed using G0511, see the corresponding Reimbursement Tips linked above for more information on these services).

Providers

Authorized Billing Providers: Qualified healthcare practitioners who are enrolled in Medicare Part B and have 'incident to' benefits for their professional services; are listed as a Medicare FQHC Practitioner, and whose scope of practice, license, education, and training includes the specified services.

FQHC Practitioner: Medicare identifies the following providers as FQHC Practitioners eligible to provide medically necessary health services in compliance with state licensure, certification laws, and scope of practice regulations:

- Physicians (MD, DO)
- Nurse practitioners (NPs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)

Auxiliary Personnel: May provide and bill for services under general supervision of the authorized billing provider. Auxiliary personnel must meet any applicable requirements to provide the services, including licensure and scope of practice, imposed by the State in which the services are being delivered. Applicable training and/or certification may also be required.

Supervision

General Supervision: Services provided by auxiliary personnel under a qualified practitioner's overall direction and control, but the practitioner's physical presence is not required during the performance of the service.

Direct "Incident To" Supervision: Services provided by auxiliary personnel, under a qualified practitioner's direction and control, and the practitioner must be physically present in the office suite, but not in the examination room, and immediately available to furnish assistance. Through December 31, 2024, direct supervision requirements may be met by the immediate availability of the supervising practitioner through real-time audio-visual technology.

Types of Visits

Visit: An FQHC visit must be a medically necessary, face-to-face, interactive medical or mental health or qualified preventive encounter between the FQHC practitioner and patient where one or more qualified FQHC services are provided.

Face-to-Face Services: One or more services furnished during a one-on-one, in-person encounter between a practitioner or as permitted, by auxiliary personnel, and a patient. (A telehealth visit is a substitution for a face-to-face visit.)

Non-Face-to-Face Services: One or more activities performed with or for a patient by a practitioner or, as permitted, by auxiliary personnel between office visits and as part of an established treatment plan. Examples of non-face-to-face activities may include phone calls, digital communication, questionnaire completion, and care management and coordination.

New Patient: Under Medicare, this is an FQHC patient who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

Established Patient: Under Medicare, this is an FQHC patient who has received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, within the previous 3 years from the date of service.

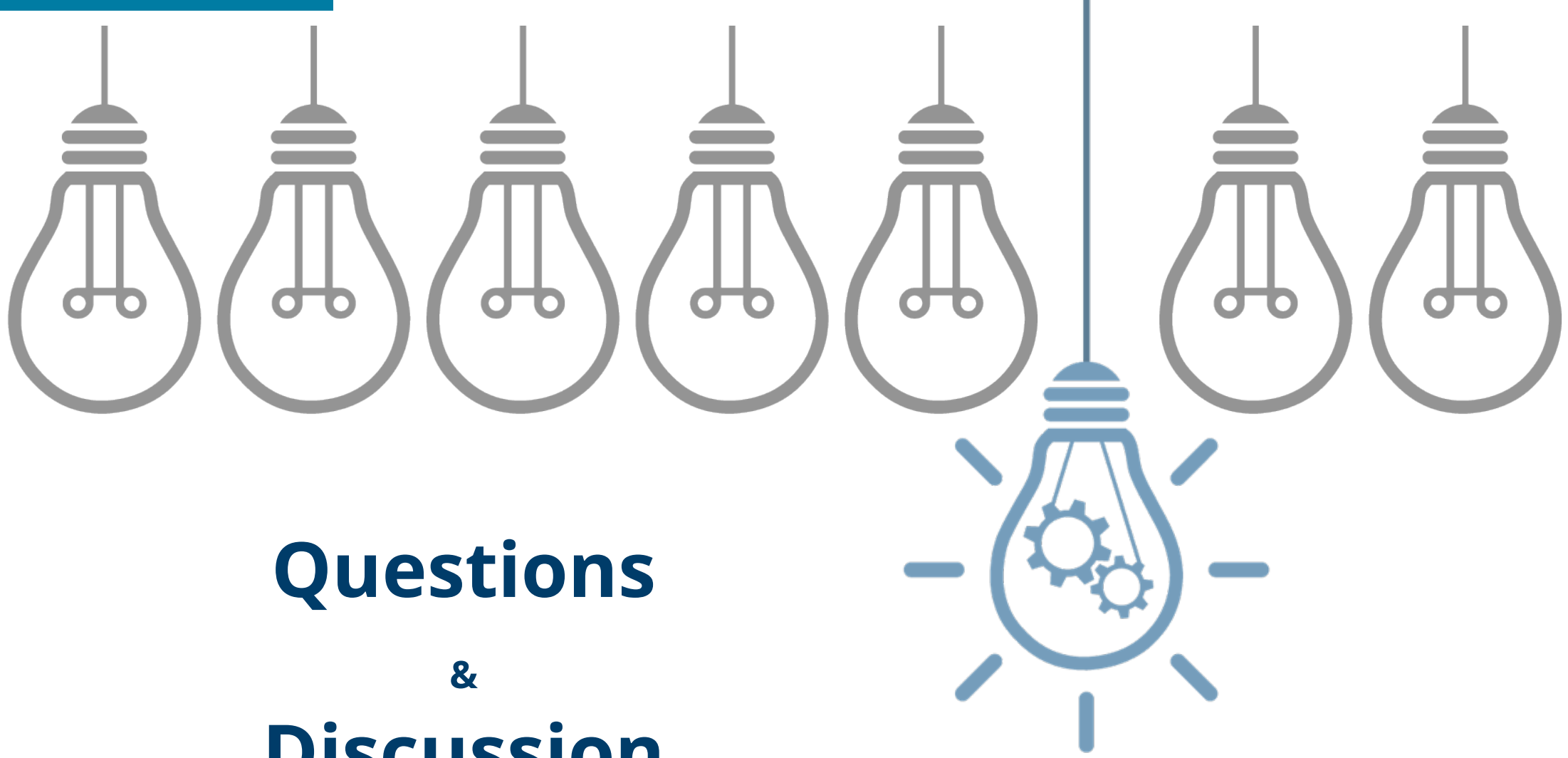
Telehealth Visit: Uses interactive audio and video telecommunications technology which permits two-way, real-time communication between the provider and patient. A telehealth visit is a substitution for a face-to-face visit. Flexibilities provided during the COVID-19 Public Health Emergency and extended through December 31, 2024 permit eligible FQHC practitioners to furnish qualified services on the Medicare Telehealth Service List as distant site including from the practitioner's home to a patient located in their home. During this extended period, telephone-only E/M services are included on the approved service list.

