Changing Medicare Payment Policies: Opportunities for Community-based Organizations

N3C
National Coalition on Care Coordination

2019 Aging in America Conference

Monday April 15, 2019

Organized by the National Coalition on Care Coordination (N3C)

Housed by the Center for Health and Social Care Integration at Rush University Medical Center

Welcome and today's agenda

Overview of Medicare opportunities for CBOs

Bonnie Ewald, Center for Health and Social Care Integration at Rush

CBO experiences

June Simmons & Sandy Atkins, Partners in Care Foundation

Jacob Bielecki, Boulder County AAA

Tim McNeill, Consultant to ACL

Reflecting on research and advocacy needs

Anne Montgomery, Program to Improve Eldercare @ Altarum Institute

Medicare Reimbursement Opportunities for Community-based Organizations

Bonnie Ewald, MA

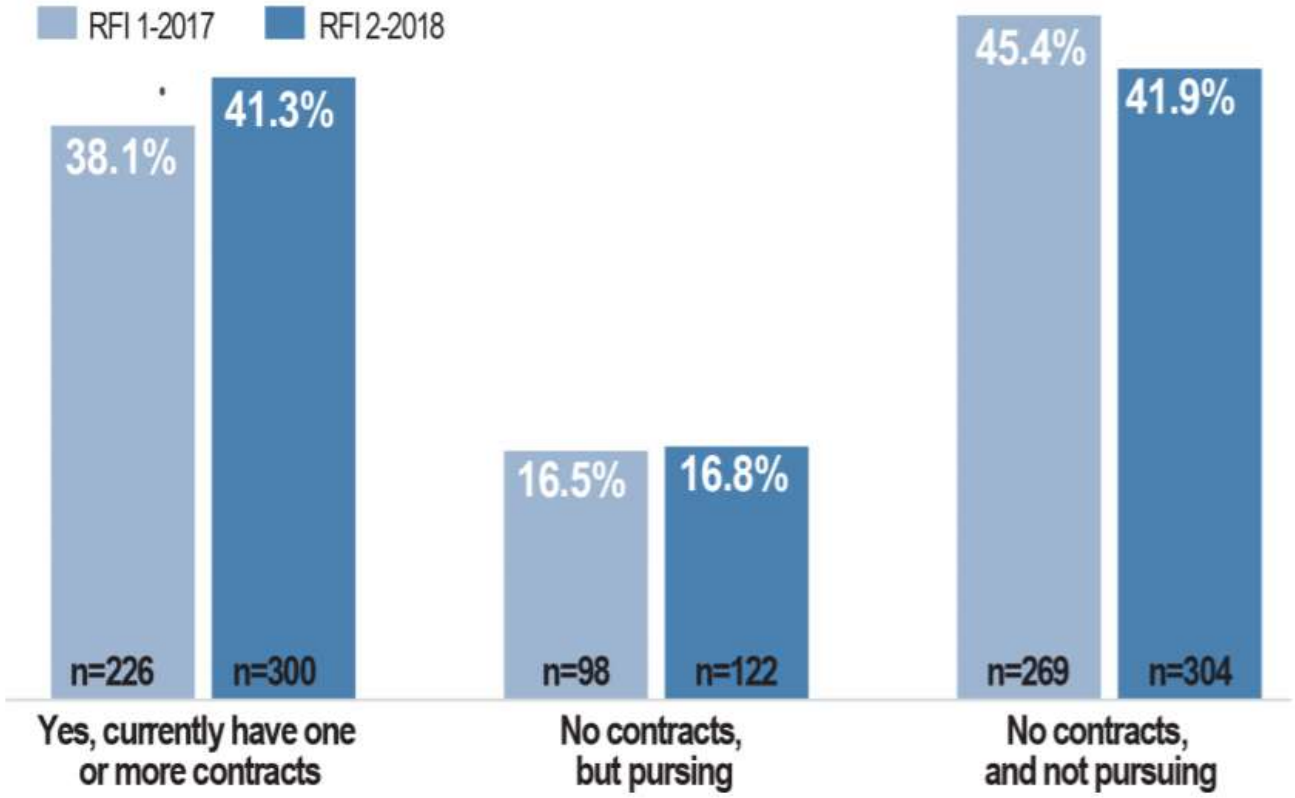
Associate Director, Center for Health and Social Care Integration

Rush University Medical Center

CBOs are increasingly focusing on contracting with healthcare entities

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

Survey from n4a and the Scripps Gerontology Center at Miami University:



https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6280/Kunkel-Community-Based-Organizations-and-Health-Care-Contracting.pdf,
https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/12/RFI-II-draft-slides_final.pdf

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Connecting Communities and Health Care

Common CBO health care partners

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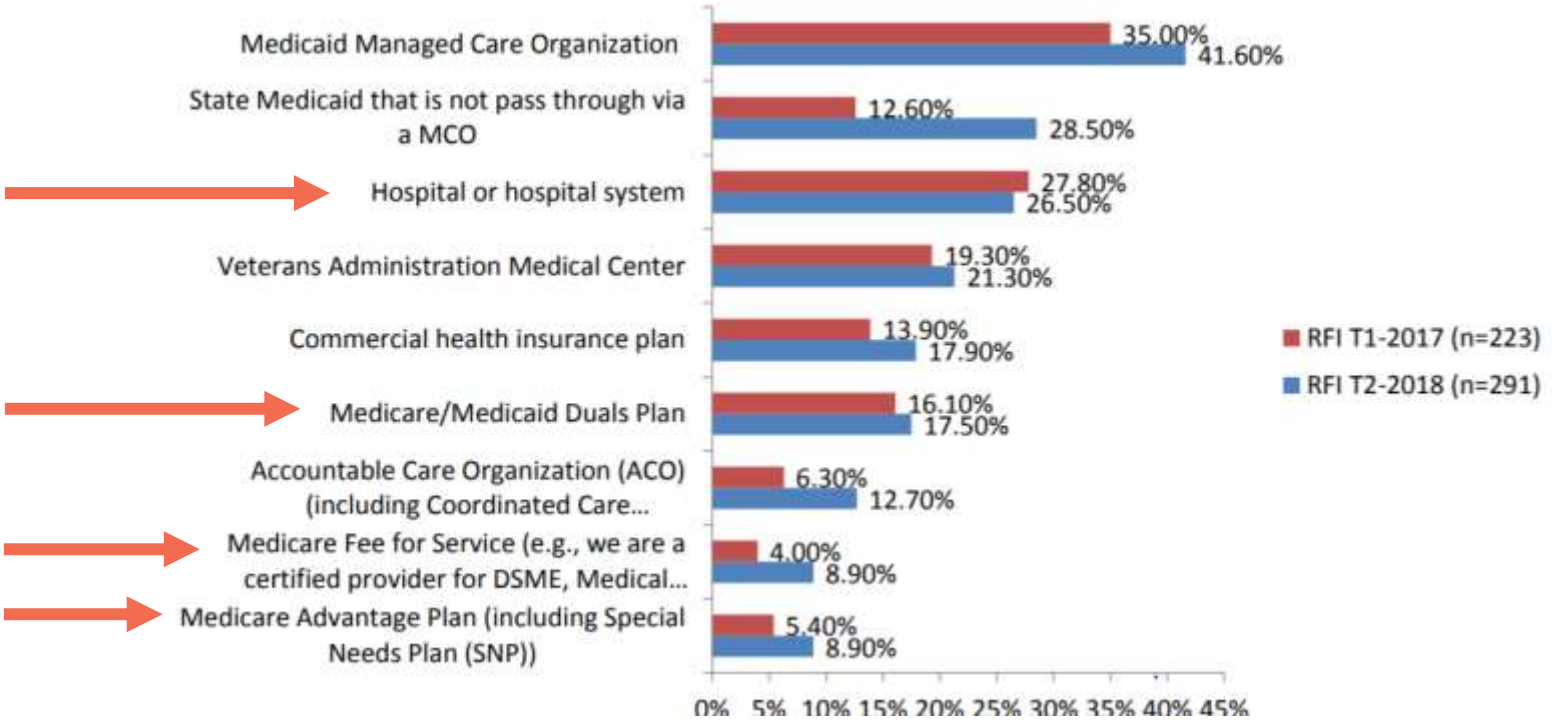

