Aging and Disability Business Institute Pre-Conference

Productive Partnerships with Health Care: What You Need to Know About Medicare Payment and Quality Assurance

April 18, 2018

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Welcoming Remarks

- Sandy Markwood, CEO, National Association of Area Agencies on Aging (n4a)
- Rani E. Snyder, MPA, Program Director, The John A. Hartford Foundation

Aging and Disability BUSINESS INSTITUTE

The “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.

www.aginganddisabilitybusinessinstitute.org

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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

- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence
- National Council on Aging
- Meals on Wheels America
- Evidence-Based Leadership Council

ilru

ASA American Society on Aging

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Partners in Care FOUNDATION
www.picf.org

ncoa Center for Healthy Aging

MEALS on WHEELS AMERICA

EBLC Evidence-Based Leadership Council

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New Opportunities and Benefits Under Medicare Advantage

- Allyson Schwartz, President & CEO, Better Medicare Alliance
- Nora Super, Director, Aging and Disability Business Institute, n4a

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Questions?

The Ins and Outs of Medicare Reimbursement for CBOs

- Tim McNeill, Independent Health Care Consultant
- Christine Vanlandingham, Fund & Development Officer, Region IV Area Agency on Aging, St. Joseph, MI
- Jessica Walker, Program Director Business Development, Dallas Area Agency on Aging, Dallas, TX
- Kelly Blair, Program Manager, Evidence-Based Programs, Dallas Area Agency on Aging, Dallas TX

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CBOs and Medicare

Timothy P. McNeill, RN, MPH

Healthcare Landscape Changes Have Arrived

- Health Reform continues to permeate through the healthcare landscape
- The Patient Protection and Affordable Care Act
  - Signed into law by President Obama on March 23, 2010
- MACRA: Medicare Access and CHIP Reconciliation Act
  - Signed into law on April 16, 2015
  - Establishes the Merit-Based Incentive Payment System (MIPS)
  - Providers will receive adjustments to their payments based on MIPS and APM participation
- Chronic Care Act

Shift Toward Value-Based Purchasing

- The current system is changing from Fee-For-Service to payment for outcomes.
- A Value-Based Purchasing system provides financial incentives for outcomes (Value)
- MACRA legislation provides direct incentives to Physicians and Hospitals to move towards a system that pays for outcomes
- In the past, there were real financial incentives to providers, when complications occur

Target Population

- The target population of many of the current changes in Healthcare are consumers in Original Medicare
  - Includes Duals
- Medicare Eligible Beneficiaries include the following:
  - People 65 or Older
  - People under 65 with certain disabilities
  - People of ANY age with End-Stage Renal Disease
    - Permanent kidney failure requiring dialysis or a kidney transplant

Emphasis on Duals

- The term “Dual” generally refers to beneficiaries that quality for both Medicare AND Medicaid
- Duals make up the population that is most vulnerable to cost increases
- Eligibility generally requires
  - Aged (65+) or;
  - Disabled AND
  - Meets means testing for Poverty status
- Many Reforms impact both Public Payers
  - Medicare + Medicaid

Which Population Provides the Most Risk in VBP?

- In 2009, total average healthcare spending:
  - Non-duals - $8,300 per year
  - Full Duals - $33,400 per year
- Most chronic conditions were more prevalent for dual-eligible beneficiaries
  - 72% of dual-eligible beneficiaries had two or more conditions
  - 98% of readmissions, in 2010, were for Medicare beneficiaries with two or more chronic conditions
    - *CMS Chronic Conditions Among Medicare Beneficiaries, Chartbook – 2012 Edition. Available Online: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/chronic-conditions/downloads/2012chartbook.pdf*

Reform Impacting Providers

- Alternative Payment Models
  - ACOs
  - Bundled Payment (BPCI)
  - CJR
- Medicare Advantage
  - STAR Rating Formula
  - MLR Requirements
  - D-SNP/C-SNP/I-SNP plans
- Medicaid Managed Care
  - MLTSS

Challenge for the CBO

- Making the shift to becoming an integrated member of the healthcare delivery system
- Establishing the systems (Health IT, Processes, Quality Improvement, Data reporting, etc.) to successfully contract with MCOs and Healthcare providers
- Developing networks of CBOs that have the capacity and geographic coverage area to serve the needs of the payer and the healthcare providers
- Embracing the Culture Change required for success

Alignment of Payment Incentives

- Incentives to reduce Medicare and Medicaid directly impacts providers that serve duals
- Reductions in Medicare costs and Medicaid costs can have a dramatic impact on the overall cost of care
- Medicare
- Medicaid (Medicare Supplemental Coverage)
- Managed Long-Term Services and Supports
  - Medicaid Waiver

