NATIONAL ASSOCIATION OF Community Health Centers®

The Building Blocks of Care Coordination: Basics, Billing, and Looking Beyond to PACE

Part I: Basics of Medicare Care Coordination

November 6, 2025

Welcome!

The first webinar in this three-part series will introduce the fundamentals of Medicare care coordination — what it is, why it matters for community health centers, and how it enhances patient outcomes.

Objective: Participants will gain a clear understanding of the key concepts and requirements that lay the groundwork for effective implementation and future billing practices.

Housekeeping

Please support **NACHC's commitment to creating a respectful and professional environment** for all webinar participants, including attendees, speakers, and moderators.

To promote a positive experience for everyone, we expect all participants to use the chat and Q&A functions in a respectful and professional manner. Harassment, discrimination, and disruptive or inappropriate behavior of any kind will not be tolerated. Failure to follow these guidelines may result in removal from the webinar at our discretion. **Thank you for your cooperation.**

Today's Speakers

Kaloua Stanhope, RN

Director of Care Management,
Eastport Healthcare

Cassie Lindholm, MPA, PCMH CCE

Deputy Director, Quality Center,
NACHC

Elizabeth Linderbaum, MPP

Director of Regulatory Affairs, *NACHC*

Why Medicare?

FQHCs can strategically leverage Medicare reimbursement and care models to:

- ✓ Increase the size of their current patient population served, and retain their current population
- ✓ Strengthen their mission by serving vulnerable older adults and individuals with disabilities
- ✓ Improve financial stability
- ✓ Enhance community health outcomes through team-based care and opportunities for reimbursement led by care team members other than the provider

Why is Care Coordination Important?

Care management programs in Community Health Centers (CHCs) support patients with chronic conditions, social risk factors, and complex care needs through structured, ongoing services.

These programs aim to improve patient outcomes, enhance coordination across providers, and optimize care transitions.

Care Coordination Connection to PACE

Joint Medicare-Medicaid program that covers all medical and social needs for participants
Goal of allowing participants to live in their homes safely for as long as possible

Patient Eligibility

At least 55 years old

Must live in a service area of a PACE organization

Certified to need nursing home level care but cleared to live in a community safely (with support)

Services Provided

- Adult day care
- Recreational therapy
- Home care and nursing home care
- Transportation to appts and the PACE center
- Hospital care and emergency services
- Prescription drugs
- Medical, dental, vision & hearing care

