Aging and Disability Business Institute Pre-Conference:

Opportunities in Health Care Payment and Delivery System Reform

April 3, 2017
“Business Institute”

**Mission:** The mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations (CBOs) and the health care system.

**Long-term outcome:** Increase in the number of CBOs successfully implementing business relationships (contracts) with health care payers.
Business Institute Funders

- The John A. Hartford Foundation
- The Administration for Community Living
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Buck Family Fund of the Marin Community Foundation
Business Institute Partners

- The National Association of Area Agencies on Aging (n4a)
- American Society on Aging (ASA)
- Independent Living Research Utilization/National Center for Aging and Disability
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence
- National Council on Aging (NCOA)
- Evidence-Based Leadership Council (EBLC)
- Meals on Wheels America (MOWA)
Aging and Disability Business Institute

Connecting Communities and Health Care

When community-based organizations (CBOs) and the health care system work together, older adults and people with disabilities get the coordinated care that lets them live with dignity and independence in their homes and communities as long as possible.
Partnering with Primary Care to Improve Access and Care Coordination

- Tim McNeill, BSN, MPH, Health Care Consultant
- Robert Schreiber, MD, Medical Director of the Healthy Living Center of Excellence; Clinical Instructor of Medicine, Harvard Medical School
Partnering with Primary Care to Improve Access and Care Coordination

Rob Schreiber MD, AGSF, CMD
Medical Director of Elder Services Merrimack Valley
Medical Director, Evidence-Based Programs at Hebrew SeniorLife
Medical Director, Healthy Living Center of Excellence
Harvard Medical School
Patient-Centered Medical Homes and the Care of Older Adults

How comprehensive care coordination, community connections, and person-directed care can make a difference
Change AGEnts - PCMH Network

Mission

- Transform PCMHs to improve the care of older adults and their caregivers.
- Advocate for and promote thoughtful insertion of geriatrics into the PCMH model.
- Identify ways to improve the skills of PCMH clinicians who may not have formal geriatric training, at both the patient and population levels.

Members

- Robert Schreiber, MD, AGSF, CMD
- David Dorr, MD, MS
- Christine Fordyce, MD
- Robyn Golden, MA, LCSW
- Molly Mettler, MSW
- Toni Miles, MD, PhD
- Aanand Naik, MD
- Harry S. Strothers III, MD, MMM,
- Tasha Woodall, PharmD, CGP, CPP
- (previous) Colleen Casey, PhD
Paper Highlights

➢ The integral role of community-based organizations in helping PCMHs maintain older adults’ independence and quality of life

➢ How practices can improve outcomes by implementing evidence-based models of care including self-management programs, care transitions programs

➢ Links to resources in addressing workforce issues, partnering with community-based organizations, accessing clinical assessment tools, ensuring patient safety, and more
Paper Highlights

➤ How advanced PCMHs can benefit under the MACRA and employ APMs without risking financial loss

➤ Challenges & opportunities PCMHs face in five areas: comprehensive care, whole-person care, patient empowerment & support, care coordination & communication, and ready access to care
Why a CBO Focus on Primary Care?

• Majority of older adults receive care from primary care teams *without formal training in the needs of older adults*;
• Historically, the bulk of high need patients in primary care practices are older;
• Primary care is increasingly the focus of health reform to reduce risk, improve outcomes, and reduce costs (in programs mostly known as *Patient-Centered Medical Homes* or *Advanced Primary Care*)
Comprehensive Primary Care (CPC) and CPC+

Track 1: Four Risk Tiers (Average $15)
- 1st risk quartile: $6
- 2nd risk quartile: $8
- 3rd risk quartile: $16
- 4th risk quartile: $30

Track 2: Five Risk Tiers (Average $28)
- 1st risk quartile: $9
- 2nd risk quartile: $11
- 3rd risk quartile: $19
- 4th risk quartile: $33

- Risk adjusted, non visit-based payment
- Designed to augment staffing and training, according to specific needs of patient population
- Paid by all payer partners (support amount will vary by payer)
- No beneficiary cost sharing
- Risk tiers relative to regional population

Complex Tier: $100
Top 10% of risk or dementia diagnosis
Why a Paper about older adults focused on PCMHs?