New Business Opportunities Abound

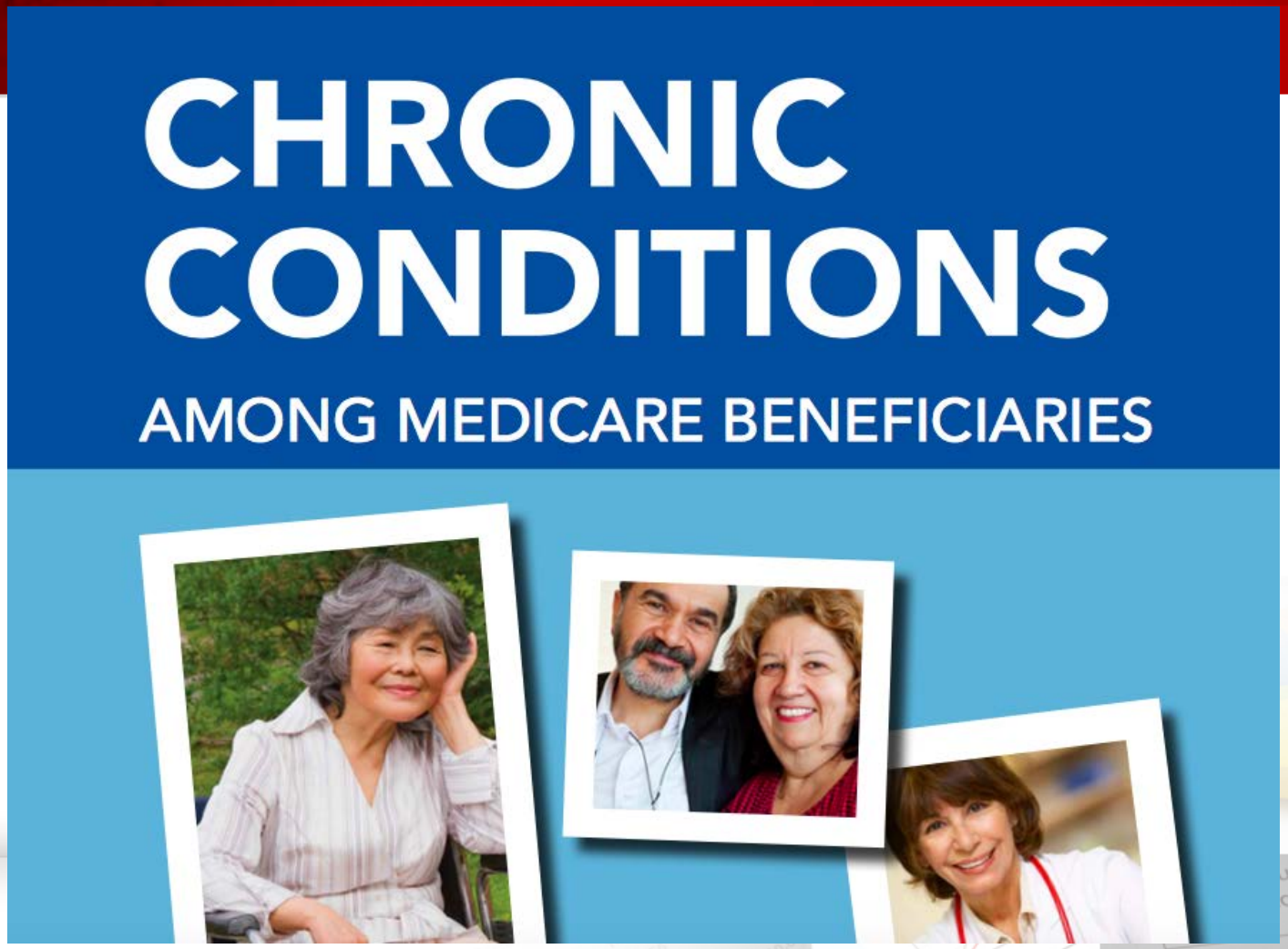
- The shift towards financial incentives that align with preventing costs has created new business opportunities
- Population Health
  - Identification of populations that are most at-risk for increasing costs
  - Stratification of the highest risk population
  - Need for programs and services that can address the factors that will lead to increased costs

What are the types of Medicare Providers?

- Organizations can become a Medicare Provider as long as they can provide at least one (1) Medicare service
  - Exception: The one service cannot be DSMT
- Example: Medical Nutrition Therapy is an acceptable service to obtain a Medicare provider number
  - The Organization will submit as a “Group Practice”
  - The dietitian will be the provider linked to the Group Practice application
  - Additional services can be provided based on additional provider types obtained (e.g. LCSW- Therapy, Nurse Practitioner

RISK STRATIFICATION STRATEGY

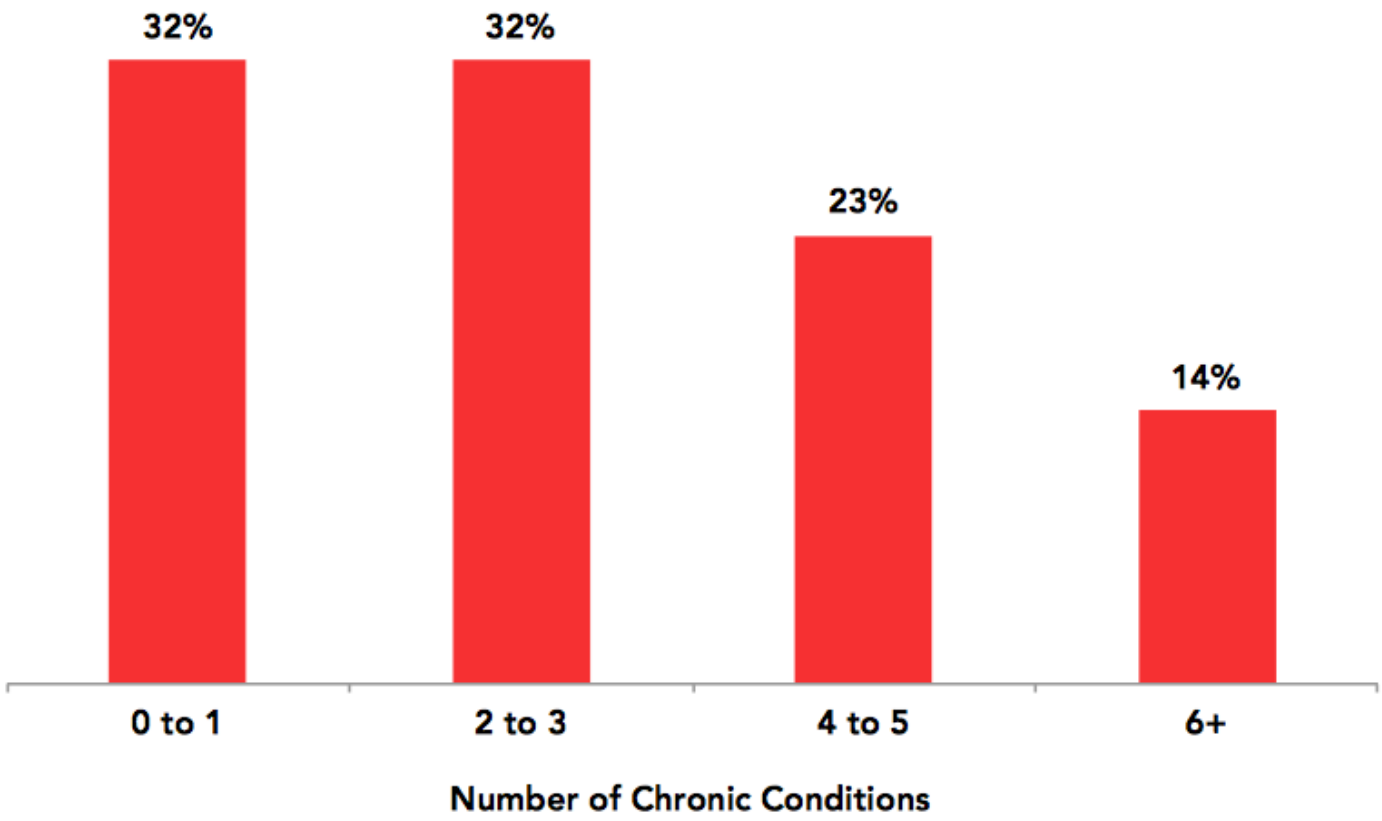
CMS Medicare Chartbook:



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

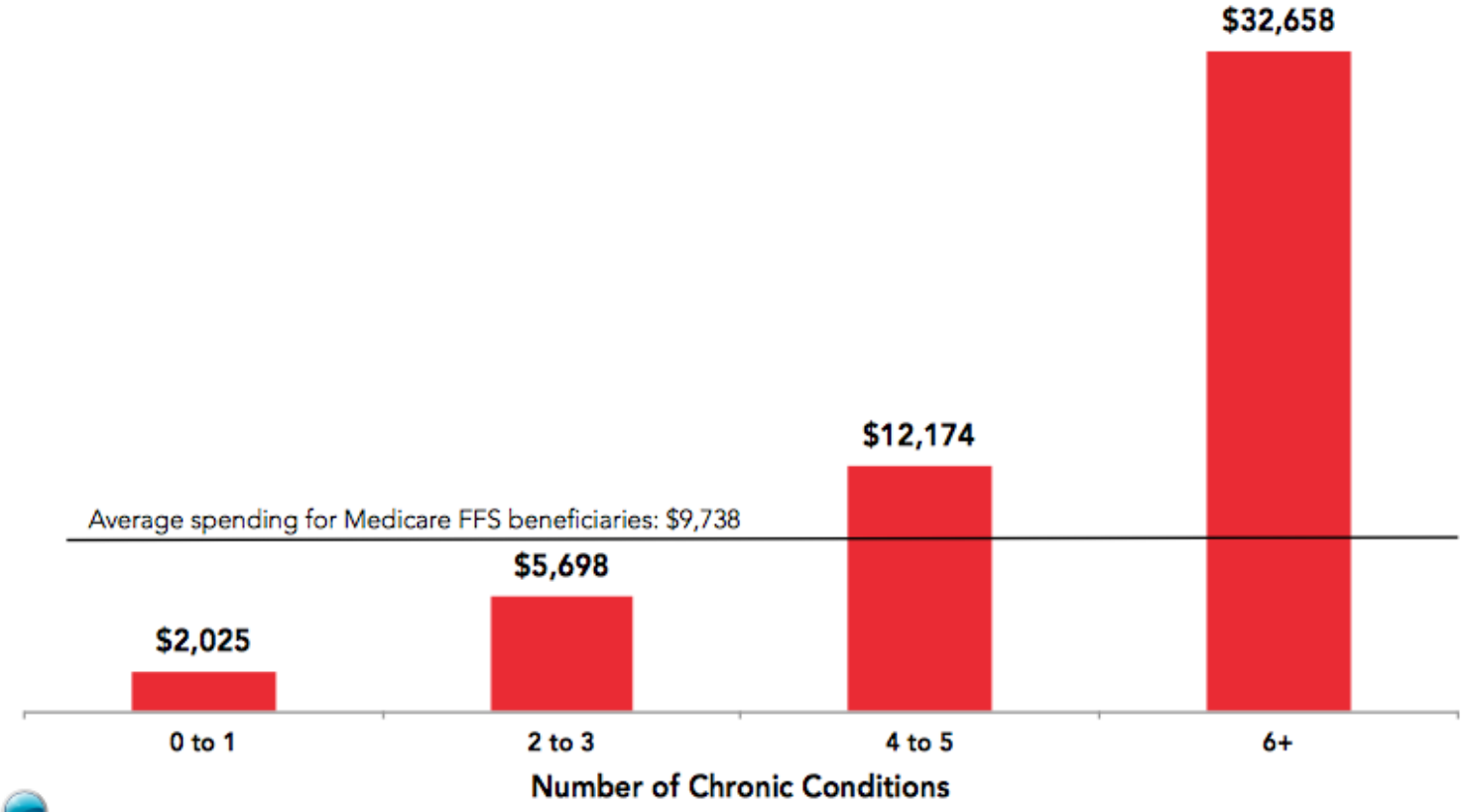
Nearly 70% of FFS Medicare has 2 or more chronic conditions

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*



CMS Analysis: Social Determinants of Medicare Advantage Plan Performance

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Examining the Potential Effects of Socioeconomic Factors on Star Ratings*

Center for Medicare

September 8, 2015

**The research presented is sponsored by CMS under contract HHSM-500-2013-00283G and performed by the RAND Corporation. The RAND Team included the work of Melony Sorbero, Ann Haas, Cheryl Damberg, Marc Elliott, and Susan Paddock.*

CMS Analysis: Social Determinants of Medicare Advantage Plan Performance

Likelihood of Receiving Recommended Care or Outcomes

HEDIS Measure (MA Contracts)	LIS/DE Adjustment Odds Ratio	Disability Adjustment Odds Ratio
Adult BMI Assessment	1.11***	0.93***
Rheumatoid Arthritis Management	0.85***	1.17***
Breast Cancer Screening	0.69***	0.72***
Controlling High Blood Pressure	0.99	1.02
Diabetes Care – Blood Sugar Controlled	0.68***	0.63***
Diabetes Care – Eye Exam	0.93***	0.68***
Diabetes Care – Kidney Disease Monitoring	0.93***	0.69***
Colorectal Cancer Screening	0.87***	0.47***
Osteoporosis Management in Women who had a Fracture	0.71***	0.56***
Plan All-Cause Readmissions#	0.87***	N/A&
Annual Flu Vaccine	0.85***	0.72***

NOTE: Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.
Measure is reverse-coded to make interpretation of Odds Ratio the same as other measures.
* Significant at $p<0.05$ ** Significant at $p<0.01$ *** Significant at $p<0.001$
Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.
Orange Odds Ratio less than 1.0 indicates a significant negative effect of being LIS/DE or Disabled.
Black Odds Ratio indicates no significant effect.
& Not further adjusted for Disability. Readmissions is adjusted for factors that might be part of a person's reason for Disability.

SERVICE IMPLEMENTATION STRATEGY

What are Services can CBOs Provide?

