

**Health Care Home Payment Process Design Team
Recommendations**

Deliverables:

- Evaluate and make recommendations to clinics on how to prospectively identify and designate health care home patients eligible for care coordination payments.
- Develop a process where by a health care home alerts the payer that the patient qualifies for care coordination payments.
Process features:
 - Define how practices will collect and submit billing
 - Identify uniform data elements that result in the ability to collect billing data for clinics and payers.
 - Meet the billing processing needs for payers.
- Identify the billing cycle duration for health care home services consistent with CMS and legislative requirements.
- Make recommendations for standardized coding and billing that meets the requirements of the AUC.

Recommendation 1: Key Process Steps

Based on the principle every patient is part of the clinics health care home and health care homes do population management to determine which patients need care coordination that is eligible for payment. Clinics will implement the following key process steps for successful billing for care coordination fees.

The clinic develops a workflow that includes the following key process steps:

- A. Implements a method of screening to determine the patient's clinical eligibility by using the registry or a screening mechanism or both.
- B. Completes a clinical assessment of the patient's risk factors and diagnosis to determine if the patient would benefit from care coordination based on the level of severity of their condition.
- C. Determine patient's complexity tier and assign the patient a complexity tier for payment and services.
- D. Identify the patient's payment source and is the patient eligible for health care home care coordination payments.
- E. Inform the patient about the health care home, what it means to the patient, the benefits, and recommendations from the clinician and the patient's payment eligibility. Seek the patient's input during the discussion that results in shared decision making about the patients engagement and participation in care coordination.
- F. Document the patient's decision in the medical record; does the patient agree to participate in care coordination.
- G. Flag the patient's complexity tier and participation in care coordination in the patient management system so everyone in the system (triage, on-call providers, billing, clinicians, and telephone answering staff) knows the patient has chosen to participate or not to participate in care coordination of the health care home.
- H. The agreed upon start date for care coordination is documented in the patient's medical record and the corresponding diagnosis and procedural billing codes are selected to start the billing process for care coordination.
- I. Ongoing care coordination activities with an active tracking mechanism for billing.

Supporting Definitions:

Eligibility:

Clinical eligibility: Does the patient's clinical situation benefit from participation in a health care home, is the patient at risk of or has a complex or chronic health condition.

Insurance eligibility: Does the patient's insurance benefit provide for payment for health care home services.

Flag: a designation in the clinic's patient management system that denotes that the patient has agreed to care coordination services.

Recommendation 2: Patient Agreement

The discussion and agreement by the patient to participate in care coordination is the trigger to starting the payment process. There is an activation / engagement action in place with documentation of the event. This could occur through phone, email or face to face. The start date for billing starts with the patient's agreement into care coordination in the health care home and identification of the complexity tier.

Recommendation 3: Billing process

The billing process should be a claims based mechanism with a monthly billing cycle with the following supporting detail:

- A. Use the appropriate HCPCS procedural billing code for health care home subject to the AUC approval such as G9002 or the new S0280 medical home program, comprehensive care coordination and planning, initial plan, S0281 medical home program, comprehensive care coordination and planning, maintenance.)
- B. There should be modifiers to indicate the level of risk severity that is being billed.
- C. Diagnostic billing codes, including any applicable V-codes identifying non-medical complexity with each claim.
- D. There is a limit of one unit billed per month per patient.
- E. The claim may be submitted to the payer at any time during the month for the full month's payment. Monthly payments will not be prorated by the number of days in the month.
- F. Billing is done based on the 837P as defined by MN Statute 62J.
- G. Care coordination fees can be billed on a claim with other charges.
- H. Recommend to the AUC that there is potential overlap for billing with codes 99339 and 99340 and those codes should not be billed together for those patients receiving care coordination services.

Recommendation 4: Insurance Eligibility

The clinic can decide if they want to check insurance eligibility prior to claim submission or not for care coordination payments. The payers eligibility portals should include a HCH benefits designation for efficient and reliable eligibility checking by health care homes

Recommendation 5: Remittance process

The clinic will develop and maintain a process for tracking ongoing care coordination for accurate payment of care coordination and prevent denials in the clinic with the following supporting detail

- A. The clinic develops a remittance process based on MN 835 and 62J for CARC or RARC.
- B. The clinic will develop an internal process for communication between the clinical staff (clinician / care coordination) and the finance staff to stop the monthly claim process when the patient is no longer receiving care coordination services.
- C. We recommend to the AUC that there is an additional remark code developed that states, this service is already paid to another clinic that alerts the billing office for a HCH of denials.
- D. The clinic establishes a process that includes when the clinic's billing office see's this type of denial code, there is a communication process in place where the front end clinic staff such as the care coordinator is notified of the denial and talks with the patient about the problem.

Recommendation 6: Notification to payer (enrollment)

The notification by the clinic of the patient's agreement for care coordination to the payer is triggered by a claim that includes the corresponding diagnostic codes (including any applicable V-codes indicating non-medical complexity), HCPCS, modifiers for complexity tier on the claim and there is supporting documentation in the patient's medical record.