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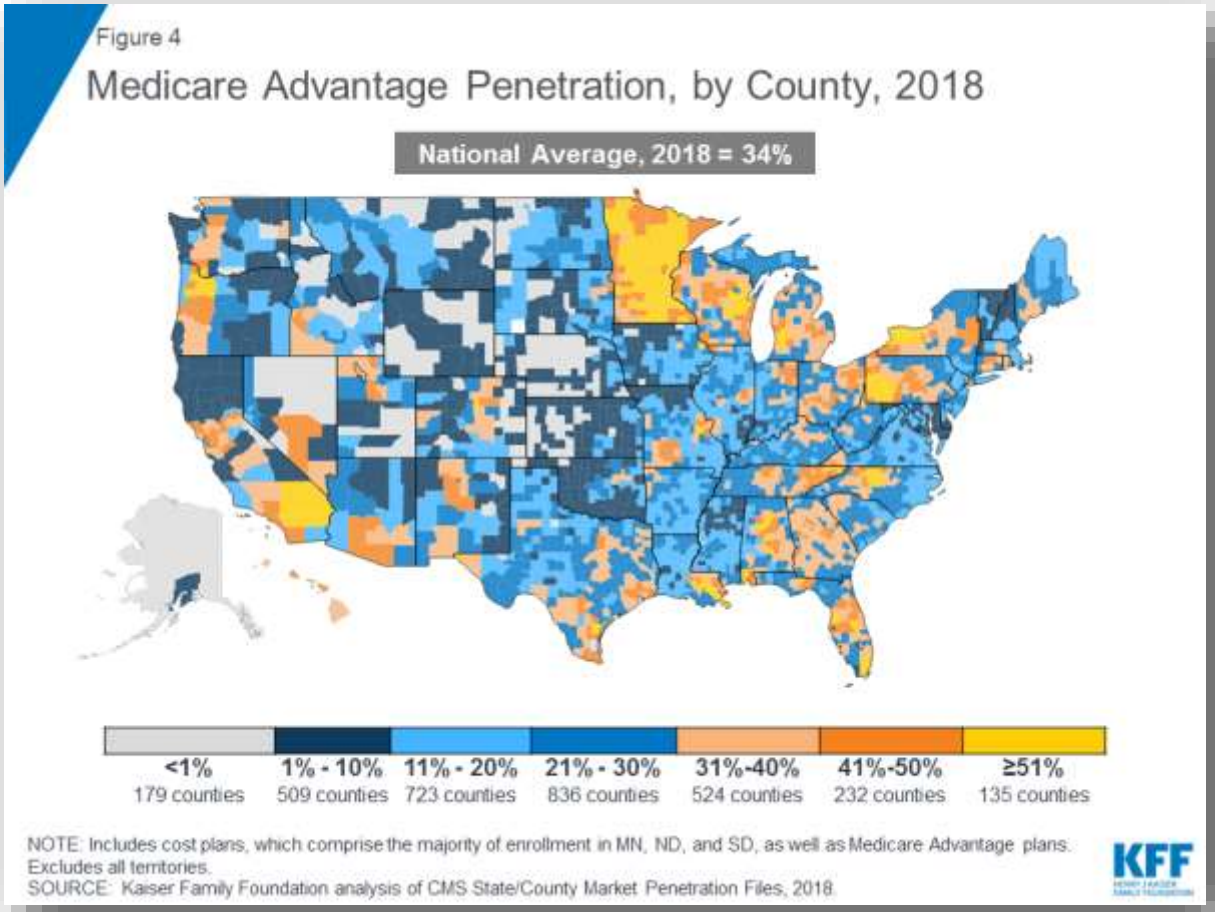
Medicare Advantage: A growing opportunity



https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/

The Medicare landscape

Part A

- Hospital Value-based Purchasing Program
- Hospital Readmission Reduction Program
- Bundled Payment initiatives
- Skilled Nursing Facility Value-based Purchasing Program

Part B

- Chronic Care Management
- Transitional Care Management
- Behavioral Health Integration
- Health and Behavior Assessment and Intervention
- Welcome to Medicare & Annual Wellness Visit
- Medicare Diabetes Prevention Program
- Diabetes Self-Management Training
- Comprehensive evaluation of cognitive impairment
- Psychotherapy

Part C

- Provision of Part B benefits
- Supplemental benefits
- Value-based care management contracts

Part A: Reducing "Post-Acute Care" Risk

Hospital Value-based Purchasing Program (VBP)

Hospital Readmission Reduction Program (HRRP)

Bundled Payment for Care Improvement (BPCI), BPCI Advanced, or Comprehensive Joint Replacement (CJR) Program

Skilled Nursing Facility Value-based Purchasing Program (SNF-VBP)

Part B: Partnering with providers or providing services directly, with MACRA as backdrop

Chronic Care Management (CCM)*
- Monthly
- 99490, 99487, 99489
- G0506, 99491

Behavioral Health Integration (BHI)*
- Monthly
- 99484
- 99492, 99493, 99494

Transitional Care Management (TCM)*
- Once per hospitalization
- 99495, 99496

Health and Behavior Assessment and Intervention (HBAI)
- 15 min increments, various
- 96150-96154

Annual Wellness Visit (AWV)*
- Annually
- G0438, G0439

Medicare Diabetes Prevention Program (MDPP) ^
- Various codes over 24 month period

Diabetes Self-Management Training (DSMT) ^
- Once in lifetime, over 12 months
- G0108, G0109