Care Coordination

Personalized care plan development

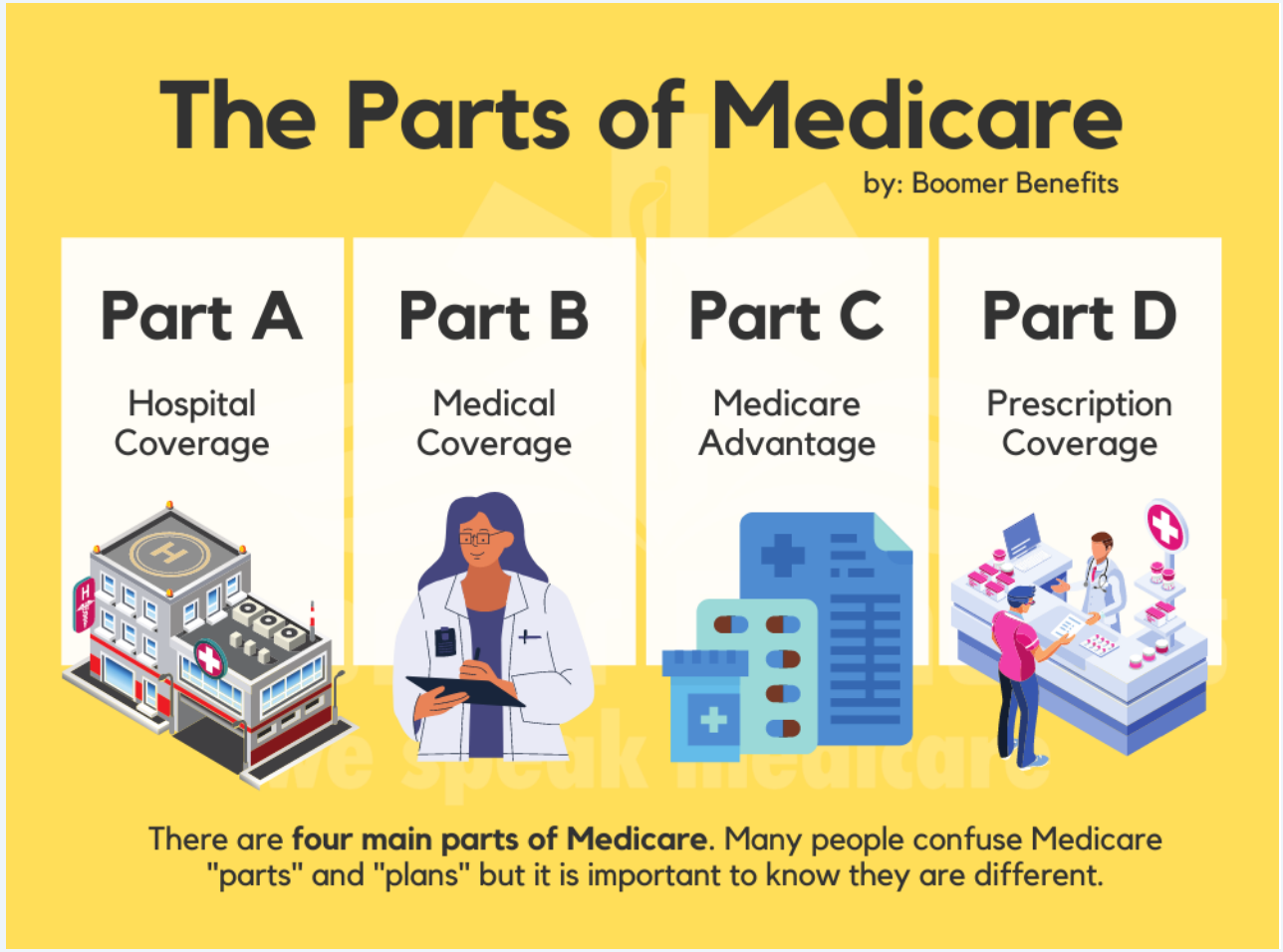
Doctors, nurses, social workers, therapists, social worker, dieticians etc all working together

Medicare Overview

- Health insurance program
  - Administered by Centers for Medicare & Medicaid Services (CMS) under Health & Human Services Department of US Government
  - Covers People
    - Age 65 or older
    - Under age 65 w/ certain disabilities
    - Of all ages w/ end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Overview

- Medicare benefits delivered through different parts:
  - Part A covers inpatient hospital services
  - Part B covers out-patient services
  - Part C allows Medicare beneficiaries to select a private Medicare Advantage plan to administer their Part A & B benefits
  - Part D covers prescription drug coverage



Medicare Advantage Plans (Part C)

- Offers everything that Original Medicare does
- Differences from Original Medicare
  - Limited provider network
  - Referrals for specialists
  - Extra benefits

Nuts & Bolts of
Care Management Services

Summary of Medicare Care Management Services

Care management services that FQHCs can provide and bill Medicare for:

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

While each care management program has unique requirements, there are key considerations that apply broadly to all care management services.

Identifying Eligible Patients

Each care management program has specific patient eligibility criteria based on factors such as diagnosis, risk level, non-clinical factors of health, and care needs.

In addition to clinical qualifications, eligible patients must also have Medicare Part B benefits and provide consent for services.

