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WHY

use Care Management with High-Risk Patients?

Value-based care requires health care organizations to assume greater care management responsibilities to better control the clinical and financial risk associated with high-risk patients. This systematic process of 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 issues and risks. Patients with complicated health and social issues 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 that contributes to achieving the Quadruple Aim: better care, better patient and provider satisfaction, and lower costs.⁷

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

WHAT

Does a High-Risk Care Management Model Look Like?

The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. Care management involves more intensive, one-on-one services by a nurse or other health worker to individuals with complex health and often social needs. The model discussed in this Action Guide includes monitoring of clinical conditions so operates under the assumption of a nurse in the role of the care manager, although other staffing models can be utilized with modification to some program components outlined here. Key components of care management (sometimes referred to as case management) include identifying and engaging high risk individuals, comprehensive assessment, clinical monitoring, coordination of services, individual care planning, and patient education.^{8,9,10}



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within the Value

Transformation Framework speaks to managing high-risk patients with more targeted services, when and how they need it. This Action Guide outlines steps health centers can take to develop a successful care management program.





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Eligibility for care management is determined through a process of risk stratification (see *Risk Stratification Action Guide*). For health centers new to risk stratification, a simple yet effective process is recommended. The methodology involves sorting patients by number of chronic conditions, a stratification technique found in many complex risk stratification approaches. This strategy becomes even more reliable when it is combined with a mechanism that allows providers to refer patients that may be missed by simple condition counts.⁸

The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs. For health centers, these groupings can include: highly complex, high-risk, rising-risk, and low-risk individuals. Unique care models and intervention strategies are then used for each group. This Guide focuses on using care management for the high-risk group.

A comprehensive needs assessment aids in the creation of an individual care plan for eligible patients. This involves more than a standard clinical exam and review of medical and social needs. It includes information on family and informal supports, patient preferences and goals, and functional capabilities. It includes feedback from other professionals (e.g., social work or mental health professionals), specialists and partners in the community involved with the patient's care. Information from the needs assessment is used to formulate an individual care plan.

The individualized care plan is at the heart of care management. This plan should be jointly created with the patient and their caregivers. Care plans include both short and long term goals and specify the types and frequency of all planned health, rehabilitation, and mental health treatments, medications, home care and supports, and other services, including who is responsible for each service.⁶

HOW

to Start-up a High-Risk Care Management Model



This Action Guide outlines a set of steps health centers can take to build a care management program for high-risk patients. Health centers should utilize the CMS requirements for Chronic Care Management to ensure that their program is designed to improve patient care and generates revenue that can support a health center care management program.

CARE MANAGEMENT STEPS:

- **Identify or hire a Care Manager**
- **Identify high-risk patients**
- **Define care manager – care team interface**
- **Define the care management model**
- **Enroll in care management**



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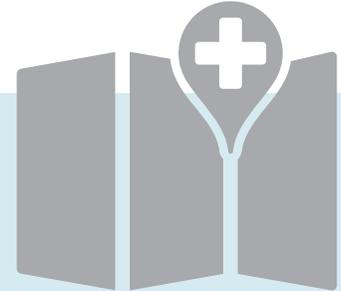


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- Create individualized care plans
- Enhance and expand partnerships
- Graduate patients from care management
- Document and bill
- Measure outcomes



Action item: Identify or Hire a Care Manager. The RN Care Manager is the central point of contact for the pool of high-risk patients identified through risk stratification. The Care Manager works one-on-one with a panel of high-risk patients to develop and manage the individual care plan and is accountable for coordination of care in partnership with the care team and across the care continuum. This includes consideration of non-clinical, social risk, and other issues. The Care Manager's importance as the central coordinating figure for high-risk patients cannot be overstated. As part of program design and set-up, it is important to define the roles and responsibilities of the Care Manager. Health centers can leverage job descriptions previously developed by other care management programs ([sample #1 CM job description](#)). Care manager training is critical to the success of a program.¹ Training should include didactic experience as well as mentoring or shadowing.⁸ Also, given that much of the work of care managers requires the building of trusting relationships with patients and caregivers, skill building in motivational interviewing is effective for activating and engaging patients.⁸



Action item: Identify high-risk patients. See *Risk Stratification Action Guide*. Depending on the resulting size of the high-risk cohort, and number of care managers, the program may need to triage the pool of patients into a manageable subgroup for initial focus (e.g., narrowed to a specific age group or those in need of a preventive service).