“If PCMHs are going to succeed in their goals of improving patient outcomes and lowering costs, they must address the unique needs of older adults.”

From Patient-Centered Medical Homes and the Care of Older Adults: How comprehensive care coordination, community connections, and person-directed care can make a difference by The John A. Hartford Foundation PCMH Change AGEnts Network.
Environmental Scan
Prevalence

- 26% of adults have MCC
- 66% of fee-for-service Medicare beneficiaries have MCC
- 67% of Medicaid beneficiaries with disabilities have 3 or more conditions

Healthcare Transformation has Begun
The Expanded Chronic Care Model, (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).
Managing chronic conditions

- Chronic disease self-management
- Diabetes self-management
- Nutrition programs (counseling, education & meal provision)
- Education about Medicare preventive benefits
- Peer supports
- Telehealth/telemedicine

Preventing hospital (re)admissions

- Evidence-based care transitions
- Care coordination
- Information, referral & assistance/system navigation
- Medical transportation
- Evidence-based medication reconciliation programs
- Evidence-based fall prevention programs/home risk assessments
- Nutrition programs (counseling & meal provision)
- Caregiver support
- Environmental modifications
- Housing assistance
- Personal assistance

Activating individuals

- Evidence-based care transitions
- Person-centered planning
- Peer supports
- Self-direction/self-advocacy tools & training
- Chronic disease self-management
- Information, referral & assistance/system navigation
- Benefits outreach and enrollment
- Employment related supports
- Community/beneficiary/caregiver engagement
- Community training
- Supported decision-making
- Assistive technology
- Financial management services
- Independent living skills
- Behavioral health services
- Nutrition education

Diversion/Avoiding long-term residential stays

- Transitions from nursing facility to home/community
- Person-centered planning
- Self-direction/self-advocacy
- Assessment/pre-admission review
- Information, referral & assistance/system navigation
- Environmental modifications
- Caregiver support
- LTSS innovations
- Transportation
- Housing assistance
- Personal assistance

The Critical Role of Community-Based Organizations in Delivery System Reform
Visual Representation of Time Spent at PCP

A patient’s experience of medical care for a chronic condition in the context of her entire life. (Riggare, n.d.).
What is the Bridge to “Community-Based Integrative Care”?

- Long-Term Service Supports
- Care Transitions
- Chronic Disease Management
- Cognitive Screening and Referrals
- Caregiver Support
- End Of Life Planning
- Behavioral Health Supports
- Activated, Empowered and Engaged Patients
Money in the Health System

• Be bilingual-“learn the language” of health care.
• Understand “what keeps them up at night” to create interventions to help them “solve their problems”.
Developing Physician Champions

http://ncoa_archive.ncoa.org/improve-health/center-for-healthy-aging/content-library/md-link-partnering.html
Community-Based Integrative Care

Social Determinants
- Housing, Transportation and Living environment
- LTSS Supports - Care Transitions
- Level of independence, caregiver and/or social supports
- Financial stability and access to benefits
- Cultural and social barriers to care
- Social Inclusion
- Education

Population Health
- Access to Health Care
- Health Disparities
- End of Life Planning
- Medication management and reconciliation
- Compliance and adherence to care and self-management
- Patient Centered Care coordination, navigation, assessment

Patient Activation Engagement
- Behavioral Health Supports
- Motivational Interviewing
- Chronic Disease Management Programs
- Values, preferences, and advanced directives
- Tool to manage health and chronic conditions
- Patient and Caregiver Activation and engagement
Value Proposition for Community-Based Integrative Care

- Conflict Free
- Patient activation

- Outcomes
  - Independence
  - “Days at home”
  - Admissions/1000
  - Functional Measures
  - Advance Directives
  - Falls in community
  - Depression
Know your value

- Cost Avoidance
- Improved activation
- Improved satisfaction

http://www.n4a.org/Files/ASA%20article_v37n4_Tabbusch_July-August2016.pdf
What does your organization do as well or Better than anyone else in your area?