Key data sources may include:

- ✓ Chronic condition reports
- ✓ Hospitalization & ER utilization reports
- ✓ Gaps in care reports
- ✓ Non-clinical factors of health screening data
- ✓ Attribution lists

Initiating Visit

Most care management programs require a separately billable initiating visit with a qualified provider prior to the start of services. Depending on program requirements, may be:

- ✓ **Evaluation and Management (E/M) Visit** (CPT 99212-99215)
- ✓ **Initial Preventive Physical Examination (IPPE)** (HCPCS G0402)
- ✓ **Annual Wellness Visit (AWV)** (HCPCS G0438, G0439)
- ✓ **Transitional Care Management (TCM)** (CPT 99495-99496)

In general, this visit must:

- ✓ Occur within 12 months of the start of chronic care management services
- ✓ Include a discussion about the care management services with the patient
- ✓ Be performed by the same billing provider who will also furnish and bill for subsequent care management services
- ✓ Establish a patient-centered treatment plan that specifies the benefit of care management support for the patient's condition(s)
- ✓ Establish the care management services as incidental to the practitioner's Medicare Part B services and explain to the patient that auxiliary personnel may perform these services
- ✓ Obtain patient consent (in most programs, if the provider does not obtain patient consent during the initiating visit, auxiliary personnel may obtain it afterward)

The Care Team

Care management services involve non-face-to-face care coordination activities performed by auxiliary personnel under the general supervision of an authorized billing provider.

Qualifications and permitted tasks vary by program and CPT code!

Clearly define roles and ensure compliance with state licensure, scope of practice, education, and training requirements for any staff included in your care management team.

Authorized Billing Provider:

- ✓ Performs initiating visit
- ✓ Determines medical necessity for services
- ✓ Obtains patient consent
- ✓ Establishes and maintains a patient-centered care plan
- ✓ Furnishes services personally and/or via general supervision of auxiliary personal
- ✓ Performs medical decision-making
- ✓ Oversees the care team's service activities to ensure effective coordination
- ✓ Retains responsibility for documentation
- ✓ Bills for services

Auxiliary Personnel:

- ✓ Provides care management services under the supervision of a qualified provider

Service Elements (examples)

CCM

Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals.

- 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

CHI

Personalized and supportive services provided to patients with unmet non-clinical factors of health needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

- 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 & emotional patient support

BHI

Personalized and supportive services provided to patients with behavioral health needs to coordinate care and develop a care plan to achieve health goals.

- Patient-centered assessment
- Ongoing monitoring using applicable validated rating scales
- Patient-centered treatment plan to address behavioral/psychiatric issues, modified as needed for status changes or lack of treatment progression
- Facilitation and coordination for any needed treatment, such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
- Assuring continuity of care with a designated care team member

Coding and Billing

Ensure services are billed accurately and in compliance with coding and reimbursement guidelines.

FQHCs must report individual services codes for general care management services, including any add-on codes (starting January 1, 2025). These services were previously reported using G0511. FQHCs requiring additional time to configure their systems were allowed to continue reporting G0511 until September 30, 2025.

Patient cost-sharing may apply, depending on the payer and service provided, and may be covered in part or in full by secondary coverage. Coinsurance may be “slid” commensurate with the sliding fee discount program policy of the health center.

Payment (examples)

CCM

99490: **$60.49** (20 min, aux. personnel)
+99439: **$45.93** (each additional 20 min, aux. personnel)

99491: **$82.16** (30 min, auth. billing provider)
+99437: **$57.58** (each additional 30 min, auth. billing provider)

CHI

G0019: **$77.95** (60 min)

+G0022: **$48.52** (each additional 30 min)

BHI

99484: **$53.05** (20 min, aux. personnel)

G0323: **$53.70** (20 min, CP, CSW, MHC, or MFT)

Implementing a Care Management Program

- ✓ **Assess patient needs:** Utilize reports and patient data to determine program priorities
- ✓ **Evaluate staff & resources:** Identify team members, training needs, and workflow adjustments
- ✓ **Analyze financial impact:** Review reimbursement models and funding considerations
- ✓ **Ensure compliance:** Understand regulatory, supervision, and billing requirements
- ✓ **Develop an implementation plan:** Outline workflows, reporting structures, and quality measures
- ✓ **Engage stakeholders:** Gain leadership and staff buy-in while educating patients on the benefits of care management
- ✓ **Monitor & adjust:** Track key performance indicators and refine the program over time to improve outcomes

Thank You!