The target caseload for an RN Care Manager will vary depending on a number of variables but is likely in the range of 50-150 high-risk patients.¹² Factors affecting caseload size and complexity include health center environment, experience of the care manager, the clinical and social complexity of patients, available social supports, and target care management outcomes.¹³ Caseload size and manageability should be evaluated on an ongoing basis.



Action item: Define Care Manager - Care Team Interface. In addition to the Care Manager, each patient is assigned a Care Team – including a designated provider - that works to carry out the patient's individualized care plan. Care management programs are most successful when integrated with the patient's primary care team.¹ It is essential to determine how, and in what ways, the care manager and care team will work together. This should include how often they meet together, what mechanisms they will use to communicate in between face-to-face meetings, documentation expectations, and follow-up.



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Action item: Define the Care Management Model. A care management program for high-risk patients should ensure comprehensive care plans that support chronic disease and prevention needs, as well as mental, social, and environmental factors. Only a provider who can furnish a comprehensive evaluation (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) to determine whether or not a patient is eligible for CMS reimbursable comprehensive care management (CCM) services. CCM payments are for the management of chronic illnesses. It does not include time spent on acute care services. CCM supports activities that are not typically furnished face-to-face such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other providers. CCM also includes activities such as patient education or motivational counseling.

Components of a care management model for high-risk patients that must be met if your health center intends to bill CMS for CCM services include:⁷



- Patients have access to care management services 24/7.
- Patients receive continuity of care so that they are able to get successive routine appointments with a designated provider or care team member.
- Care management is provided for chronic conditions that include:
 - Assessment of a patient's medical, functional and psychosocial needs through either an initial preventive physical exam or a comprehensive evaluation and management visit.
 - Timely receipt of all recommended preventive care.
 - Patient's medication is reconciled.
 - There is oversight of patient self-management of medication.
- Development of a patient-centered care plan that includes the patient's choices. The care plan is based on a physical, mental, cognitive, psychosocial, functional and environmental assessment. A copy of the care plan is provided to patients.
- Care transitions between providers and care settings is managed.
- Services provided by home- and community-based clinical service providers is coordinated.
- Patients and caregivers can communicate with the provider by phone or using other electronic methods for non-face-to-face consultation.
- The care plan is electronic and is available 24/7 to all providers furnishing care to the patient.



Action item: Enroll in Care Management. A warm handoff and introduction of a patient to the care manager by the provider is a best practice.¹⁴ In the absence of a warm handoff, a care manager may reach out to a patient via phone or letter to a patient indicating their provider has recommended the patient for care management. The Care Manager then coordinates a comprehensive clinical and non-clinical assessment of the patient, and a visit with provider – culminating in an individualized care plan. Care plans should include steps for patient engagement in self-care.



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As long as the provider discusses CCM services with the patient during a visit, other clinical staff (e.g., nurse, medical assistant, and others under direct supervision of the provider) can complete the consent process. Direct supervision means that a provider is immediately available to guide the process; the provider does not need to be in the room when a service is furnished. Patient consent to CCM is required for initiation. Once a provider initiates the discussion of CCM with the patient and the patient has consented, any provider (e.g., MD, PA, NP, PharmD., RPh, CSW or qualified support staff with direct supervision) can provide CCM services. After the initial CCM visit, there is not a face-to-face visit requirement.