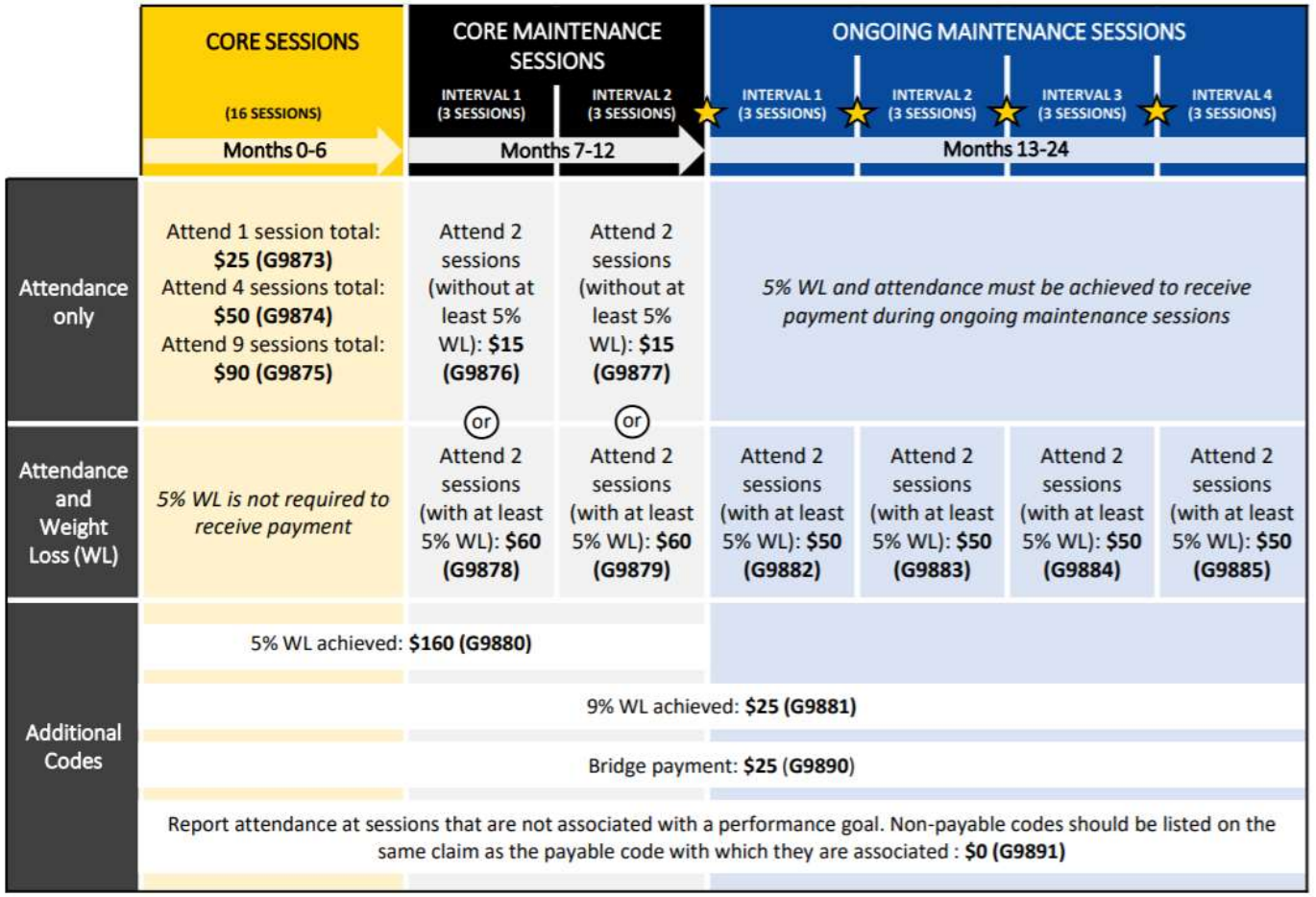
Comprehensive evaluation of cognitive impairment*
- Once / 6 months (max)
- 99483

Psychotherapy
- Various codes
- Individual and group

*** Physician or non-physician qualified provider "drops" the bill and provides general or direct supervision**
^ Accreditation needed

A look at the Medicare Diabetes Prevention Program

Maximum possible payment per eligible beneficiary: $670



- *HCPCS G-codes and their payment amounts are **bolded** next to each payment description*

★ *Represents when a specific performance goal (i.e., attendance, weight loss) must be met for the beneficiary to be eligible to continue receiving services*

https://innovation.cms.gov/Files/x/mdpp-billingpayment-refguide.pdf,
https://journals.lww.com/lww-medicalcare/Abstract/2018/11000/New_Medicare_Diabetes_Prevention_Coverage_May.3.aspx

Part C: Increasing opportunities under Medicare Advantage

- Provision of Part B benefits
- Value-based care management contracts
- Supplemental benefits

Medicare Advantage's advantage

Figure 1: New Supplemental Benefit Offerings in 2019

Examples of Supplemental Benefits Categories	Number of Plans Offering Benefit
Nicotine Replacement Therapy	1,653
Caregiver Support Services	429
In-home Support & Personal Care Services	107
Social Worker Phone Line	80
Adult Day Care	26

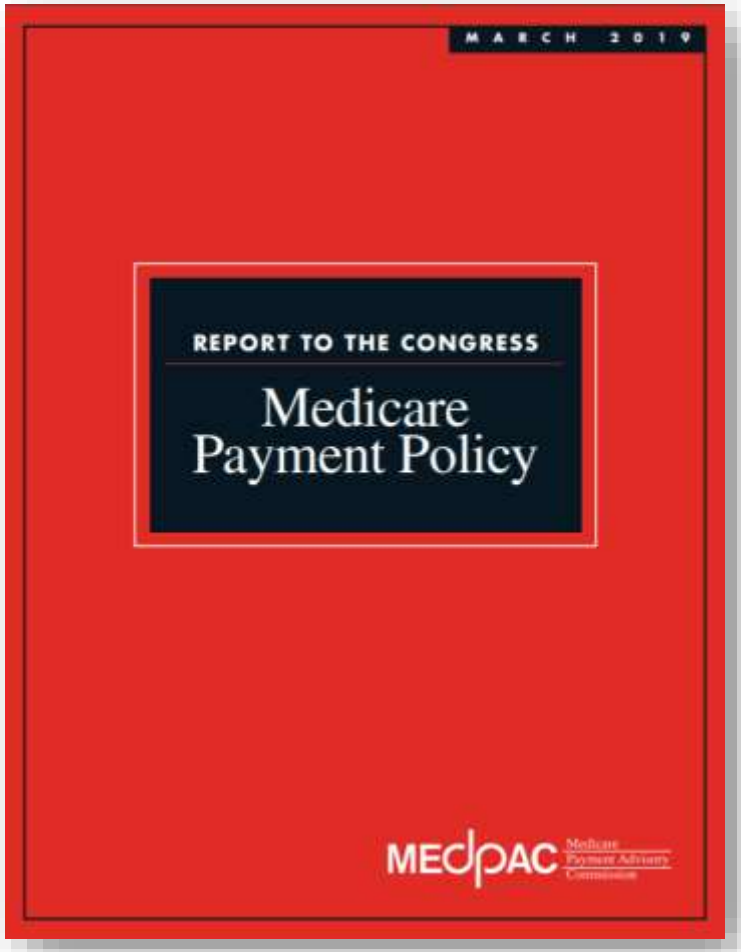
Note: Includes plans in the market in both 2018 and 2019 and new plans entering the market in 2019.

Avalere

https://avalere.com/press-releases/medicare-advantage-beneficiaries-will-see-a-jump-in-new-supplemental-benefit-offerings-in-2019

What else lies ahead?

- **Medicare will continue evolving toward value-based payments**
  - Pay for performance
  - Growth in at-risk value-based contracting opportunities
- **Commercial payers**
- **Networks of CBOs**
  - Management Services Organizations (MSOs)



Navigating it all

"You've got to have a full-picture understanding of the ultimate contract your organization is being asked to sign before you agree on rates, otherwise you could wind up with surprises that impact business and the cost to deliver on what you've agreed to."

- Suzanne Burke, CEO of the Council on Aging of Southwestern Ohio

https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2019/02/Partnership-Profile-CC-COA-508.pdf

Bonnie Ewald, MA
Associate Director, Center for Health and Social Care Integration
Rush University Medical Center