Example: We…
– serve our clients for life, not episode focused.
– have a holistic approach to support individuals in their homes.
– serve individuals across all care settings.
– are the eyes and ears of medical professionals in the home.
– provide one door to many services to support individuals in their homes.
– are the best value to improve the health of your community/patients.
– have served your community/patients for 30+ years and continue to do so today.
– Not Insurance Driven
– “Mission driven BUT Data Informed”
How can you Develop an “Adding Value” Strategy?

• Align your work with the priorities, and fiscal imperatives of Integrated Care Organizations and the other payers in the health care system such as hospitals and emerging ACOs.

• Understand the fiscal incentives driving those organizations – capitation, pay-for-performance, financial penalties for avoidable admissions.

• Redefine – and, if necessary, restyle – your products and services to support the payors’ needs. Why do they need you?

• “Value Added” areas can include:
  ➢ Prevention & chronic disease management
  ➢ Patient activation and education
  ➢ Reduced unnecessary utilization of health care
  ➢ Improved access to care
  ➢ Reduced incidence of avoidable hospitalizations
  ➢ Improved overall patient experience and satisfaction

• Information Systems to track services and outcomes
Integrated in Health Care Goals

- Expansion of the “Care Team” to include the patient’s home and community-based networks
- Improve coordination of care and provide appropriate nonmedical interventions to patients with difficulties, such as socioeconomic, physical, functional, and behavioral health issues
- Effective communication for timely and efficient referrals, hand offs, and “closing the loop”
- Patient centered care plans with realistic goals and resources for implementation
- Measurement for required matrix (Tobacco, BMI, Fall Risk, Advanced Directive, Vaccinations)
Integration in Action: The Healthy Living Center of Excellence

Vision: Transform the healthcare delivery system. Medical systems, community-based social services, and older adult will collaborate to achieve better health outcomes and better healthcare, both at sustainable costs.

Key Features:
* Statewide Provider network of diverse community based organizations
* Seven (7) regional collaboratives
* Centralized referral, technical assistance, fidelity, & quality assurance
* Multi-program, multi-venue, multicultural across the lifespan approach
* Centralized entity for contracting with statewide payors
* Diversification of funding for sustainability
* EBP integration in medical home, ACO and other shared settings
Massachusetts by the Numbers

- 90+ member CBO provider network
- 7 regional collaboratives
- 600+ program leaders
- 14 evidence-based programs
- 16,000+ participants since 7/2013
- 20,000+ older adults since 2008

HLCE website traffic
- Over 1,000,000 annually
- 2,600 visits per month
- 1,300 unique visitors per month

www.healthyliving4me.org
Odds of Hospital Use for Ambulatory Care-Sensitive Conditions after Year One, by Patient Activation Level

Judy Hibbard et al, Health Services Research On-Line August 23, 2016,
Stories of Use by Stakeholders

Incorporating AAA social worker in PCMH care management

Community-Based Organizations Working with Federally Qualified Health Centers
Get the paper: bit.ly/2cjVpG8

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Join the conversation on Twitter: #PCMH_Roadmap
Questions
The Role of the CBO in Leading Change in the Healthcare Market

Timothy P. McNeill, RN, MPH
Healthcare Market Changes

MACRA

Chronic Care Management

Creating a Win-Win for each party
Healthcare Landscape Changes Have Arrived

- The Patient Protection and Affordable Care Act
  - Initiated massive changes to the healthcare payment system
- MACRA: Medicare Access and CHIP Reconciliation Act
  - Shift from fee-for-service to payment for Value
  - Physician fees will increase or decrease based on quality and cost performance
- MLTSS Final Rule Changes
  - Medical Loss Ratio
- General Theme – We must reign in Medicare & Medicaid spending because current growth is unsustainable
Where are there costs in the system

• A system that pays for value will focus on where the highest cost drivers are:
  – Improve clinical outcomes and reduce costs
  – Institutional Care (Acute and Post-Acute Care)
    • Reduce preventable admissions
    • Readmissions
    • Avg. length of stay at a SNF is 20 days
    • Goal is to eliminate SNF stay or reduce the LOS to 12 – 14 days
  • HCBS is essential to support these goals
How CBOs Impact Spending on Medicare beneficiaries