Cassie Lindholm, MPA, PCMH CCE

Deputy Director, Quality Center

clindholm@nachc.org

Care Management

Kaloua Stanhope BSN RN
Director of Care Management
Eastport Health Care

Care Management

We have three Care Management programs at Eastport Health Care:

-CCM

-BHI

-CHI

Chronic Care Management

The CMS definition for Care Management is: “Chronic care management (CCM) is managing a patient’s multiple (2 or more) chronic conditions expected to last at least 12 months, or until their death.”

Objectives are to keep patients’ chronic conditions managed so they:

-Keep ER utilization to a minimum

-Keep Inpatient utilization to a minimum

-Allow patient to remain in home until death.

CHI

We know when patients do not have enough food to eat, transportation, housing, etc…they have poorer health outcomes.

OBJECTIVES

-Find and offer non-medical resources for patients with need to improve medical outcomes.

BHI

With lack of adequate number of Behavioral Health Providers, we recognize need for more support for patients with Mental Health conditions.

OBJECTIVE

- To provide an extra layer of support for patients suffering with Mental Health conditions to prevent hospitalization and foster healthy coping skills.

Staffing Model

CCM-Two RN's: Director of Care Management and Care Manager

CHI-One CHW supervised by Director of Care Management

BHI-One RN supervision by Director of Care Management

How these programs work together:

- Can one patient be on one or more program during the same time period?

Work flows for each program

Our CCM program is ever changing. We modify our daily workflow with patients based on patient need as well as regulation changes.

CHI and BHI workflow models are based on the CCM program workflow

Documentation of each program

CCM- Care plans are documented in the EMR's built in care plan feature. Each time we speak with the patient we document in a running "patient case" in the patient's chart. If there is an immediate, need we make a new patient case and send to provider immediately.

CHI-Care plan is documented in a patient case. All subsequent notes are also documented in this patient case.

BHI- Documentation is the same as the CCM process.

Keeping track of time spent with patients is different for these programs!

Tracking of the patient panels

CCM-There is a box to check in Athena for CCM patients therefore our IT data analyst can pull a report for this panel. We also can pull a monthly report via Dulcian.

BHI-this is tracked through the billing process as well as an Excel spreadsheet.

CHI-this is also tracked through the billing process and an Excel spreadsheet.

Documents: Consent

Eastport Health Care, Inc.
Our Specialty is YOU!

Rowland B. French Medical Center
Vogl Behavioral Health Center
30 Boynton Street
Eastport, Maine 04631
Phone: 207-853-6001
Fax: 207-853-6180

CARE MANAGEMENT AGREEMENT – EASTPORT HEALTH CENTER

I would like to receive care management services from Eastport Health Center Nurses Care Managers and/ or Community Health Workers and/or Patient Navigators.

The benefits of these services include:

- Check-ins, care coordination services, and assistance with any social needs.
- A copy of my personalized care plan or action plan.
- Access to my care team 24/7 such as telephone access and patient portal communication.
  Eastport office during and after hours at 207-853-6001 and Machias during and after hours at 207-255-8290.

- I understand that depending on my insurance coverage, I may be billed a monthly copay when services are billed.

- Medicare will only pay one provider or health care professional to provide me with Chronic Care Management services within the given month.

-I understand that I can revoke this agreement at any time by calling my Care Manager or PCP and stating I would like to stop services. Discontinuation of services will be effective at the end of the calendar month.

Please check the box of the service you will be receiving:

☐ Chronic Care Management

☐ Community Health Worker

☐ Behavioral Health Care Management

Patient Name: _____ Date: _____

Patient DOB: _____

Consent given verbally to: _____ Date: _____
(Health Center Staff)

CHI Care Plan

SDOX dx: 10/15/2025 Food insecurity

Patient Need:Patient is running out of food the last 3-4 days of the month. He needs resources for food.

Goal: For patient to verbalize he is not running out of food at all in the month.

