NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

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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 risks 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: improved health outcomes, improved patient and staff experiences, lower costs, and improved equity[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.

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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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Eligibility for care management is typically determined through a process of **risk stratification** (see Risk Stratification Action Guide). For health centers that are new to risk stratification, we recommend a simple yet effective method that sorts patients by number of chronic conditions—a technique found in many more advanced risk stratification approaches. This strategy becomes even more reliable when it is combined with a process that allows providers and staff 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 interventions are then used for each group. This Action Guide focuses on care management of the high-risk group.

The **individualized care plan** is at the heart of care management. This plan should be created in partnership with patients and their caregivers. Care plans include both short- and long-term goals and address 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].

A **comprehensive needs assessment** aids in the creation of individual care plans for eligible patients. Creating care plans 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 in terms of self-care. It also includes feedback from other professionals and specialists (e.g., dental, social work, or mental health), as well as information from community partners involved with the patient's care.

HOW to Start-up a High-Risk Care Management Model?

CMS requirements for Chronic Care Management (CCM) can be used to frame a care management program targeting high-risk patients. Following these guidelines can help ensure that the care management program, designed to improve patient care and outcomes, can also generate revenue.

CARE MANAGEMENT STEPS:

This Action Guide outlines a set of steps that health centers can take to build a care management program for high-risk patients.

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 develop, coordinate, and manage the individual care plans of each patient in their panel. An RN often serves in this role.

STEP 2 **Identify High-Risk Patients:** See the Risk Stratification Action Guide.

STEP 3 **Define Care Manager – Care Team Interface:** Define how, when, and where the care management program is integrated with the patient's primary care team.

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STEP 4 **Define the Services Provided as Part of Care Management:** Create a care management program for high-risk patients that is modeled after CMS's reimbursable CCM services.

STEP 5 **Enroll Patients in Care Management:** Establish processes to refer, introduce, and onboard patients into care management.

STEP 6 **Create Individualized Care Plans:** Develop and document personalized care plans by the care manager, in collaboration with the provider and patient.

STEP 7 **Enhance and Expand Partnerships:** Establish relationships with a continuum of providers and other partners in the community for the referral and care of patients' health, social, and related needs.

STEP 8 **Document and Bill for Chronic Care Management:** Utilize the existing electronic health record (EHR) care plan template, or create another, to document all billable care management services. Use applicable diagnosis codes for billing.

STEP 9 **Graduate Patients from Care Management:** Establish a process for patients to move out of high-risk care management as they reach care plan goals and return to routine care and follow-up.

STEP 10 **Measure Outcomes:** Track care management program effectiveness, including performance on Uniform Data Systems (UDS) measures, and the extent to which patients reach care plan goals.

STEP 1

Identify or Hire a Care Manager. The care manager is the central point of contact for a group of high-risk patients typically identified through a risk-stratification process. Most often, the care manager is a registered nurse (RN), but other staffing models may be used. The care manager works with a panel of high-risk patients, one-on-one, to develop and manage their individual care plans. S/he is accountable for coordinating care in partnership with the care team and across the care continuum. This includes consideration of social risk and other issues. The care manager's importance as the central coordinating figure for high-risk patients cannot be overstated.

It is important to define the roles and responsibilities of the care manager with a clear job description. Health centers can leverage job descriptions previously developed by other care management programs (sample #1 CM job description). Also, care manager training is critical to success.[1] Training should include didactic experience as well as mentoring or shadowing[8]. Skill building in motivational interviewing helps, given that much of the work of care managers requires building trust with patients and caregivers[8].

Action item: Identify or hire care manager(s), provide a clear job description, and train care manager(s) to manage a full panel of high-risk patients.

STEP 2

Identify High-Risk Patients. (See Risk Stratification Action Guide.) Risk stratify the health center's patient population to identify a group of high-risk patients. Depending on the size of the high-risk cohort, and the number of care managers, the program may need to triage the pool of patients into a manageable subgroup for initial focus. For example, it may be easier to start with a specific age group or those in need of a certain preventive service.

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The target caseload for an RN care manager varies depending on several variables. It is likely to be in the range of 50-150 high-risk patients[11]. 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, and target care management outcomes[12]. Evaluate caseload size and manageability on an ongoing basis.

Action item: Define the caseload of high-risk patients for each care manager based on factors such as his or her experience level and patients' social complexity. Evaluate and adjust the size of the caseload as needed.

STEP 3

Define Care Manager - Care Team Interface. In addition to the care manager, each patient is assigned a care team. This includes a designated provider who works with the care manager and patient 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, what mechanisms they will use to communicate in between face-to-face meetings, documentation expectations, and follow-up.

Action item: Define a clear system of communication and interface between the care manager and primary care team.

STEP 4

Define the Services Provided as Part of Care Management. 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. A provider who can furnish a comprehensive Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) determines whether or not a patient is eligible for CMS reimbursement for CCM services. CCM payments cover the management of chronic illnesses for Medicare and dual-eligible patients. It does not cover time spent on acute care services. CCM reimburses activities not typically furnished face-to-face, including telephone communication, the review of medical records and test results, and the coordination and exchange of health information with other providers. CCM also includes activities such as patient education and motivational counseling.