• Keep people healthy, active, and engaged in their community as long as possible
  – Reducing institutional care
    • Readmissions
    • Increase the use of HCBS to support consumers in the community as long as possible
  – Increasing patient activation / Health Coaching
    • Complex Care Management
  – Improving consumer disease self-management skills
    • DSMT, Falls Prevention, CDSME, PEARLS
CMS Recommendations in Physician-CBO alignment

• CMS - Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries (2015)
  – Direct collaboration between hospitals, community physicians, and CBOs to address the medical, social, and behavioral factors impacting health outcomes

• CMS Interpretive Guidance for Hospitals
  – Discharge Planners should directly engage Area Agencies on Aging, ADRCs, and CILs to determine eligibility and delivery of expanded HCBS for hospitalized patients
Where are there opportunities for CBOs?

• MACRA
  – MIPS Physician Quality Reporting Requirements

• Alternative Payment Models
  – ACOs
  – Bundled Payment - BCPI
    • CJR – Lower extremity joint replacement (Moves to risk phase in 2017)
    • AMI / CABG / Cardiac Rehab (2017)
    • SHFFT – Femur and Hip Fracture (2017)

• MLTSS
  – MLTSS Rule Changes – Standard Quality requirements
  – MLR Requirements
MACRA
MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT
• 2017 is the MIPS transition year
  – All Physicians accepting Medicare must report
  – Baseline established for future payment adjustments
• electronic Clinical Quality Measures – eCQMs
• Specific clinical quality measures that must be reported by physicians, providers, and hospitals that are eligible for incentive payments
• MACRA regulations begin to link provider performance on eCQMs to payment
MIPS Overview

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
Provider MIPS Categories applicable to CBOs

• Quality
  – Diabetes outcomes
  – Depression screening
  – Fall risk

• Advancing Care Information
  – Referrals to community programs
  – Send a summary of care

• Improvement Activities
  – Care transitions documentation
  – Engagement of community for health status improvement
  – Evidence-based interventions to promote self-management
  – Chronic care and preventive care management
Chronic Care Management
SUPPORT FOR MANAGING 2 OR MORE CHRONIC CONDITIONS
What is Chronic Care Management

• An extensive range of services intended to support a person to improve clinical outcomes and reduce exacerbation of disease
  – Managing Transitions
  – Care Management Services
  – Coordinating community and social support services
  – Coordinating with external agencies supporting the consumer
  – Disease self-management support
  – Health Education
  – Symptom management
  – Medication management
Description of the population receiving CCM today

- Initial CCM benefit
  - Began in 2015. Expanded January 1, 2017
- 2015 – 2016: 513,000 Unique Medicare beneficiaries received the service
- Frequency = 4 times per person
- Participants tend to have a higher disease burden and suffer from social determinants of health
- Recipients are more likely to be dual-eligible
- Physicians report clinical staff spending 45 – 60 min per month per beneficiary on CCM
What are the characteristics of Duals?

- Nationally, there were **9.6 million dual-eligible** beneficiaries
  - 3.9 million were under age 65
  - 5.7 million were aged 65 and older
- Per capita spending (Medicare)
  - Duals $17,668
  - Non-Duals $8,381
- Per capita spending when the ESRD population is removed
  - Duals $16,216
  - Non-Duals $8,042

*Data book: Beneficiaries dually eligible for Medicare and Medicaid — January 2015 MedPAC*
Medicare Beneficiaries in Maryland

- Nationally only 513,000 Medicare beneficiaries received any Chronic Care Management Services 2015 - 2016
- In contrast the State of Maryland Medicare Beneficiaries (CY2010) – 827,000
- Dual-Eligible Beneficiaries (CY2010) – 119,000

*Data book: Beneficiaries dually eligible for Medicare and Medicaid — January 2015 MedPAC*
I conducted an Interview with a hospital with higher than average readmission rates and a higher volume of Medicaid Dual-Eligible beneficiary population.