CHW tasks: Give patient names of food pantry closes to patients home as well as hours of operation and contact number. Make patient aware of dates/times of free fresh produce days as well as free emergency food bags and community table here at EHC. Assist patient in filling out DHHS application for SNAP benefits.

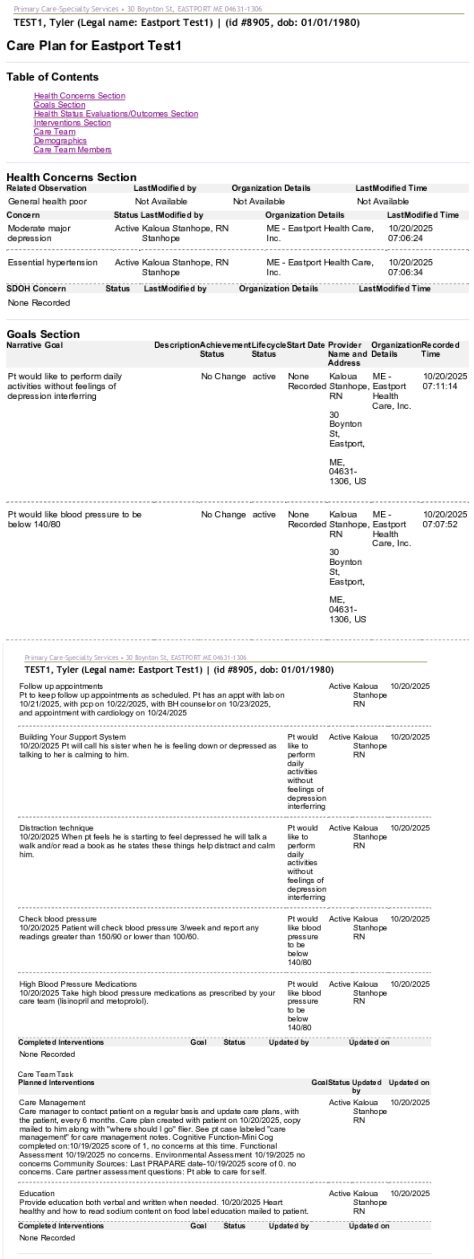
Patient tasks: To gather financial information required for DHHS application. Schedule an appointment with CHW to assist with application as soon as possible. Go to food pantry EHC for food products.

Outcome:10/30/2025 Patient verbalized items from food pantry and EHC have closed the gap in food insecurity this month. DHHS application has been completed. Pt is waiting to see if he qualifies for SNAP benefits.

Time Frame to completion:30 days

Time spent with patient (each date/time this month):
10/15/2025 33 minutes initial interaction with patient to identify needs and complete PRAPARE
45 minutes assisting with DHHS application

CCM and BHI Care Plans



Primary Care-Specialty Services • 30 Boynton St, EASTPORT ME 04631-1306

TEST1, Tyler (Legal name: Eastport Test1) | (id #8905, dob: 01/01/1980)

Care Plan for Eastport Test1

Table of Contents

Health Concerns Section

Related Observation	Last Modified by	Organization Details	Last Modified Time
General health poor	Not Available	Not Available	Not Available

Concern	Status	Last Modified by	Organization Details	Last Modified Time
Moderate major depression	Active	Kaloua Stanhope, RN Stanhope	ME - Eastport Health Care, Inc.	10/20/2025 07:06:24
Essential hypertension	Active	Kaloua Stanhope, RN Stanhope	ME - Eastport Health Care, Inc.	10/20/2025 07:06:34

SDOH Concern	Status	Last Modified by	Organization Details	Last Modified Time
None Recorded				

Goals Section

Narrative Goal	Description Achievement Status	Lifecycle Status	Start Date	Provider Name and Address	Organization Details	Recorded Time
Pt would like to perform daily activities without feelings of depression interferring	No Change	active	None Recorded	Kaloua Stanhope, RN 30 Boynton St, Eastport, ME, 04631-1306, US	ME - Eastport Health Care, Inc.	10/20/2025 07:11:14
Pt would like blood pressure to be below 140/80	No Change	active	None Recorded	Kaloua Stanhope, RN 30 Boynton St, Eastport, ME, 04631-1306, US	ME - Eastport Health Care, Inc.	10/20/2025 07:07:52