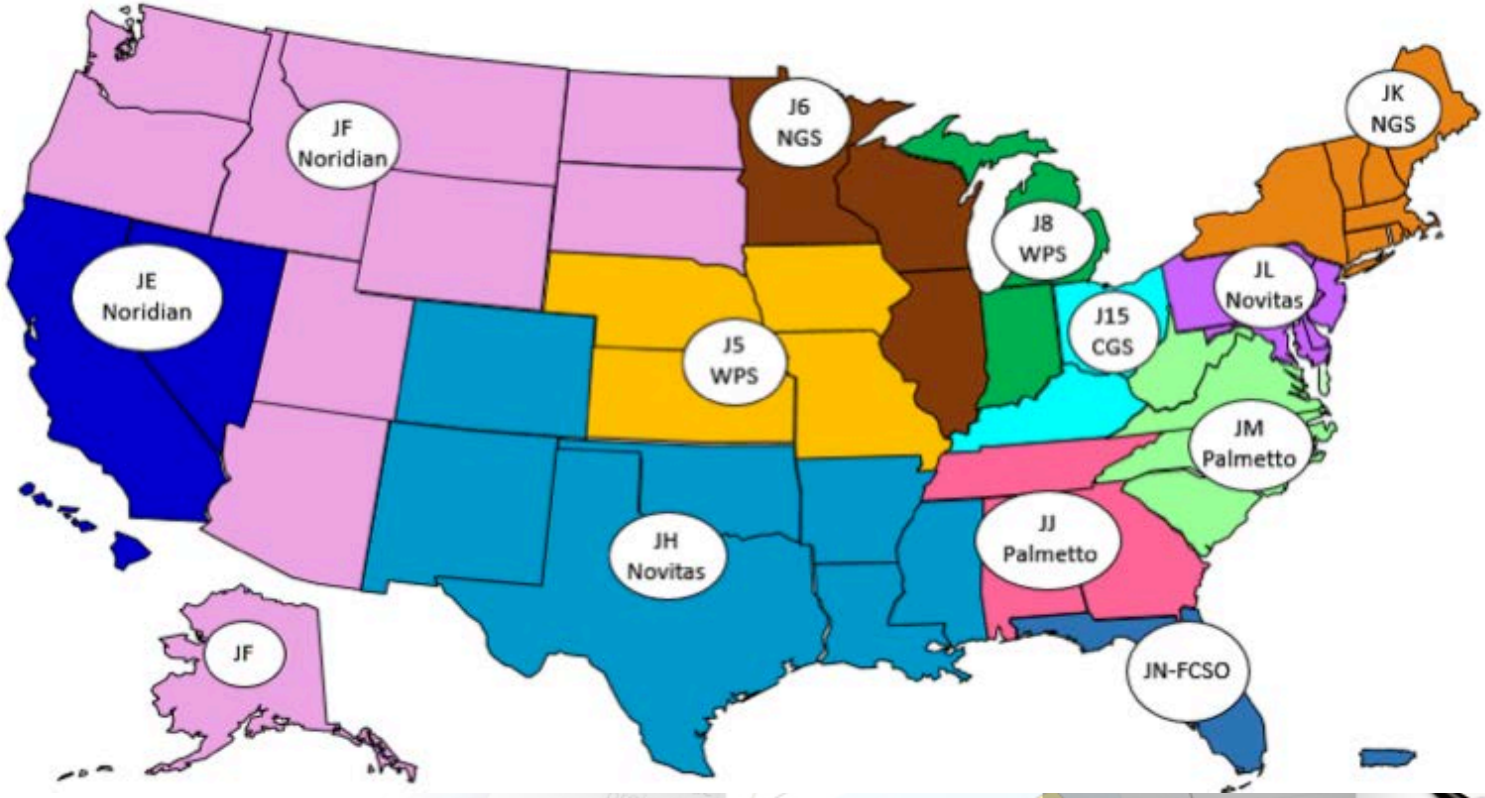
- Mental Health Counseling / Psychotherapy
- DSMT
- MNT
- HBAI
- DPP (New Benefit – April 2018)
- Care Coordination
  - TCM (Transitional Care Management)
  - CCM (Chronic Care Management)
  - CoCM (Collaborative Care Management)

What is the Application Process

- Who will operate as the Medicare Provider
  - Provider Partner / CBO / Hybrid approach
  - FQHS / RHC
- MAC: Medicare Administrative Contractor
  - Process Medicare FFS claims
  - Enroll providers in the Medicare FFS program
  - Review medical records
  - Respond to provider inquiries
  - Find your MAC at this address:
  - https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-October-2017.pdf

MAC Map

A/B MAC Jurisdictions
as of October 2017



Application Forms

- 855B http://www.cms.gov/Medicare/CMS=Forms/CMS=
- Forms/downloads/cms855b.pdf
- 855i http://www.cms.gov/Medicare/CMS=Forms/CMS=
- Forms/downloads/cms855i.pdf
- 855R
- http://www.cms.gov/Medicare/CMS=Forms/CMS=
- Forms/downloads/cms855r.pdf
- 588 http://www.cms.gov/apps/files/aco/cms588.pdf

Form Completion Process

- Complete forms simultaneously
- The Primary application is the 855B
- Submit completed application forms to the MAC using the PECOS system
- PECOS
  - Internet-Based Provider Enrollment, Chain and Ownership System
  - Faster than paper-based enrollment
  - Available: https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

Ownership Interest

- All Medicare Provider applicants must disclose each member that has control of the organization
  - Board Members for a Non-Profit
  - Each person must sign a form stating that they have No Adverse Legal Action History that prevents their participation
  - Liability is shared when fraud occurs