Originating Site: The location of the patient at the time the telehealth service is provided. Through December 31, 2024, the originating site includes the patient's home. Outside the PHE flexibilities and extension, only the FQHC and not the patient's home may be the originating site location for medical telehealth visits.

FQHC Billing & Coding Expert

Lisa Messina, MPH, CPC, CPCO
Messina Consulting, LLC

Lisa Messina is an independent consultant and the Compliance Lead for the FQHC division of Coronis Health. Lisa has over 20 years of health care health information management and operations experience working in the inpatient, outpatient, community clinic, and physician practice arenas. She has conducted research and authored dozens of articles and blogs on coding, billing, and general compliance specific to community health centers.



Questions

&

Discussion

FREE Professional Development Trainings

Lifestyle Coaching

Professional Development Opportunity

For: *Health center staff with some knowledge of the National Diabetes Prevention Program who are interested in facilitating a PreventT2 lifestyle change program.*

Healthy Weight

Professional Development Opportunity

For: *Health center staff interested in enhancing care for people with higher weight, including those with diabetes and other related conditions.*

Trainings begin May 1st & 2nd

Application available here, due April 12th!

Complete VTF Assessments ➡ Access FREE OSV Tool

Complete 3+ VTF Assessments:

Health centers can receive a 6-month trial membership to an online document management platform to support health center Operational Site Visit (OSV) preparation and ongoing compliance!

Trial offer - $6,000 value

Missed the information session on the free Trial Subscription?
Email support@reglantern.com to express interest