Primary Care-Specialty Services • 30 Boynton St, EASTPORT ME 04631-1306

TEST1, Tyler (Legal name: Eastport Test1) | (id #8905, dob: 01/01/1980)

Planned Interventions	Goal	Status	Updated by	Updated on
Follow up appointments Pt to keep follow up appointments as scheduled. Pt has an appt with lab on 10/21/2025, with pcp on 10/22/2025, with BH counselor on 10/23/2025, and appointment with cardiology on 10/24/2025		Active	Kaloua Stanhope RN	10/20/2025
Building Your Support System 10/20/2025 Pt will call his sister when he is feeling down or depressed as talking to her is calming to him.	Pt would like to perform daily activities without feelings of depression interferring	Active	Kaloua Stanhope RN	10/20/2025
Distraction technique 10/20/2025 When pt feels he is starting to feel depressed he will talk a walk and/or read a book as he states these things help distract and calm him.	Pt would like to perform daily activities without feelings of depression interferring	Active	Kaloua Stanhope RN	10/20/2025
Check blood pressure 10/20/2025 Patient will check blood pressure 3/week and report any readings greater than 150/90 or lower than 100/60.	Pt would like blood pressure to be below 140/80	Active	Kaloua Stanhope RN	10/20/2025
High Blood Pressure Medications 10/20/2025 Take high blood pressure medications as prescribed by your care team (lisinopril and metoprolol).	Pt would like blood pressure to be below 140/80	Active	Kaloua Stanhope RN	10/20/2025

Completed Interventions	Goal	Status	Updated by	Updated on
None Recorded				

Care Team Task

Planned Interventions	Goal	Status	Updated by	Updated on
Care Management Care manager to contact patient on a regular basis and update care plans, with the patient, every 6 months. Care plan created with patient on 10/20/2025, copy mailed to him along with "where should I go" flier. See pt case labeled "care management" for care management notes. Cognitive Function-Mini Cog completed on:10/19/2025 score of 1, no concerns at this time. Functional Assessment 10/19/2025 no concerns. Environmental Assessment 10/19/2025 no concerns Community Sources: Last PRAPARE date-10/19/2025 score of 0. no concerns. Care partner assessment questions: Pt able to care for self.		Active	Kaloua Stanhope RN	10/20/2025
Education Provide education both verbal and written when needed. 10/20/2025 Heart healthy and how to read sodium content on food label education mailed to patient.		Active	Kaloua Stanhope RN	10/20/2025

Completed Interventions	Goal	Status	Updated by	Updated on
None Recorded				

Primary Care-Specialty Services • 30 Boynton St, EASTPORT ME 04631-1306

TEST1, Tyler (Legal name: Eastport Test1) | (id #8905, dob: 01/01/1980)