bonnie_ewald@rush.edu
www.chasci.org
@RushSWCH

CHaSCi
Center for Health and Social Care Integration

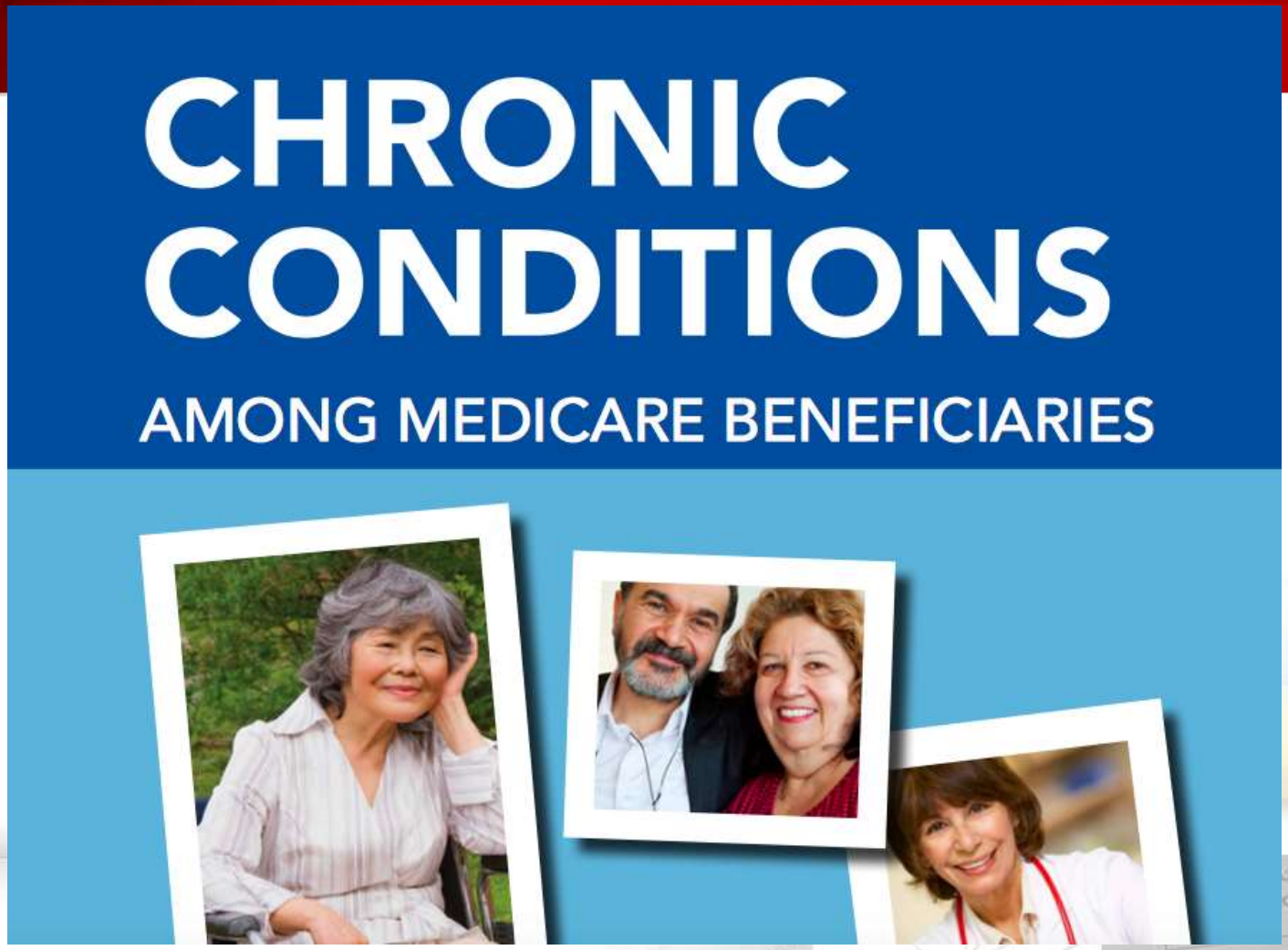
Policy to Practice: The role of the CBO in Chronic Care Management (CCM)

Timothy P. McNeill, RN, MPH

Changing Business Model Requires Care Management Service Expansion

- Value-Based Contracting will continue to increase the demand for care management services for targeted populations.
  - MACRA
    - Merit Incentive Payment System (MIPS)
    - Alternative Payment Models (APMS)
- Population Health
  - Identification of populations that are most at-risk for increasing costs
    - Multiple chronic conditions
    - Social Determinants
    - Poor Disease self-management skills

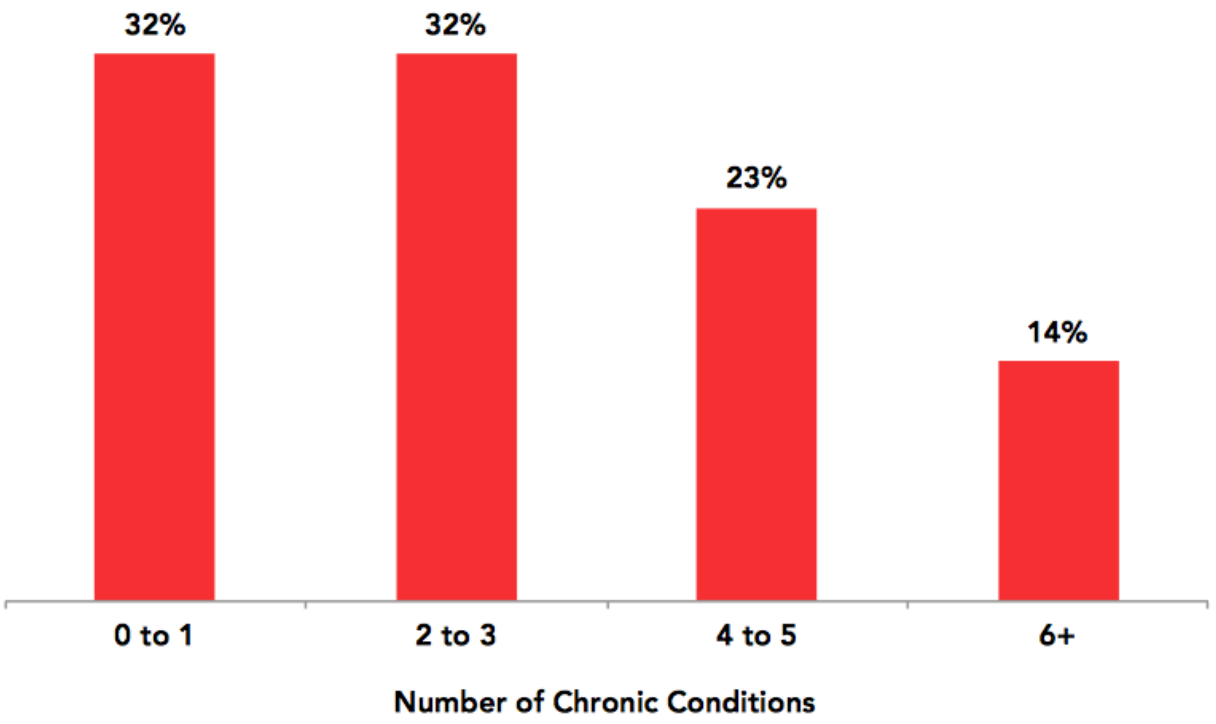
CMS Medicare Chartbook:



https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

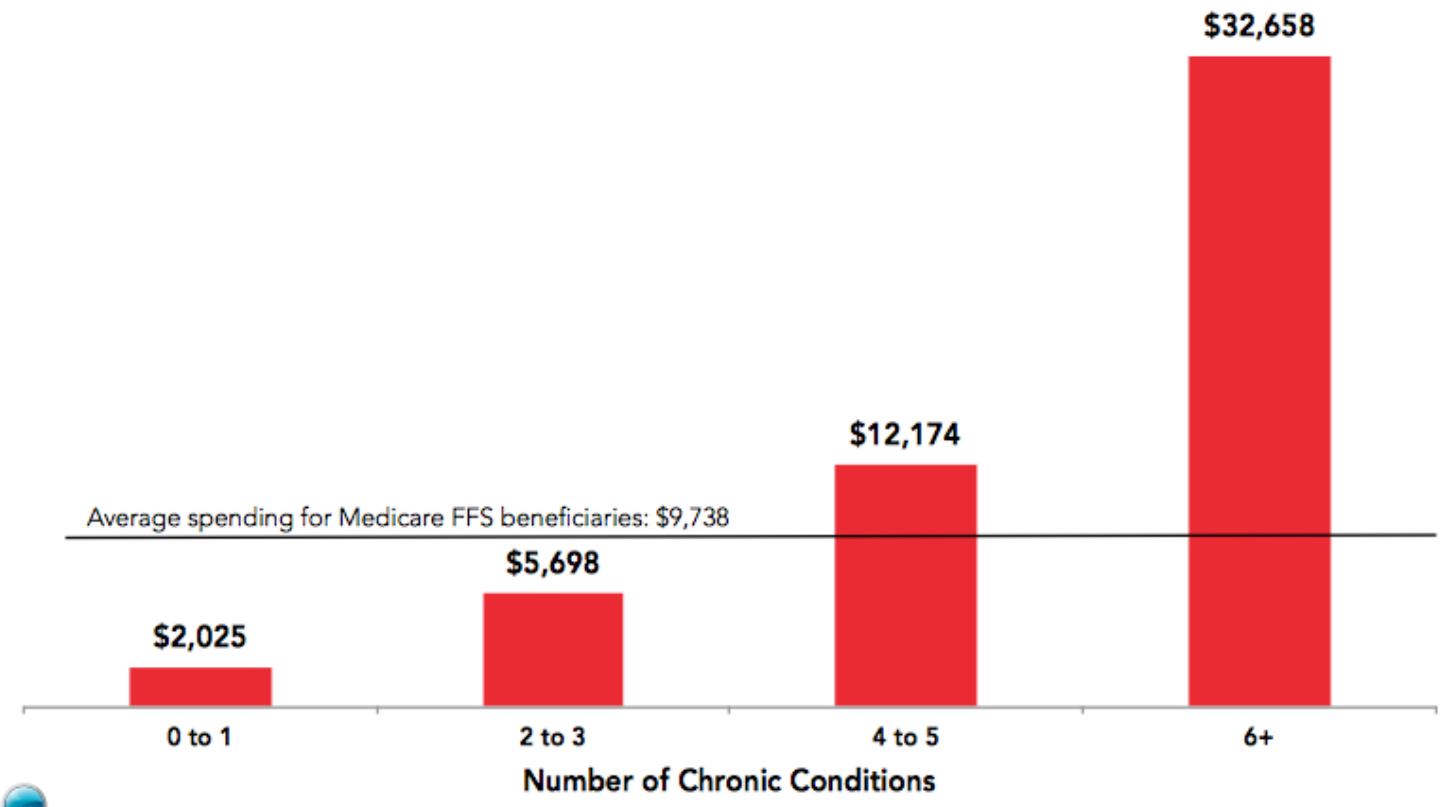
Nearly 70% of FFS Medicare has 2 or more chronic conditions

Figure 1.2a *Percentage of Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010*

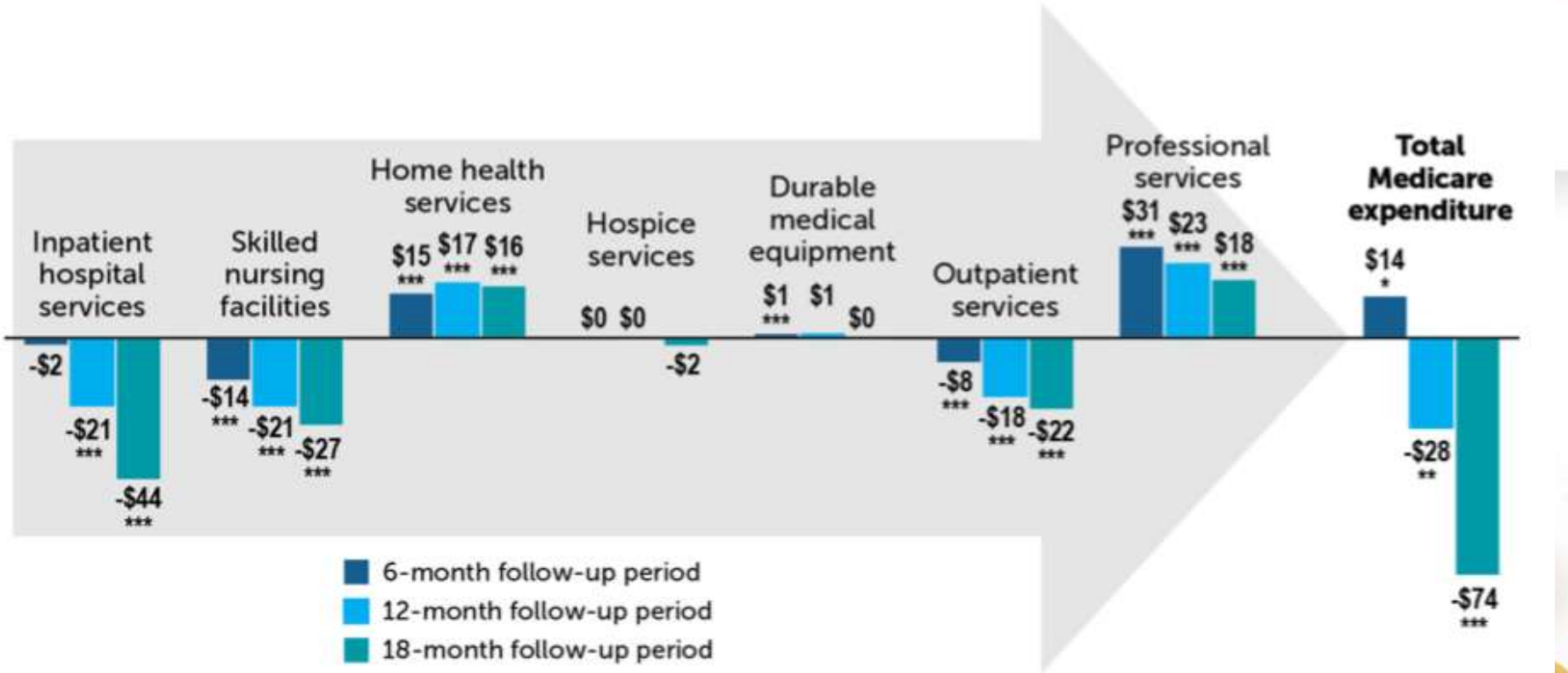


Per Capita Expenditures increase as the conditions increase

Figure 3.1a *Per Capita Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010*



Impact of CCM on Total Medicare Expenditures: PBPM Total Impact (two-tailed test, $p < 0.05$; $p < 0.01$)



Source: Medicare 2014–2016 enrollment and FFS claims data.

Ref: CMS. *Evaluation of the Diffusion and Impact of Chronic Care Management Services: Final Report.* November 2, 2017. Mathematica Policy Research. Contract Number HHSM-500-2014-000341

CARE MANAGEMENT CONTRACTING

Medicare Part B: Care Management Services

- Transitional Care Management (TCM)
  - 30-Day intervention to coordinate care after an acute hospitalization or institutional placement
- Chronic Care Management (CCM)
  - 20-Min care coordination intervention with low-complexity
- Complex Chronic Care Management
  - 60-Min Moderate – High complex care coordination
- Behavioral Health Integration (BHI)
  - Care Coordination to address behavioral health issues, such as Depression
- Collaborative Care Management (CoCM)

CPT Codes for Care Management Services

- Transitional Care Management
  - 99495 (Moderate Complexity)
  - 99496 (High Complexity
- Chronic Care Management CCM
  - 99490 (20 Minutes)
- Complex Chronic Care Management
  - 99487 (60 Minutes)
- Collaborative Care Management
  - 99492 (Initial 70 Minutes)
  - 99483 (Subsequent monthly services 60 Minutes)

Chronic Care Management Opportunity

- Medicare Providers can deliver this service or contract with a third-party care management company to provide the service
- Services can be provided by “General Supervision”
  - Incident To rules have been changed to include Transitional Care Management and Chronic Care Management Services as services that can be rendered under General Supervision
- Requires development of a Person-Centered Care Management Plan

Health Policy Timeline for Care Management Svcs

- January 1, 2015
  - CMS introduced non-face-to-face Chronic Care Management (CCM) services [CMS-1612-FC, 2014]
  - 20 minutes of clinical staff time for CCMS services in a given month
- November 16, 2016
  - CCM Rule revised to reduce the administrative burden of providing CCM.
- January 1, 2019
  - Expanded CCM codes for services provided directly by the physician instead of clinical staff.