Additional Forms

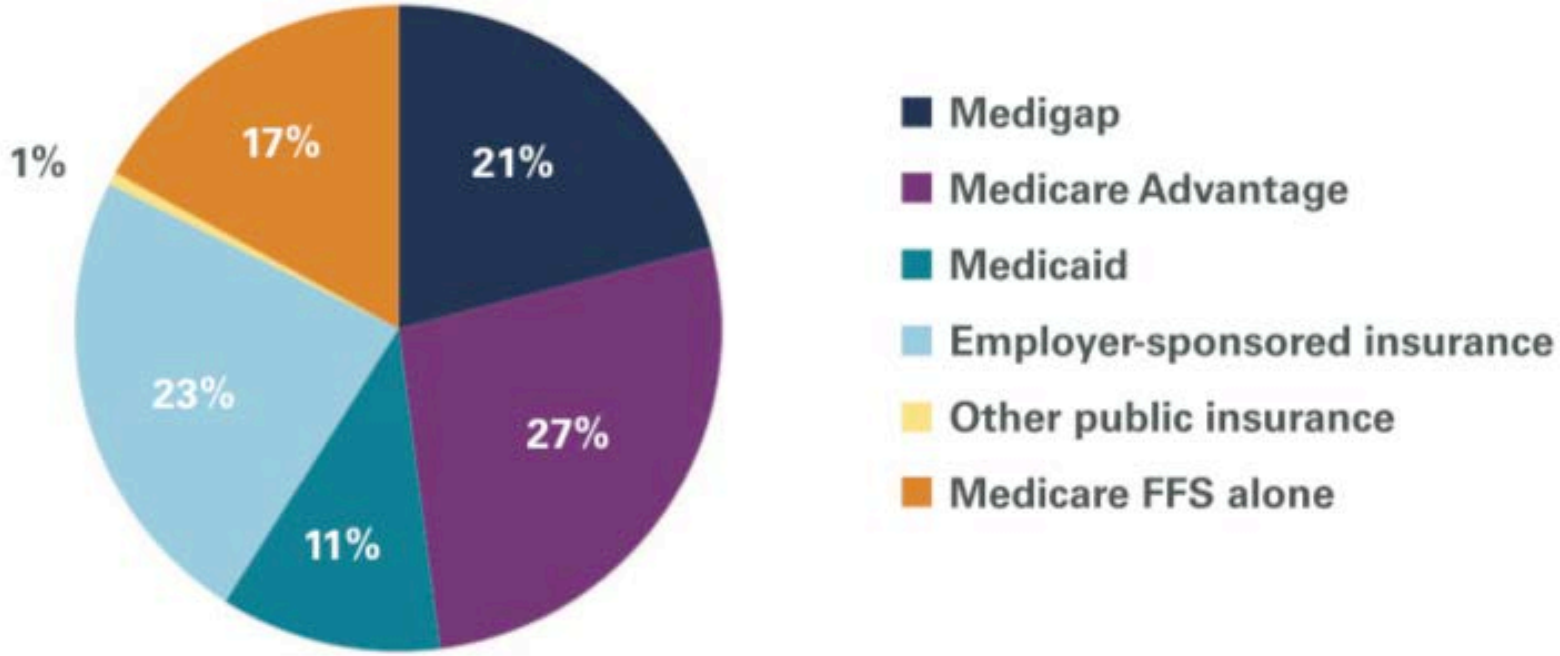
- CMS Form 588: Authorization for Electronic Funds Transfer
- CMS Form 855i: Registers the provider with Medicare
- CMS Form 855R: Authorizes CMS to pay the organization for professional services rendered by the independent provider

Medigap Market

- Medicare Part B beneficiaries can purchase a Medigap or supplemental policy to cover the 20% coinsurance requirements
- A Medigap policy defined
  - Health insurance sold by private insurance companies to fill gaps in Original Medicare coverage
    - Coinsurance, copayments, deductibles
    - If a beneficiary elects Medicare Advantage, they cannot be sold or use a Medigap policy
    - Beneficiaries with Medicaid (Duals) generally cannot buy a Medigap policy

Medigap Market

Figure 1: Distribution of Medicare Beneficiaries by Coverage Type, 2012



AHIP: BENEFICIARIES WITH MEDIGAP COVERAGE

Medigap Market

	A	B	C	D	E	F+	G	H	I	J++	K	L	M	N
Basic Benefits*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓	✓+++	✓++++	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓+++	✓++++	✓+++++	✓
Medicare Part B Deductible			✓			✓				✓				
Medicare Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓++++++
Medicare Part B Excess Charge						✓	✓		✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Percent of Medigap Purchasers with Type of Standard Medigap Plan	2%	4%	13%	3%	1%	53%	5%	1%	1%	7%	**	1%	**	4%

Medicare Number and Liability

- Submitting Medicare claims for services opens an organization to legal and financial liability
- You must obtain proper insurance coverage to protect against potential liability
  - Professional liability insurance
    - Outline each service to be provided along with the licensed professionals that will participate, if any
  - Cyber Insurance
  - General liability coverage
- Liability coverage does not protect against fraud

Common Billing Terms

- EOB: Explanation of Benefits – When a claim for medical insurance benefits is processed, Medicare sends a notice called an EOB to the individual. This informs the beneficiary what services were included on the claim and the decision regarding payment to the provider. The EOB also informs the beneficiary or their requirement to pay a portion of the payment, if required. If a person has a Medigap policy, the amount owed by the beneficiary is usually shifted to the Medigap or Medicaid policy.
- CPT Coding: Current Procedural Terminology. CPT codes are the copyrighted material of the American Medical Association (AMA).
- G Codes: Special set of codes that are not described in normal CPB coding. An example of commonly used G codes are the diabetes self-management training (DSMT) codes.

Medicare Providers and Alternative Payment Models

- The Medicare Access and CHIP Reauthorization Act (MACRA) will expand provider participation in Alternative Payment Models (APMs)
- Two primary APMs include the following:
  - Accountable Care Organizations
  - Bundled Payment
- APMs provide an opportunity for Gainsharing and shared savings participation
- Gainsharing requires having a Medicare provider number to participate

Dual Eligible Beneficiaries

- Duals are persons with both Medicare & Medicaid
- Commonly referred to as a Dual Eligible or a Medi-Medi
- Medicaid is required to pay the co-insurance and deductibles for Duals
- Provider must first bill Medicare and then bill Medicaid for the second portion

Coverage for Dual Eligible Beneficiaries

- Participate in Medicare VBP program models
- Duals hold the greatest financial risk in a VBP contract
- Duals Eligible beneficiaries have Medicaid as the Medigap coverage policy
- Medicaid must cover the co-insurance, even if the service is not a current Medicaid covered benefit in that particular State.

Key Billing Issues

- DSMT requires proof of accreditation
  - Accreditation certificate must be submitted to your MAC
  - Any updates, changes, reaccreditation documents have to be submitted to your MAC
- If claims are denied, make sure you know why the claim was rejected
  - Call your MAC if you are unsure
  - Submit for redetermination vs refile your claim
- If services require a referral, you have to capture the NPI of the referring provider
  - Referring provider must be enrolled in Medicare and be eligible to provide the referral for services

Co-Insurance

- Make sure you understand the Co-Insurance requirements
- Capture an image of the Medigap policy
- Medicaid is required to pay the Part B co-insurance
  - Must be an enrolled Crossover provider
  - Must submit for the crossover payment
  - If your claim is rejected, make sure to follow-up
  - Appeal decisions that you do not agree with

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS – MMCO – CM Informational Bulletin

Date: June 7, 2013

From: Cindy Mann, Director
Center for Medicaid & CHIP Services (CMCS)

Melanie Bella, Director
Medicare-Medicaid Coordination Office (MMCO)

Jonathan Blum, Director
Center for Medicare (CM)

Subject: **Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs)**

This Informational Bulletin provides information for state Medicaid agencies and other interested parties regarding the treatment of claims for Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs). The Bulletin also reminds states of the statutory requirement to process Medicare cost-sharing claims for QMBs from Medicare-certified providers, and to be able to document proper processing of such claims. This Informational Bulletin is provided as a companion to communications on this topic to Medicare providers in the form of a Medicare Learning Network Matters article, and a CMCS Informational Bulletin published in 2012, which are available at: http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf; and http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