Recommendation 7: Documentation Requirements

Care coordination requires a reasonable level of documentation that provides evidence that the patient is being actively managed based on the patient's defined complexity tier. Documentation is based on the patient's complexity tier and the required work for that complexity tier.

Complexity tier: Documentation requirements for care coordination

Level Zero: Standard preventive maintenance, patient's preferred mechanism of communication. Basic medication reconciliation to avoid interactions or duplications. Ongoing support, oversight and guidance by a primary clinician and team. Basic instructions regarding clinic access.

Level One: Routine clinic panel or registry management and tracking of hospital and other admissions.

Level Two: Evidence based guidelines are implemented and there is staff monitoring to ensure use of evidence-based guidelines and clinical decision making to facilitate diagnostic test tracking, pre-visit planning and after visit test / set follow-up. The patient may or may not require an individualized active care plan. Documentation supports patient's understanding of access to the clinic and after hours plan. There is review of medication changes occurring outside of an E/M visit. Designated primary care provider and care coordinator is documented.

Level Three and Level Four:

An active individualized care plan with ongoing updated goals based on the patient's plan

There are identified process steps in the billing process and required documentation to support the work and billing for each step:

Process Step	Documentation Recommendation
A. Implements a method of screening to determine the patient's clinical eligibility by using the registry or a screening mechanism or both.	The screening documentation is noted in the medical record. The documentation options are a pre-defined standardized tool, the registry, documentation template such as a smart phrase, a flow sheet, or an order set.
B. Completes a clinical assessment of the patient's risk factors and diagnosis to determine if the patient would benefit from care coordination based on the level of severity of their condition.	The clinical assessment of the patient's risks and chronic conditions is documented by the qualified clinician or nurse to complete an assessment. The patient's problem list is completed. The risk assessment does not require a face-to-face visit. There is integrated planning for ongoing medical care including communication and coordination with other physicians and health care professionals.
C. Determine patients complexity tier and assigns the patient a complexity tier category for payment and services.	The patient's complexity tier is noted in the medical record in a location where the health care team and specialty providers can see the patient's health care home status and complexity tier. In addition, the complexity tier is documented in the billing system.
D. Identify the patients insurance eligibility ie, is the patient eligible for health care home payment.	Insurance eligibility is documented in the clinic's usual manner.
E. Inform the patient about the health care home, what it means to the patient, the benefits, and recommendations from the clinician and the patient's payment eligibility. Seek the patient's	The certified clinic has established a procedure with standards in place for this process / discussion. There is documentation that this discussion occurred. It may be as simple as "HCH discussion

<p>input during the discussion that results in shared decision making about the patients engagement and participation in care coordination.</p> <p>F. Document the patient's decision in the medical record: Does the patient agree to participate in care coordination.</p> <p>G. Flag the patient's level of participation in care coordination in the patient management computer system so everyone in the system knows the patient has chosen to participate or not to participate in the health care home, care coordination.</p>	<p>patient agrees / disagrees to participate in care coordination." A variety of tools can be used for this documentation.</p>
<p>H. The defined data for enrollment for care coordination is documented in the patient's medical record and the corresponding diagnosis codes and billing codes are selected to start the billing process for care coordination.</p>	<p>See the tools for identifying the patient's complexity tier.</p>
<p>9. Care coordination activities are documented in the medical record based on the complexity tier the patient has been associated with.</p>	<p>There is documentation in the medical record for ongoing care coordination that reflects the patients complexity tier that includes evidence of active panel / registry management such as visit reminders, phone calls, use of a call back report, registry maintenance. Standard preventive maintenance and the patient's preferred mechanism of communication. (see complexity tier documentation recommendations)</p>
<p>Recommendation 8: Billing audits</p> <p>Implement care coordination payments audits using the current standard auditing process that health plans currently have in place today until the HCH payment evaluation committee can further determine if there are additional auditing needs.</p>	
<p>Recommendation 9: Complexity tier re-evaluation</p> <p>The clinic implements a process for re-evaluation of the patient's risk. Re-evaluation of the patient's complexity tier is done annually or sooner as warranted by the patient's change in condition.</p>	
<p>Recommendation 10: Payment process evaluation</p> <ul style="list-style-type: none"> ❖ Implement an ongoing HCH payment evaluation committee to evaluate the broader HCH payment implementation. This committee would address the following: <ul style="list-style-type: none"> • Develops metrics for evaluation and works with the Commissioner to design an evaluation process for care coordination billing • Technical, workflow and documentation issues • Evaluates the audit process • A place for clinics and payers to bring questions • Has authority to make ongoing recommendations for consistency in design of the care coordination payment process. • Addresses new methodologies for billing for care coordination that is innovative and not claims based ❖ Membership should include payers, certified health care homes, consumers, payment experts with similar representation as workgroups participating in the design workgroups. ❖ There should be a mechanism for communication of the committees work to clinics and payers. 	