Key Policy Changes to Support Expanding CCM

- CFR §410.26
  - "Incident To" rules changed to define the fact that Transitional Care Management and Chronic Care Management services can be furnished under general supervision of the physician or other practitioner.
  - Services can be provided by clinical staff
- November 2016 Policy changes
  - Verbal Consent is acceptable prior to initiating CCM services
  - One (1) initiating visit required, prior to CCM
    - e.g., Level 3 E/M, TCM, Annual Wellness Visit
  - New Patients can receive CCM services
  - CCM is not limited to a primary care provider

Additional Policy Changes Supporting CCM

- Reimbursement for care management planning
  - G0506: Comp. assessment and care planning for CCM
- Separate CPT when CCM services are directly provided by the Provider
  - 99491: CCM delivered by provider for 30 min
- Remote Patient Monitoring
  - CCM and Remote Patient Monitoring can be provided to the same beneficiary during the same month.
  - 99453: RPM initial set-up and patient education
  - 99454: Remote monitoring of physiologic data, each 30 days
  - 99457: 20 min of clinical staff time req. interactive communication with patient/caregiver during the month

Beneficiary Requirements

- Two or more chronic conditions expected to last at least 12 months
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established
  - Plan should have measurable goals
  - Defined interventions
  - Monthly update of the plan based on achievement or lack of achievement of measurable goals

Common Questions

- Can more than one provider deliver CCM to the same beneficiary in the same month?
  - No. Only 1 provider can bill for CCM. Utilization remains low.
- Does Complex CCM mean that there has to be a greater number of chronic conditions?
  - The time (60 Min) and complexity of the intervention.
- Can a provider contract with a third-party care management entity to provide CCM under general supervision?
  - Yes. Third party entities can contract with providers to do CCM services

Common Questions (cont.)

- What is clinical staff mean?
  - CPT definition of clinical staff. Any person operating under general supervision of the billing provider and operating within the defined scope of practice in the state where services are rendered
- Is this only limited to primary care providers
  - PCP can bill
  - Specialists can bill
  - Providers can bill for CCM provided to new patients, even if there is no prior relationship
  - Congress mandates reporting of CCM for disadvantaged populations

Physician Outreach to expand CCM

- MACRA mandates CMS report to congress CCM utilization for high-risk groups.
  - Minority Populations
  - Low-income
  - Rural
- Establish a marketing outreach campaign to increase utilization for high-risk populations.
  - CCM Connected Care Website:
  - https://www.cms.gov/about-cms/agency-information/omh/equity-initiatives/chronic-care-management.html
- American Medical Association training module on the use of health coaches to deliver CCM

Questions

- Tim McNeill, RN, MPH
  - Phone: (202) 344-5465
  - Website: www.freedmenshealth.com
    - Resources and Podcasts
  - Email: tmcneill@me.com

CBO Experience in Expanding Medicare "Business"

W. June Simmons, CEO
Sandy Atkins, VP, Strategic Initiatives

Partners in Care Foundation

April 15, 2019

Partners in Care
FOUNDATION

Partners in Care Foundation

Changing the Shape of Healthcare

- Partners is a **think-tank** and a **proving ground**
- Partners changes the shape of health care by **creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities**
- Partners' direct services **test, measure, refine and replicate innovative programs and services**, and **bring needed care to diverse populations**

Partners in Care
FOUNDATION

Changes We Want to See

- Integration of medical care and social services to address social determinants of health
- Enhanced self-management/empowerment of consumers
- Integration of behavioral health
- Evidence-based interventions
- Community Agencies forming into regional delivery systems/networks, like IPAs

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Why CBOs? Bridge to the Home

- CBOs have worked to improve health and functioning at home for decades
- Local trust, history and community support
- Know the lay of the land — quality of services
  - Not a call center approach — local employees
- Mobility and flexibility— responsive, nearby
- Health coaches, navigators, social workers, community health workers - an alternative and affordable workforce
- Culturally & linguistically matched

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Contracts in Medicare Space

- Blue Shield of California (Medicare Advantage)
  - **HomeMedsPlus:** Home visits, HomeMeds, assessment, implement care plan
  - **Chronic Disease Self-Management** w/ outreach & enrollment and workshops
- UCLA (MA) – HomeMedsPlus
- Providence (FFS) – **Care Transition Choices**
  - Coleman CTI *with* HomeMeds or Bridge
- Saint John's Health Center – TCM (Transitional Care Management) Medicare FFS code

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Next Up

- Providence – Add TCM to help cover Care Transition Choices (CTC) and move patients into CCM
- Saint John's Health Center – Switch to CTC (better outcomes)
- Partner with ACE (hospitalist group) to create TCM/CCM model with home-based primary care and pilot in
  - Holy Cross Hospital where they are hospitalists
  - Our Medicaid waiver programs
- Consult for managed care physician groups about Special Supplemental Benefits for the Chronically Ill

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Now is the time!
Population Health & Value-based Payment

- **FFS TCM, CCM, Behav. Health, Adv. Care Plan, & Dementia Assessment Codes**
- **Dual eligible plans**
- **MA SNP-D & SNP-C**
- **Medicaid Waivers**

Exactly the populations where SBDOH impede success of medical care and where CBOs excel at providing home and community-based services

Whither goes Medicare…there goes Commercial!

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Example of True Partnership:
Partners in Care and UCLA Medicare Advantage & Med Group

- *Partners'* CEO participates in Primary Care Redesign Team
- Apply together for home palliative care CMMI
- Collaborative Root Cause Analysis about readmissions
- CMS Community-based Care Transitions Program - >8,300 patients
  - Integration of *Partners'* HomeMeds with UCLA MyMeds pharmacists
  - Outstanding outcomes
- Complete data sharing
- Access to EPIC EHR
- Both CM referrals and automated LACE-Plus
- Incentives aligned
- Apply together for awards, letters of support/commitment
- Co-present at conferences (see us tomorrow)

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FOUNDATION

Outcomes of Partnership with UCLA

- >8,300 patients helped by *Partners* in CMS-funded Community-based Care Transitions Program
  - Average **34% reduction in readmission rate** vs. baseline
  - New propensity-score-matched study found substantial & significant **decreases in 30, 60 and 90-day readmissions and 30-day ED use**
  - Innovative partnership between health coach and UCLA MyMeds Pharmacists using *Partners'* nationally recognized HomeMeds program
- Over 1,000 Medicare Advantage/Medical Group patients paid by UCLA
  - **>60% reduction in pre-post readmission rate** within high-risk group
  - 3% fewer readmissions across the entire high-risk MA population

"Concerning the 10 cases that you pulled of the Medicare Advantage intervention:

I read them and found them to be impressive. This appears to be the sort of post-discharge intervention that a high risk patient should receive."