Make it a Win - Win

- Outline the opportunity to improve revenue to partner / referral source
- Outline the opportunity to the beneficiary
- Define sustainability for your organization
- Be realistic about the level of revenue that your program will require
  - Healthcare is a Volume business
  - You must have a strategy to drive volume

Contact Information

- Timothy P. McNeill, RN, MPH
- Direct: 202-344-5465
- Email: tmcneill@me.com

A CBO's Journey to Medicare Reimbursement

n4a Policy Briefing: Aging and Disability Business Institute Pre-Conference

Christine Vanlandingham, Fund & Product Development Officer
Region IV Area Agency on Aging, St. Joseph, MI

Why Pursue Medicare…

- Medicare attempting to structurally reach to impact social determinants
- A tool for creating structural connectivity with local health partners
- Fully consistent with OAA mission of fostering comprehensive coordinated systems

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Where we started…

Interagency Care Team (ICT)

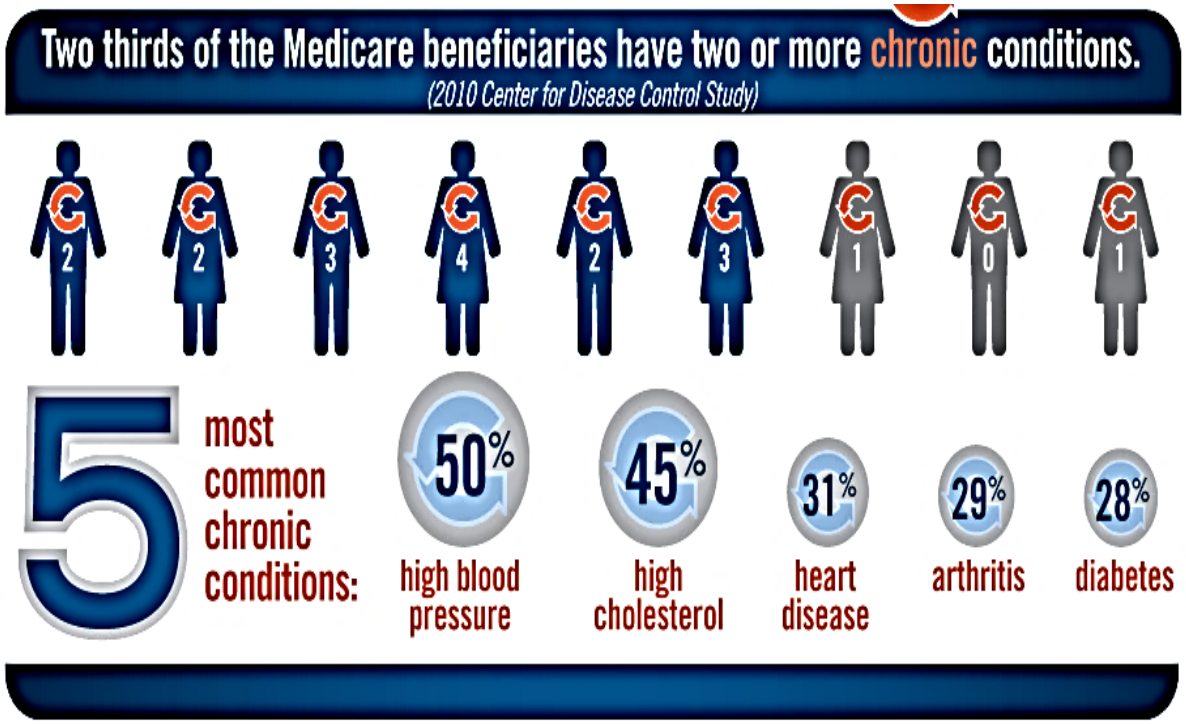
A project initiated by Healthy Berrien Consortium:

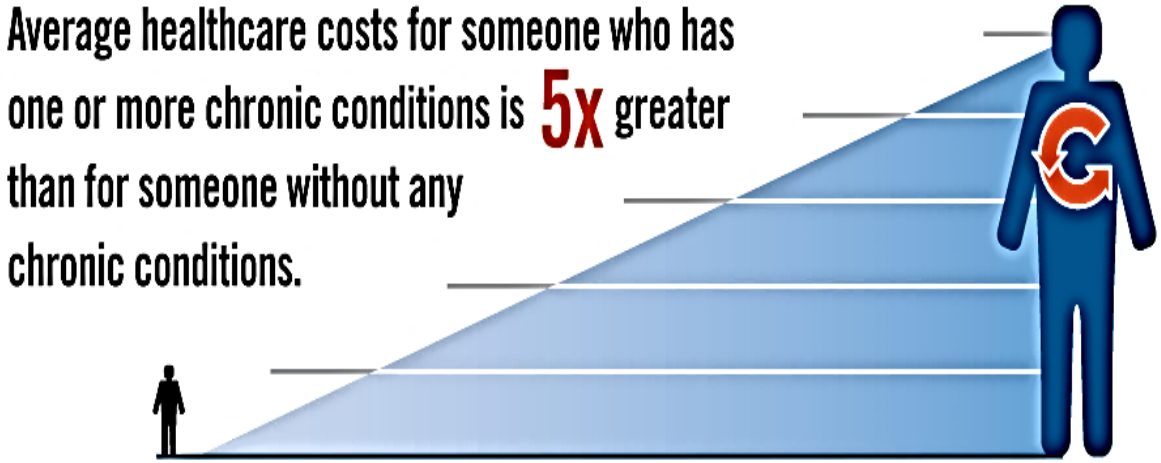
Membership

- Area Agency on Aging
- Berrien County Dept. of Human Services
- Berrien County Health Department
- Berrien County Medical Society
- Cassopolis Family Clinic (FQHC)
- Consortium for Community Development
- Hospice At Home
- InterCare Community Health Network (FQHC)
- Lakeland Health (Health System)
- Riverwood Mental Health Authority
- United Way
- Various Community Leaders

The issue:

Older adults with multiple chronic conditions experience some of the worst health outcomes.





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Interagency Care Team (ICT)

Purpose:
To link persons with multiple chronic health conditions with flexible interagency care teams that promote self-direction and person-centered planning to achieve positive health outcomes.

Strategies:

- Coordinated Care Management encompassing primary care, acute, specialty and home and community based services
- Web-based communication tool linking professionals involved with patient allows multiple agencies to coordinate care and share progress notes towards common goals.