Action item: Design a care management program that includes CCM services billable through CMS, including[7]:

- o Patient access to care management services 24/7.
- o Continuity of care with a designated provider or care team member.
- o Care management for chronic conditions, including:
  - An assessment of a patient's medical, functional and psychosocial needs through either an IPPE or E/M visit.
  - Timely receipt of all recommended preventive care.
  - Reconciliation of a patient's medications.
  - Oversight of patient self-management of medications.

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- o Development of a patient-centered care plan that is based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment and includes patient's choices.
- o Provision of the care plan patients.
- o Management of care transitions between providers and care settings.
- o Coordination of services provided by home- and community-based clinical service providers.
- o Access to the provider by phone or other electronic methods for non-face-to-face consultation.
- o Access to the care plan electronically, 24/7, to all providers caring for the patient.

STEP 5

Enroll Patients in Care Management. Enroll patients in care management by having providers offer warm handoffs and introductions to the care manager[13]. If this is not possible, the care manager can call, email or mail a letter indicating that their provider has recommended them for care management. The care manager then coordinates a comprehensive clinical and non-clinical assessment and a visit with the provider to create an individualized care plan.

Patient consent (written or verbal) to CCM is required for initiation in care management. As long as a provider discusses CCM services with a patient during a visit, another member of the care team (e.g., nurse, medical assistant, and other staff under direct supervision of the provider) can complete the consent process. After patient has consented to services, any provider (e.g., MD, PA, NP, PharmD., RPh, CSW or qualified support staff with direct supervision from the provider) can provide CCM services. Direct supervision means that a provider is immediately available to guide the process. The provider does not need to be in the virtual or actual exam room when a service is furnished. After the initial CCM contact, no other face-to-face visit is required.

Action item: Discuss care management services with a patient during a visit, obtain consent, and initiate a warm hand-off from the provider to the care manager.

STEP 6

Create Individualized Care Plans. Working with the patient and provider, 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 and should include steps for patient engagement in self-care. The American Academy of Family Physicians developed a rubric with suggested care plan interventions and goals based on patient risk. 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 with the patient and his or her agreement to the care plan. A copy of the care plan is shared with the patient and patient's provider.

CMS requires that care plans be documented in a certified Electronic Health Record (EHR) and include: patient demographics, medical problems, medications, and medication allergies. In addition to 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.

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Action item: Create individualized care plans in partnership with patients and their providers.

STEP 7

Enhance and Expand Partnerships. Care in a value-based environment requires a continuum of providers rather than the traditional 'silo' model. It is critical that care managers have a list of the community resources and partners that the patient and care team will interface with to carry out a plan of care. Where necessary, look to expand partnerships to address patients' clinical and social needs. Some high-performing health care organizations coordinate with providers who follow up with high-risk patients in their home, or support telehealth and other self-care activities.

Action item: Develop a plan for working closely with relevant community and partner organizations (e.g., mental health partners, addiction clinics, housing partners) to deliver comprehensive and coordinated care for each patient.

STEP 8

Document and Bill for Care Management. Utilize the existing EHR care plan template, or create a new 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. CMS requires a minimum of 20 minutes per month to bill for services. (See NACHC's Billing Checklist for CMS Chronic Care Management Services.)

Health centers that lack a means to capture and track time electronically can use a manual log to capture this information. Time spent performing secure messaging or email consultation is counted toward billable minutes, if measurable and documented. Development of the care plan is also counted towards the 20-minute minimum.

Submit claims monthly to your Medicare Administrative Contractors. Eligible providers may bill under G0511 for at least 20 minutes each month of non-face-to-face clinical staff time directed by a physician or other qualified health professional 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].

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While the most common revenue code to bill for Chronic Care Management (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 the patient.

The 2021 billing code and Medicare physician fee schedule payment for CCM services are:

Type of visit	Eligibility	
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.	$65.25

Note: this Action Guide will be updated in early 2022 to reflect the Principal Care Management (PCM) reimbursement codes CMS introduced in 2021.

Check here for the latest CMS payment schedules.

Standard cost-share rules apply to these services. 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: the majority of dual eligible beneficiaries (Medicare and Medicaid) are exempt from cost sharing. Health centers can slide (or waive, if appropriate) the copay for patients who are eligible for the health center's sliding fee scale.

Action item: Document and bill for care management services on a regular schedule. Take care to bill for all relevant care management services to receive payment from one or more payers (CMS, CCM, Medicaid Health Home, or commercial payers).

STEP 9

Graduate Patients from Care Management, as appropriate. The duration of care management will vary by patient, depending on their needs. Generally, contact is more frequent at first, 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[14]. The effectiveness of care management programs increases with face-to-face time. Telephone-only interventions have little success[4]. 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 the patient and care manager agree that continued engagement is not needed (e.g., 60–90 days after reaching goals). Document patients' graduation from care management using a closeout form.

Action item: Determine the point at which each patient graduates, transfers, or terminates from care management; document.

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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

Action item: Identify measures to track patient progress in reaching care plan goals and clinical outcomes based on UDS and other measures.

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