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FFS Medicare Care Transitions 2.0

- Providence Health & Services
  - 5 hospitals
  - Goal: Reduce readmission penalties
  - Care Transition Choices (3 evidence-based programs)
    - Patient chooses either:
      - Coleman CTI plus HomeMeds or
      - Rush U. Medical Center's Bridge telephonic social work program

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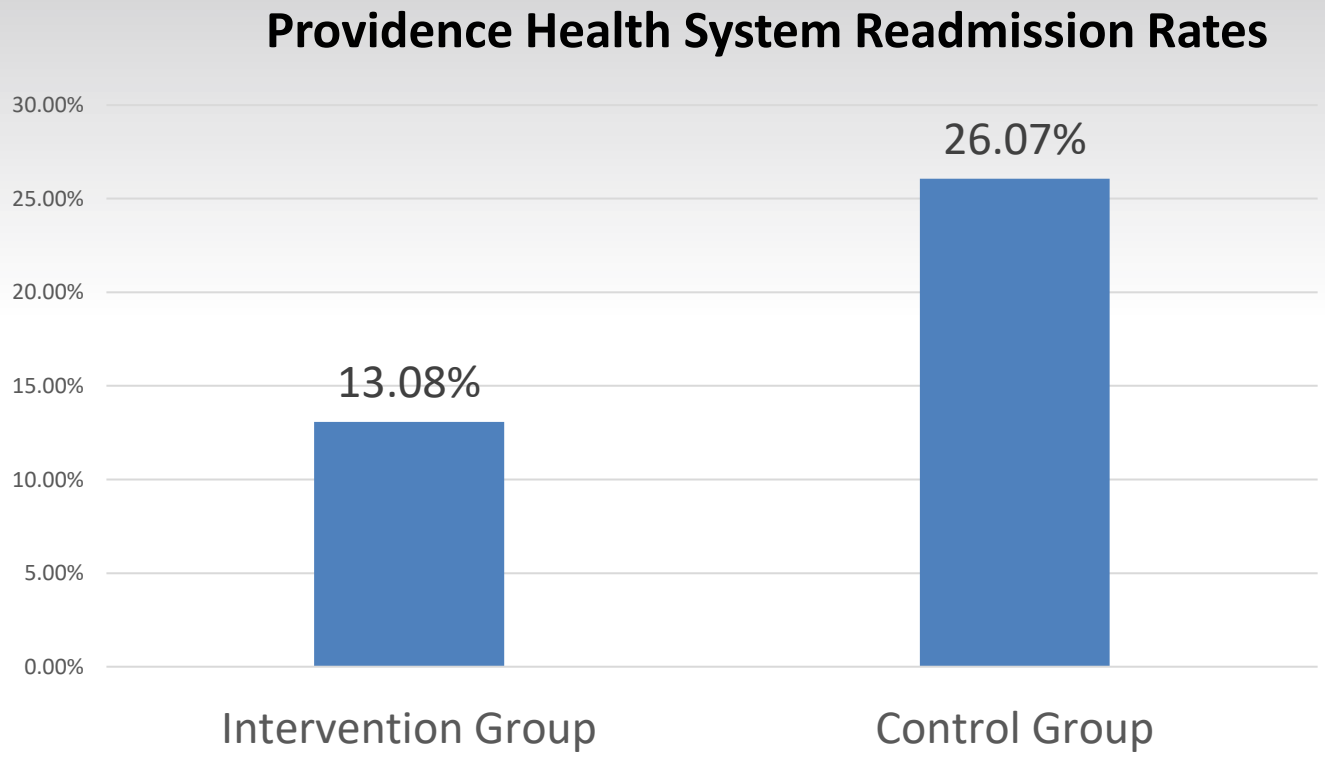
Care Transition Choices Outcomes

- Program Began October 2017: Results through June 2018
- Coach access to EPIC
- Outperforms TCM program at sister hospital



Analysis completed by HSAG

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Working towards CCM: Model & Issues

- Workgroup – Tim, hospitalist, JD, foundation CEO
- Model:
  - Team is hospitalist/home visit MD group & *Partners*
    - *Both have contracts with Holy Cross Hospital*
  - TCM leads to CCM if person has been in hospital
    - TCM face-to-face visit by NP, either in the home or via telehealth
  - LTSS waiver clients get CCM coordinated with PCP
    - Affiliate with home-PCP program for those who don't have community PCP or prefer not to go out
- Planning issues involving consent:
  - *Refusal*: People have too many PCPs for us to contract with, most don't do TCM or CCM, but patients don't want to deal with other physicians
  - *Refusal:* Issue of co-pay
- Politics: Docs don't want their patients "stolen"

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Working towards CCM: Practical Issues

- CCM requires previous relationship with patient via TCM or regular primary care
  - Some states' Medicare fiscal intermediaries (MAC – Medicare Administrative Contractor) allow hospitalist care to establish relationship…others don't
- Coordinating care with all those PCPs
- IT:
    - Capable of tracking minutes of service
    - User-configurable assessment/care plan
    - CMS-level documentation
    - Communicate with PCP EMR via continuity of care document, Direct protocols, etc.
    - Dashboard, workflows, alerts
    - Certified EHR
- All day (24-hour) response to patients
- Is it financially viable with all the fingers in the pie?
  - IT
  - Billing

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Starting on the SDOH path… how we can help

- America's Physician Groups – Group Purchasing Offering for managed care physician groups
  - Direct Services:
    - California: Through Partners at Home Network
    - Rest of the country: Aging & Disability Business Institute and other partners
  - HomeMeds
  - Planning and consultation about SDOH and CBO services
  - Toolkits, e.g., workflows, job descriptions
  - Targeting criteria
  - Evidence-based assessment of patients' non-medical needs:
    - socioeconomic factors, home safety, medication safety, functioning, cognition/depression/anxiety, health behaviors
  - Measurement – value-based outcomes

HOMEMEDS

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Thank you!!

Feel free to follow up for more information with:

June Simmons

jsimmons@picf.org

(818) 837-3775 x.101

Partners in Care FOUNDATION

Boulder County Area Agency on Aging's Experience with Medicare Opportunities

Jacob Bielecki, M.Sc

Business Results Manager

Boulder County
AREA AGENCY ON AGING
Community Services Department

Open discussion / Q & A

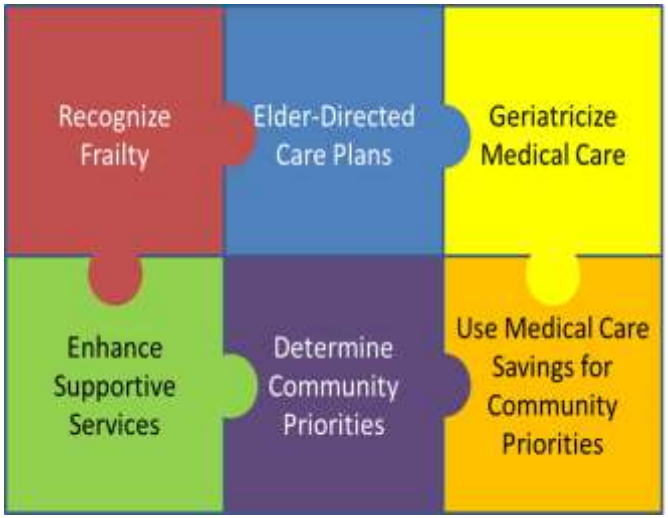
Moderated by Anne Montgomery

Changing Medicare Payment Policies,

Opportunities for Community-based Organizations, and the Role of Research, Advocacy & Policy in our Journey Towards COMMUNITY-ANCHORED CARE