REGLANTERN

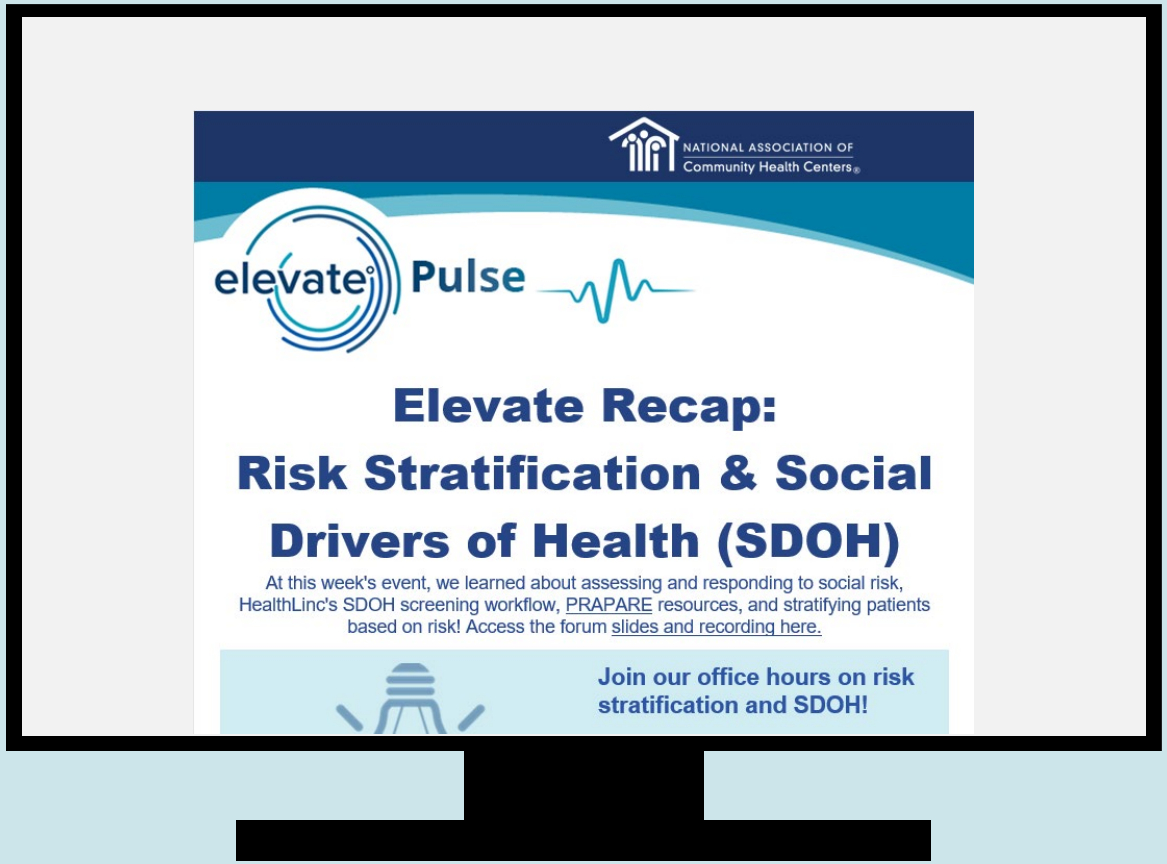
RegLantern Continuous Compliance Tool

- Cloud-based platform that helps health centers move toward continuous HRSA compliance
- FTCA Application Tool
- Allows health centers to compile and organize all documents demonstrating compliance in one place
- Embedded with checklists, alerts, and reminders
- Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV) through Citrix ShareFile integration
- Access to exclusive discounts for health centers interested in continuing subscription after trial period.
- Free Form 5A Review

Elevate Pulse

Be on the lookout for the **Elevate Pulse** from the **NACHC Quality Center:**

- ✓ Slides & recordings
- ✓ Tools & resources
- ✓ Upcoming opportunities



NACHC's Learning Hub

***FREE* on-demand learning sessions, microlearning courses, and printable resources, developed by NACHC exclusively for health centers and partners!**

- ✓The Aging Population and Dementia
- ✓Patient Engagement
- ✓Care Management
- ✓Value-Based Care
- ✓Optimizing Care Teams
- ✓Elevate Session Recordings and Slides

Access the NACHC Learning Hub here!

Need help signing in?
Click here for instructions!

National Committee for Quality Assurance

Video Opportunity!

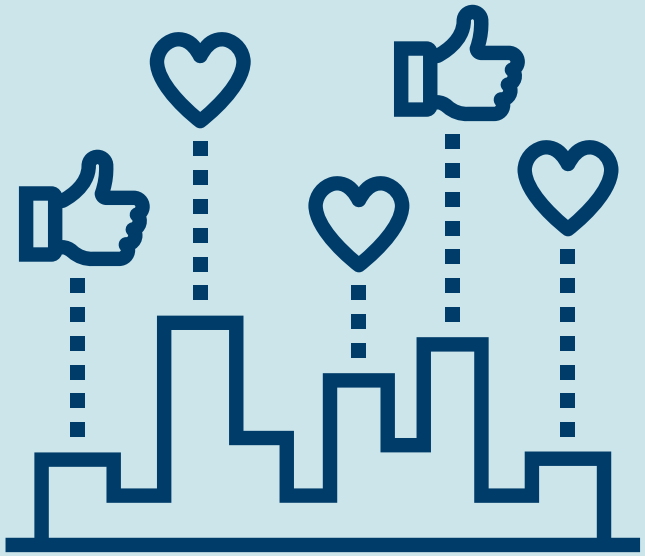
NCQA is creating an ongoing video series highlighting community health center success stories, *How the PCMH model assists health centers with serving patients & meeting the mission,* and **YOUR health center could be featured!**

- **Current video topic: *How PCMH helps health centers operate under value-based arrangements***
- Commitment: two days of on-site filming with video subcontractor
  - Staff & patient interviews plus "b roll" background footage
- Exact schedule prepared to minimize disruptions
  - Individual interviews take around 60 minutes

If interested, email qualitycenter@nachc.org with a statement of interest and brief description of how PCMH helps your health center operate under value-based arrangements. The NACHC Quality Center will share all responses with NCQA for final selection.

Previous videos in the series available here.

NCQA
Measuring quality.
Improving health care.



Provide Us Feedback

FOR MORE INFORMATION CONTACT

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Next Monthly Learning Forum:

Health Information Technology

and Cost

elevate

May 14, 2024
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, Holly Nicholson, Tristan Wind, Rachel Barnes

qualitycenter@nachc.org