Department of HUMAN SERVICES

Chronic Condition Health Home PMPM Fee Schedule

The CCHH will bill a S0280 with the appropriate modifier to identify the member's enrollment tier with the health home service informational codes on subsequent lines on the claim to attest to health home services provided.

Tier	Procedure Code	Modifier	PMPM Rate	Health Home Service	Informational Only Procedure Codes
1 (1-3 CC)	S0280	U1	$13.48	Chronic Care Management	G0506
2 (4-6 CC)	S0280	TF	$26.96	Care Coordination	G9008
3 (7-9 CC)	S0280	U2	$53.91	Health Promotion	99439*
4 (+10 CC)	S0280	TG	$80.87	Comprehensive Transitional Care	G2065
				Individual &Family Support Services	H0038
				Referral to Community and Social Support Services	S0281

*99439 replaces G2058 for Health Promotion for dates of service beginning January 1, 2021.

This reimbursement model is designed to only pay for health home services as described in the six core service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services) and may or may not require face-to-face interaction with a health home patient. However, when these duties do involve such interactions, they are not traditionally clinic treatment interactions that meet the requirements of currently available billing codes.

The criteria required to receive a monthly PMPM payment is:

- The member meets the eligibility requirements as identified by the provider and documented in the members electronic health record (EHR).
- Member's eligibility requirements verified within the last 12 months.
- The member has full Medicaid benefits at the time the PMPM payment is made.
- The member has agreed and enrolled with the designated health home provider.
- The Health Home provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards.
- The minimum service required to merit a Patient Management PMPM payment is that the person has received care management monitoring for treatment gaps defined as health home services in this State Plan. The health home must document health home services that were provided for the member.
    - The patient medical record will document health home service activity and the documentation will include either a specific entry, at least monthly, or an ongoing plan of activity, updated in real time and current at the time of PMPM attestation.