Value Expectations…

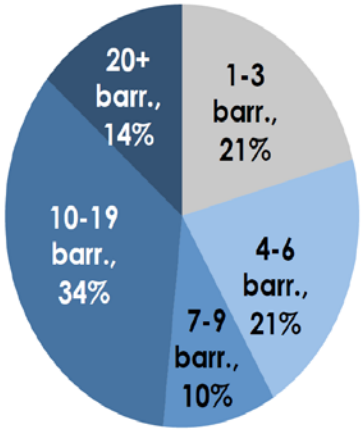
Stabilized Health for Seniors with Multiple Chronic Diseases

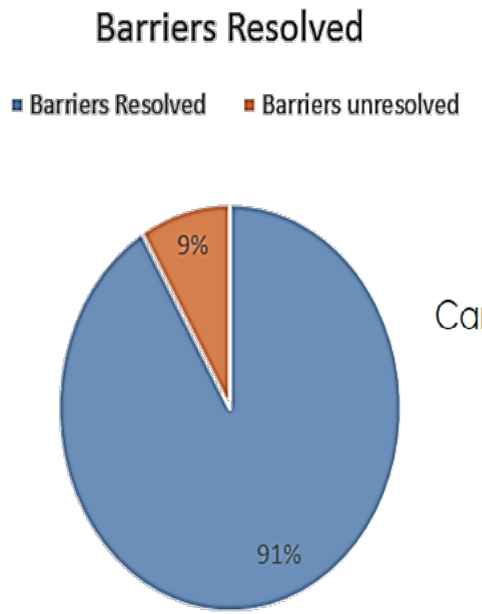
Reduced Hospitalization/ED visits Increased Primary Care

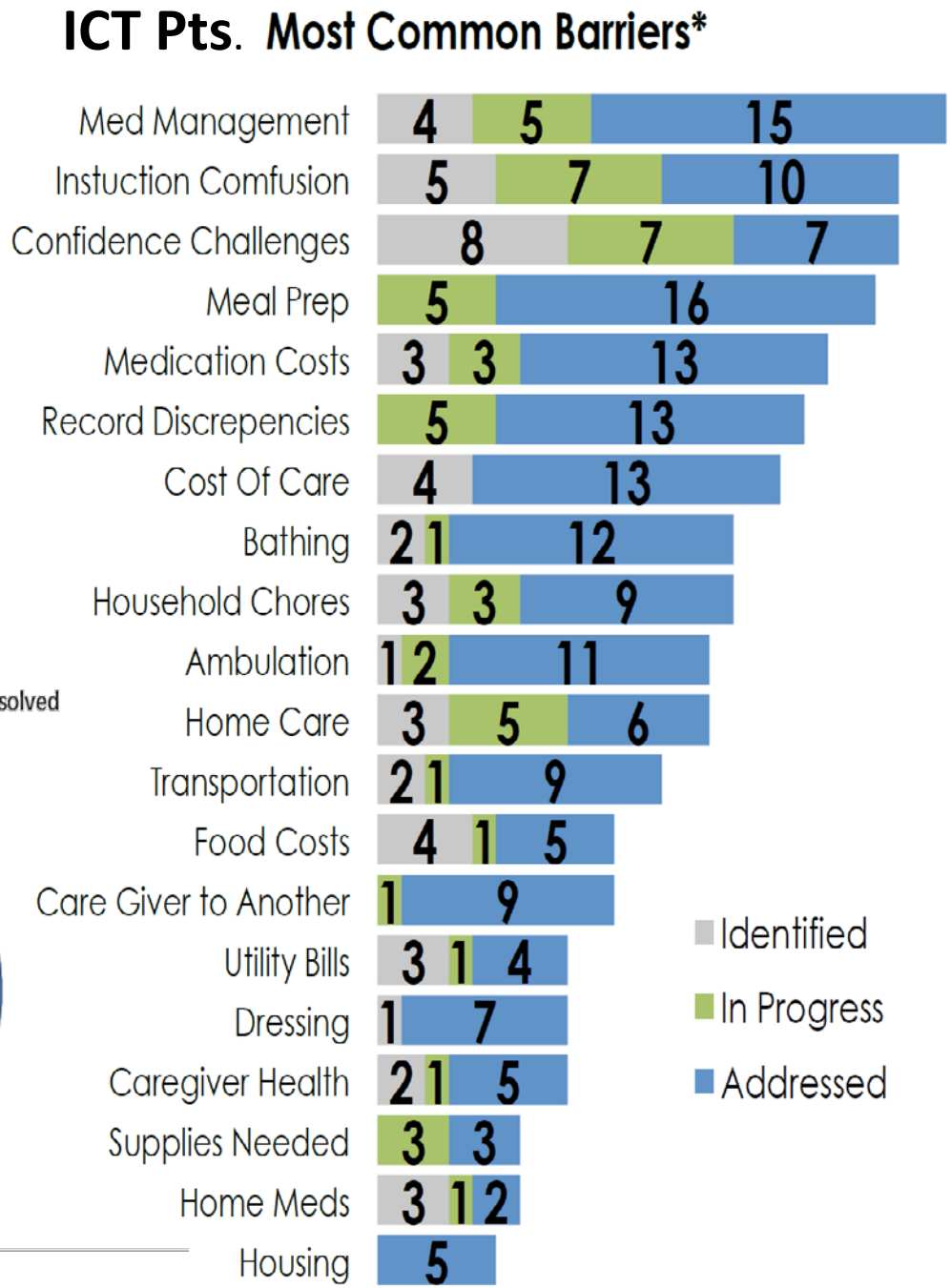
Sustainability through Establishment of Payment Model

Identify/Address barriers to improved health

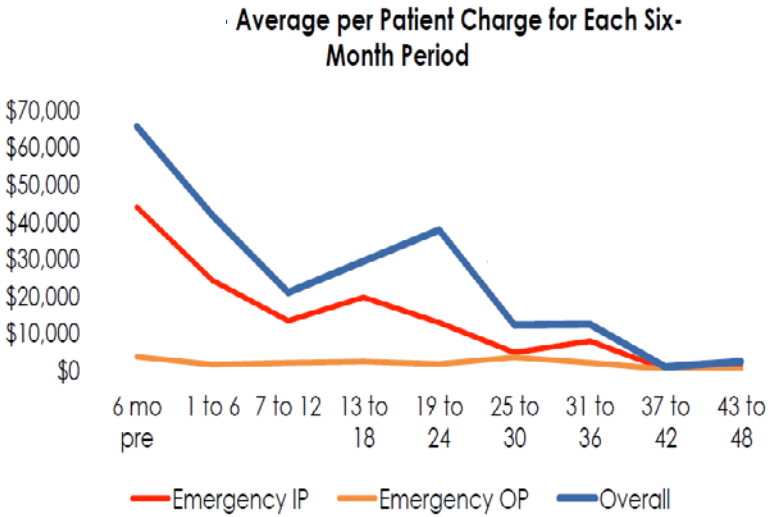
iEval report:
91% of barriers were resolved through coordination of care and connection to community resources, services and supports.