Health Status Evaluations/Outcomes Section

None Recorded

Interventions Section

Patient Task

Planned Interventions	Goal	Status	Updated by	Updated on
Depression medications 10/20/2025 Pt to take medications as prescribed by care team (sertraline).	Pt would like to perform daily activities without feelings of depression interferring	Active	Kaloua Stanhope RN	10/20/2025
Healthy diet InstructionsGrains: 6 to 8 servings a day. One serving is one slice bread, 1 ounce dry cereal, or 1/2 cup cooked cereal, rice or pasta. Vegetables: 4 to 5 servings a day. One serving is 1 cup raw leafy green vegetable, 1/2 cup cut-up raw or cooked vegetables, or 1/2 cup vegetable juice. Fruits: 4 to 5 servings a day. One serving is one medium fruit, 1/2 cup fresh, frozen or canned fruit, or 1/2 cup fruit juice. Fat-free or low-fat dairy products: 2 to 3 servings a day. One serving is 1 cup milk or yogurt, or 1 1/2 ounces cheese. Lean meats, poultry and fish: six 1-ounce servings or fewer a day. One serving is 1 ounce cooked meat, poultry or fish, or 1 egg. Nuts, seeds and legumes: 4 to 5 servings a week. One serving is 1/3 cup nuts, 2 tablespoons peanut butter, 2 tablespoons seeds, or 1/2 cup cooked legumes (dried beans or peas). Fats and oils: 2 to 3 servings a day. One serving is 1 teaspoon soft margarine, 1 teaspoon vegetable oil, 1 tablespoon mayonnaise or 2 tablespoons salad dressing. Sweets and added sugars: 5 servings or fewer a week. One serving is 1 tablespoon sugar, jelly or jam, 1/2 cup sorbet, or 1 cup lemonade. Pt will also stop using table salt and be mindful of sodium intake in pre packaged foods.	Pt would like blood pressure to be below 140/80	Active	Kaloua Stanhope RN	10/20/2025
Physical Activity 10/20/2025 Perform regular physical activity-pt to walk outside 30 minutes a day 3 days a week.	Pt would like blood pressure to be below 140/80	Active	Kaloua Stanhope RN	10/20/2025
Mental/Behavioral Counseling Attend and engage in mental and/or behavioral counseling sessions. 10/20/2025 Pt to continue to see Ann Obrien for PTSD counseling. Next appointment is 10/30/2025	Pt would like to perform daily activities without feelings of depression interferring	Active	Kaloua Stanhope RN	10/20/2025
Symptom management 10/20/2025 Pt to call EHC if he is having symptoms that are out of his normal and are concerning. He can use after hours service if EHC office is closed. This is the same number as our front desk 853-6001. Pt will go to ER if symptoms are emergent.		Active	Kaloua Stanhope RN	10/20/2025

Primary Care-Specialty Services • 30 Boynton St, EASTPORT ME 04631-1306

TEST1, Tyler (Legal name: Eastport Test1) | (id #8905, dob: 01/01/1980)

Care Team

Name	Role	Member ID	Specialty	Address	Phone
TAMMY CARR LCPC, LADC	Other	19950	Mental Health	30 Boynton St, Eastport, ME	
ANN OBRIEN NP	Referring Provider	19989		30 Boynton St,Eastport Health Care Behavioral Health Dept, Eastport, ME	(207) 853-6001
ADAM SIMMONS DPM	Podiatrist	31409		30 Boynton St, Eastport, ME	(207)853-6001
WILLIAM RICHARDSON MD	Primary Care Provider	55352		30 Boynton St, Eastport, ME	(207) 853-6001
KALOUA STANHOPE RN	Care Manager	55353		30 Boynton St, Eastport, ME	(207) 853-6001
NORTHERN LIGHT CARDIOLOGY	Cardiologist	55354		1 NE Dr, Bangor, ME	(207) 275-3800

Demographics

Sex:	Male	Ethnicity:	Hispanic or Latino/Spanish
DOB:	01/01/1980	Race:	Information not available
Preferred language:	pt	Marital status:	Married

Contact: 1 Main Street, Cambridge, MA 02142, Ph. tel:+1-000-000-0000

Benefits to these programs:

-Better health outcomes for the patient

-Patients are staying in homes longer.

-Cost saving for insurance companies.

-Financial benefits for organization.