Anne Montgomery, Deputy Director, Program to Improve Eldercare, ALTARUM

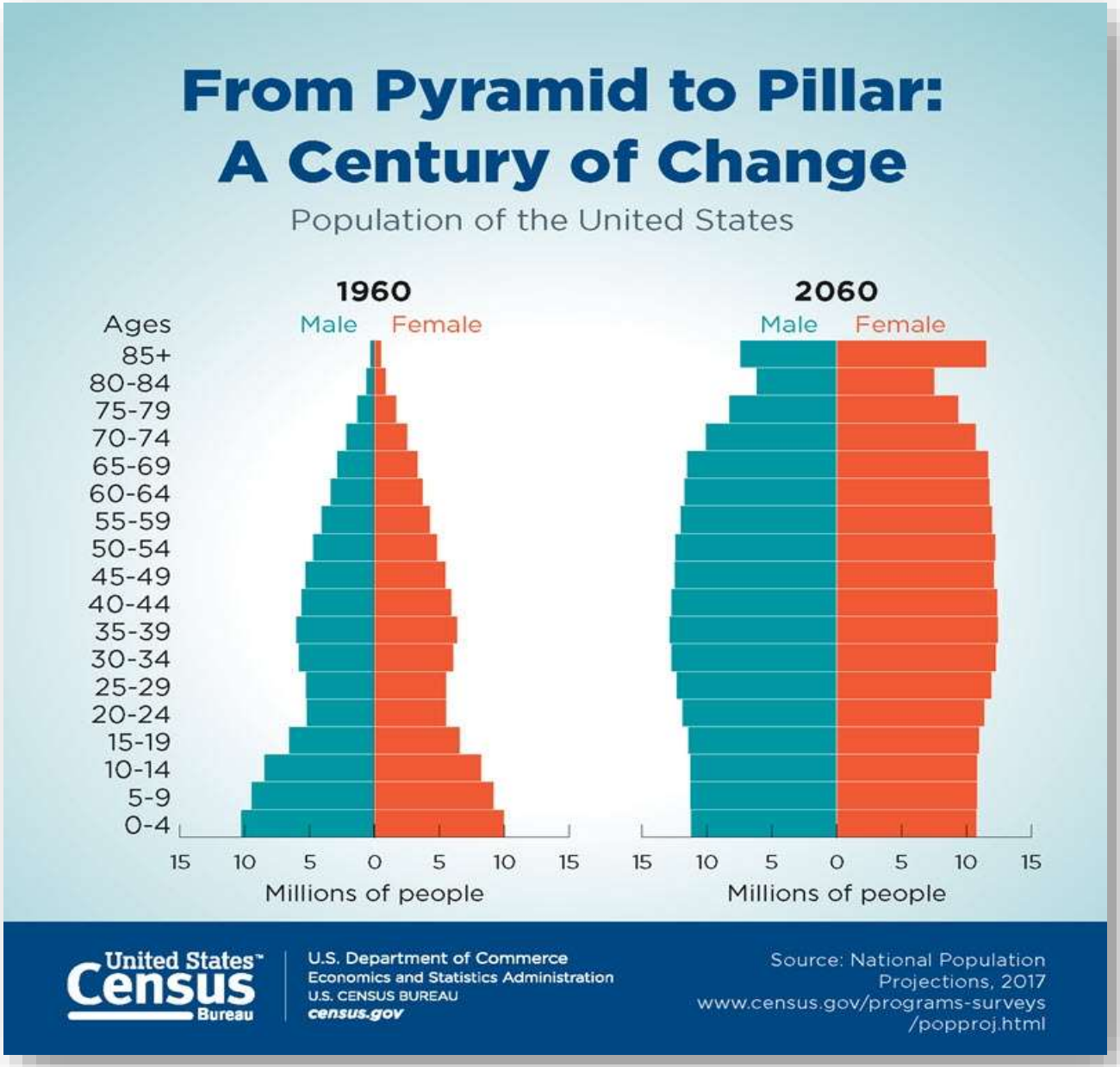
Community-Anchored Care: Common Characteristics

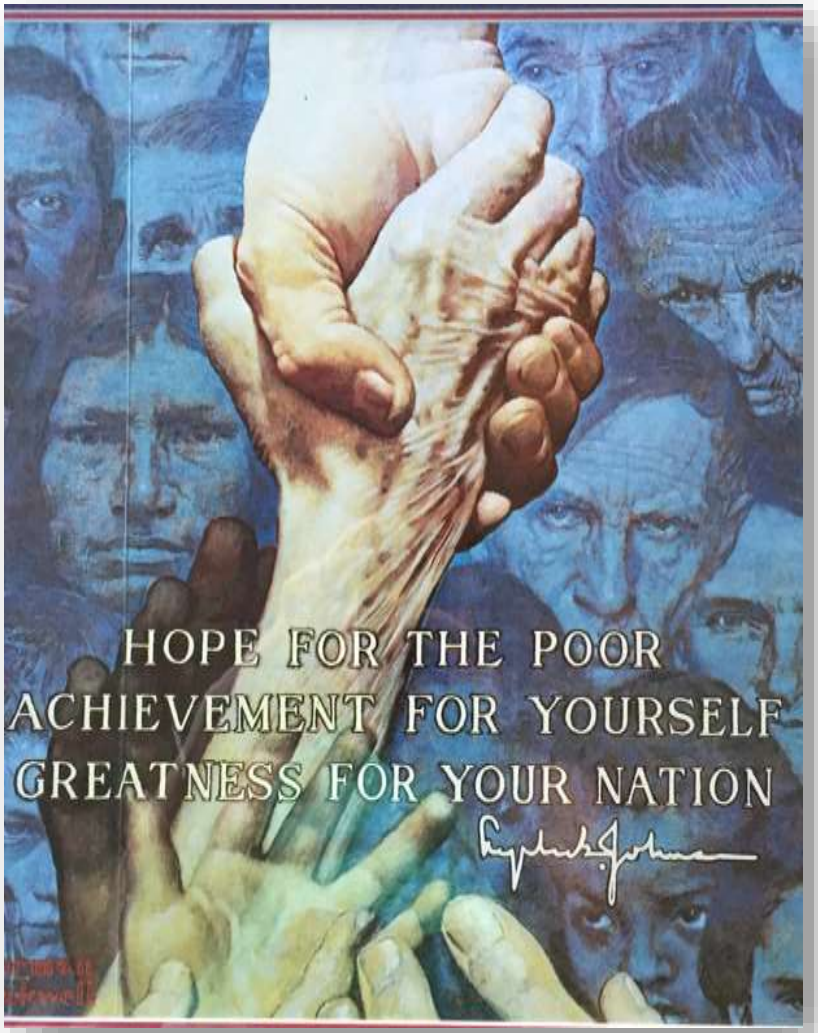


- **FRAILTY** is infrequently diagnosed and tracked -- but federal IMPACT law will soon require standardized documentation of ADLs across PAC settings
- **COMPREHENSIVE, LONGITUDINAL CARE PLANS** that include treatments, personal goals & prognosis mostly do not exist, but ongoing funding to address data-sharing barriers between providers' EHRs can be tapped to improve communication, connectivity w/ supportive services orgs
- **GERIATRICIZED MEDICAL CARE** – growing recognition of need for this, i.e., addition of LTSS supplemental benefits for MA plans, chronic care mgmt codes
- **ENHANCED SUPPORTIVE SERVICES** exist in some integrated service delivery models that encompass medical care & LTC. PACE is the leading model and should be expanded!
- **DETERMINING COMMUNITY PRIORITIES --** begins with pilot communities (can be led by AAAs, services agencies, providers) that work on interagency collaboration & w/ key providers, elder advocates on data sharing, interventions, tracking outcomes
- **SAVINGS** from avoided high-cost medical care: Financial forecasting tools, ROI calculators are being used to make the case for more cost-effective care, but little work has been done to capture, reinvest savings in improved community services

Margaret Mead – Researcher, Advocate

- *"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."*


From Pyramid to Pillar:
A Century of Change
Population of the United States
1960
Male
Female
Ages
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
15 10 5 0 5 10 15
Millions of people
2060
Male
Female
15 10 5 0 5 10 15
Millions of people
United States Census Bureau
U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov
Source: National Population Projections, 2017
www.census.gov/programs-surveys/popproj.html



Carol Idol and Hale Livingston Montgomery

THANK YOU.

Anne Montgomery

Anne.Montgomery@altarum.org | (202) 776-5183

N3C

National Coalition on Care Coordination

Thank you for joining us!

N3C meeting: Tuesday 3:45-5:15pm

Room: Imperial 11 (Level 4)

Rush and CHaSCI gathering:

Wednesday, 6:30-8:00pm

Room: Suite 2732