TCM/CCM Solution: Outsourced care management to a for-profit third party care management company.

Findings: Third party company makes a person-centered plan and makes suggestions about community resources to obtain necessary services – “They often give patients the number to the Office of Aging to get help”

- Outcomes: Services not available (waiting lists)
- System difficult to navigate
Eligibility

• Chronic Care Management services can be provided to any Medicare FFS beneficiary that meets the following criteria:
  – Must have Medicare Part B benefits
  – Co-Insurance requirements apply
  – Must have two or more chronic conditions that are expected to last at least 12 months
  – Chronic conditions could lead to worse health outcomes or death is not properly managed

• Eligibility for CCM and Complex CCM are the same
  – Intensity of services defines which code to use
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
Target Population

• Concerns have been raised that certain populations will have limited access to these services
  – Minority Populations
  – Rural Populations
  – Low-income Populations (Duals)

• Congress mandates that CMS report the utilization of these services by high-risk populations
Benefits to the Clinician

- Increased compliance with prescribed treatment regimen
- Increased revenue resulting from increased E/M visits and preventive health visits
- Additional support for moderate-high risk patients without building the chronic care management delivery system
- Improved quality measures
  - Alternative Payment Models
  - Merit Incentive Payment System (MIPS)
Benefits to the CBO

- Clinical Integration with community providers
- Incorporation of preventive health programs into the treatment regimen
- Program sustainability pathway by operating as a contact case management organization serving moderate-high risk Medicare beneficiaries with 2 or more chronic conditions
- Reliable revenue source to support program expansion
Prepare for Potential Push-back

- Your Organization has no experience providing care management services
  - We are the leading waiver case management provider in the region serving primarily duals and Medicaid and the only OAA service provider
- We cannot outsource the service unless your staff become our employees
  - Regulations specifically allow physicians to outsource the service to a third party and have no employer relationship with the staff performing the work
  - Services can be provided under General supervision
Prepare for Potential Push-back (cont.)

- You don’t have evidence-based programs for this population
  - PEARLS, Stanford, Fall Prevention, etc.

- Only licensed staff can perform care management service
  - Requirements include clinical staff using CPT definition (AMA specifically supporting Health Coaches for this purpose)

- ACA will be eventually fail and be repealed and replaced
  - MACRA is a separate bipartisan bill

- HIPAA prevents us from sharing any information with you to provide care management services
  - Requirements specifically outline that HIPAA requirements DO NOT prevent a physician from sharing clinical information with third party for this purpose
## Rate and Duration of Services

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<tr>
<th>CPT Code</th>
<th>Rate</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490 - CCM</td>
<td>$42.71</td>
<td>Billed each calendar month</td>
</tr>
<tr>
<td>99487 - Complex CCM</td>
<td>$93.67</td>
<td>Billed each calendar month *only one CCM code can be billed per month</td>
</tr>
<tr>
<td>99489 – Add on per 30 min</td>
<td>$47.01</td>
<td>Billed for each 30 min of additional services beyond the 99487 - 60 min encounter</td>
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Path to Sustainability

- Identify local providers participating in alternative payment models
- Identify small to medium size physician practices that lack infrastructure to build a chronic care management program
- Meet with the practice manager and/or medical director to present the model
- Outline the potential revenue and the benefits to each organization along with expected health outcomes
Process Steps

• Express your interest in providing chronic care management services as a contracted CBO partner
• Define the services that your organization would provide
• Provide a sample care management plan that includes the services you will provide
• Outline how you will provide the necessary staff to implement the program and the frequency
• Define how your services will integrate with the clinical services provided by the clinic
• Define the methods that will be employed to increase revenue to the practice
Creating a Win Win for both organizations

- **Physician**
  - Improved patient compliance
  - Dedicated care management staff to provide additional support to patient population
  - Access to community resources
  - Access to Medicaid-funded LTSS provider resources and staff that are experts in serving older adults and persons with disabilities

- **CBO**
  - Clinical Integration
  - Sustainable Revenue
  - Partnership that supports MCO contracting
Questions

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Questions?