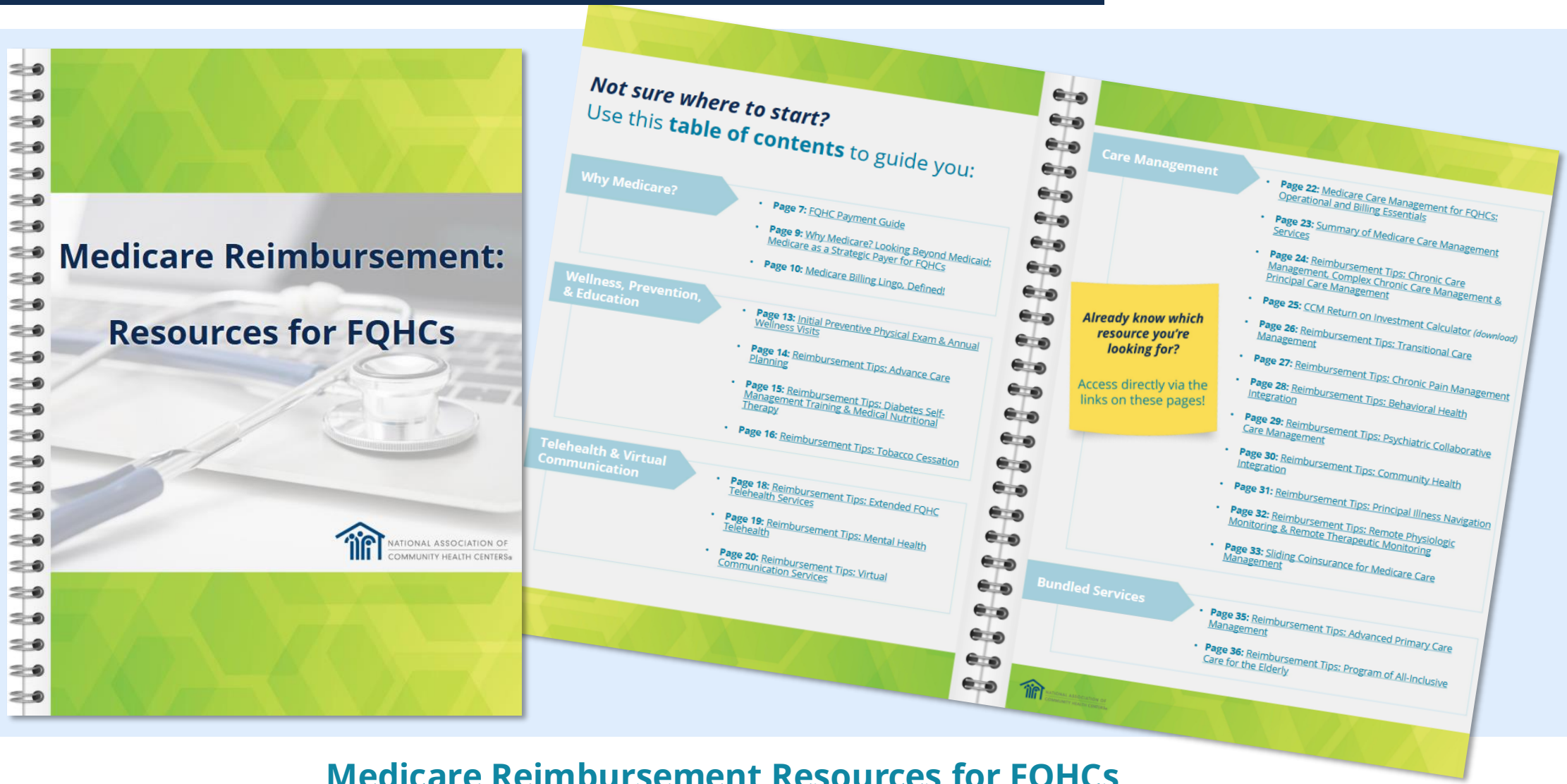
THANK YOU!

If you have any questions, please feel free to email or call me at:

kstanhope@eastporthealth.org

207-853-0051

Resources



[Medicare Reimbursement Resources for FQHCs]

QUESTIONS?

Be sure to join us for the next webinars in this series!

Monday, December 8, 2025 | 4:00 PM ET

- The Billing Side of Care Coordination

Thursday, January 8, 2026 | 4:00 PM ET

- PACE Programs & Other Options for Community Health Centers

Thank You!

Elizabeth Linderbaum
Director of Regulatory Affairs
elinderbaum@nachc.org

Cassie Lindholm, MPA, PCMH CCE
Deputy Director, Quality Center
clindholm@nachc.org