Action item: Create Individualized Care Plans. Working with the patient, 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 agreed to by the patient. The American Academy of Family Physicians has developed a rubric with suggested care plan interventions and goals based upon patient risk. Application of this rubric, and other care management tools and resources, can be found at [Patient Centered Primary Care Institute's Care Coordination Resources](#). Care plans must document discussion and agreement to the care plan by the patient. A copy of the care plan must be shared with the patient and patient's provider. Care plans must be documented in a certified Electronic Health Records (EHR) and include: patient demographics, medical problems, medications, and medication allergies. In addition to care management documentation templates available in the health center's EHR, care managers are encouraged to use [care plan templates](#) that address the full range of medical, social and other issues that need to be addressed in an individualized care plan.



Action item: Enhance and Expand Partnerships. Care in a value-based environment requires care across a continuum of providers rather than the traditional 'silo' model. Care Managers should develop a list of community resources and partners who the patient and care team will interface with in carrying out a plan of care. Some high performing health care organizations coordinate with providers who follow-up high-risk patients in their home, or support patient's use of telehealth, or other self-care activities.



Action item: Graduate patients from care management, as appropriate. While the frequency of interaction between a care manager and patient will vary depending on the medical and social needs of each patient, and individual care plan goals, contact is typically more frequent initially then tapers as the patient reaches goals. One study found that structured visits by an RN Care Manager every two to three weeks until goals were reached, followed by telephone follow-up every four weeks, was effective.¹¹ The effectiveness of care management programs increases with face-to-face time, with telephone-only interventions having little success.⁴ The duration of care management will vary, depending on the needs of the patient, although there is some indication that longer programs (e.g., six months or more) are more effective.⁴ Cases are typically closed at a point when all goals have been reached and patient and care manager agree continued engaged is not needed (e.g., 60–90 days after reaching goals). Document each patient's graduation, transfer, or termination from the CCM program.



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Action item: Document and bill for care management. Utilize the existing EHR care plan template, or create a structure within current EHR capabilities, to document each patient’s individual care plan. Establish a system to track time spent on care management services including phone calls, emails, coordination with others, prescription management and medication reconciliation. Document time spent on care management for each patient monthly. Time spent performing secure messaging or email consultation is counted toward time that can be billed to CMS if measurable and documented. The development of the care plan can be counted towards the minimum 20 minutes required for billing.

Submit claims to your Medicare Administrative Contractors monthly for eligible Medicare patients where there has been a minimum of 20 minutes of non-face-to-face clinical staff time documented. Eligible providers may bill under G0511 for at least 20 minutes of non-face-to-face clinical staff time directed by a physician or other qualified health professionals each month for Medicare or dual-eligible (Medicare and Medicaid) beneficiaries who have two or more serious chronic conditions that are expected to last at least 12 months.⁷



While the most common revenue code to bill CCM services is 052X, CMS does not have a revenue code restriction for CCM services. All claims must include a diagnosis code and providers should use the most appropriate diagnosis code for that patient.

The billing codes and Medicare physician fee schedule payments for CCM services are:

Type of visit	Eligibility	
CCM Initial visit+	New patients or those not seen within a year prior to starting CCM	\$223.51 x geographic adjustment
Chronic Care Management G0511	20 minutes or more of clinical staff time spent on non-complex CCM per calendar month that requires establishment, implementation, revision, or monitoring of a care plan.	\$62.28

The usual cost-share rules apply to these services so patients are responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if they do not have supplemental ('wrap-around') insurance. Please note that the majority of dual eligible beneficiaries (Medicare and Medicaid) are exempt from cost sharing. Patients are also subject to health center guidelines around receipt of service regardless of the ability to pay.



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Action item: Measure Outcomes. Care management effectiveness can be measured by the degree to which patients achieve care plan goals. Performance should also be measured against key clinical and quality indicators, including performance on relevant Uniform Data Systems (UDS) measures and patient experience.

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