Improve health outcomes and reduce costs - iEval report



6 months post ICT intervention Patient survey results:

- Pts indicate "*I know who to call if I am getting worse or feeling bad*" (100%)
- Pts indicate that rather than immediately presenting to the ER, he/she would telephone a known contact for advice first. (86%)
- Only one patient thought they would definitely be going to the ER or hospital in the next 30 days

6 month post ICT intervention Cost Evaluation report:

- After the first six months of enrollment, the **overall costs** for all 30 patients **decreased by 41%.** (Apr. 2017 iEval Report)

ICT AAA Services:

Health coaching; Care management; Program Development; Project Administration; Fiduciary

ICT Payment Structure:

Initially self-funded by partners: AAA, hospital, PCP groups, FQHCs, Health Dept., other

Current:

Foundation(s) - 4 local entities funding services, evaluation & payment model development for scalability; Medicare – Medical Nutrition Therapy

Planned – bundled payment for flexible team participation, FFS for distinct **Medicare billable codes**

Where we are now…

- Obtained Medicare Provider Number in 2017
- Currently billing Medicare directly for MNT
- Contracts under development for Medicare codes:
  - Transitional Care Management (TCM) 99495 & 99496
  - Chronic Care Management (CCM) 99490
  - Complex Chronic Care Management & add on 99487 & 99489
  - Behavioral Health Integration (BHI)
    - Collaborative Care Management (CoCM)

One size does not fit all…

Payment Models differ with each partner:

- Rural Health Clinic -
  - Transitional Care Management (TCM)
  - Chronic Care Management (CCM)
- Housecalls –
  - Chronic Care Management
- Federally Qualified Health Center -
  - Chronic Care Management
  - Complex Chronic Care Management

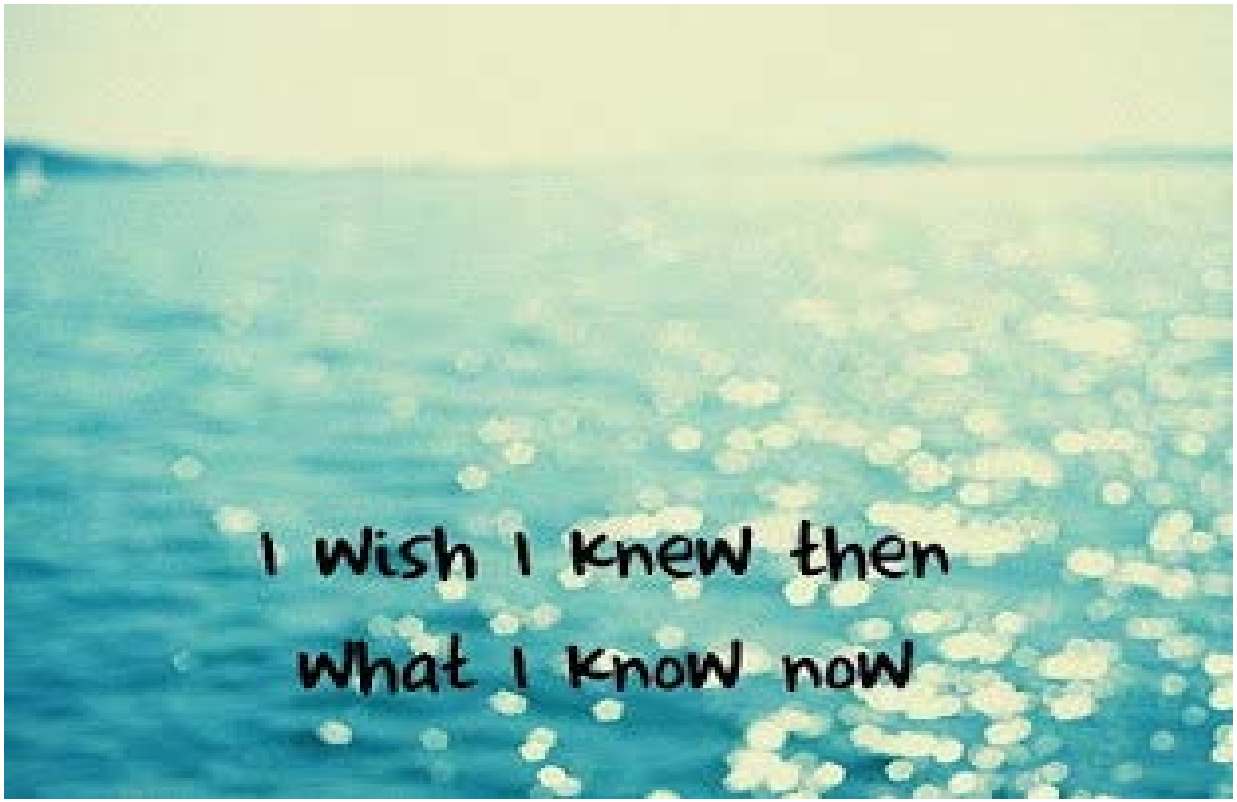
Implications/Considerations

- **Technology**
  - EMR - EPIC/Next Gen/other?
  - Communication tool – ResourceConnection

- **Billing**
  - Contractual arrangements – ability to document encounters and capture/communicate data with partners
  - Direct Medicare billing – currently paper process; scaling up will require exploration of billing partner or billing software/service

- **Possible establishment of subsidiary or LLC to accommodate growth**
- **Recruitment of Board expertise**

Challenges and Lessons-Learned…



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SPECIALISTS IN AGING

Jessica Walker,
Program Director, Business Development

Kelly Blair, MPH, CPH
Manager, Evidence-Based Programs

Community Council

Advancing Solutions...Empowering Lives

About Us

Mission

The Community Council serves the community by providing leadership in:

- Determining priority issues in the human services area
- Convening partners to significantly impact service delivery
- Increasing awareness of, and access to services

Vision

The Community Council is dedicated to enhancing the quality of life in North Texas, enabling each individual to achieve his or her full potential.

Community Council
Advancing Solutions...Empowering Lives

About Us

Strategic Goals

- Lead high-priority issues
- Serve as a neutral convener
- Conduct research into emergency and current issues
- Provide advocacy on issues within the Council's mission

Services

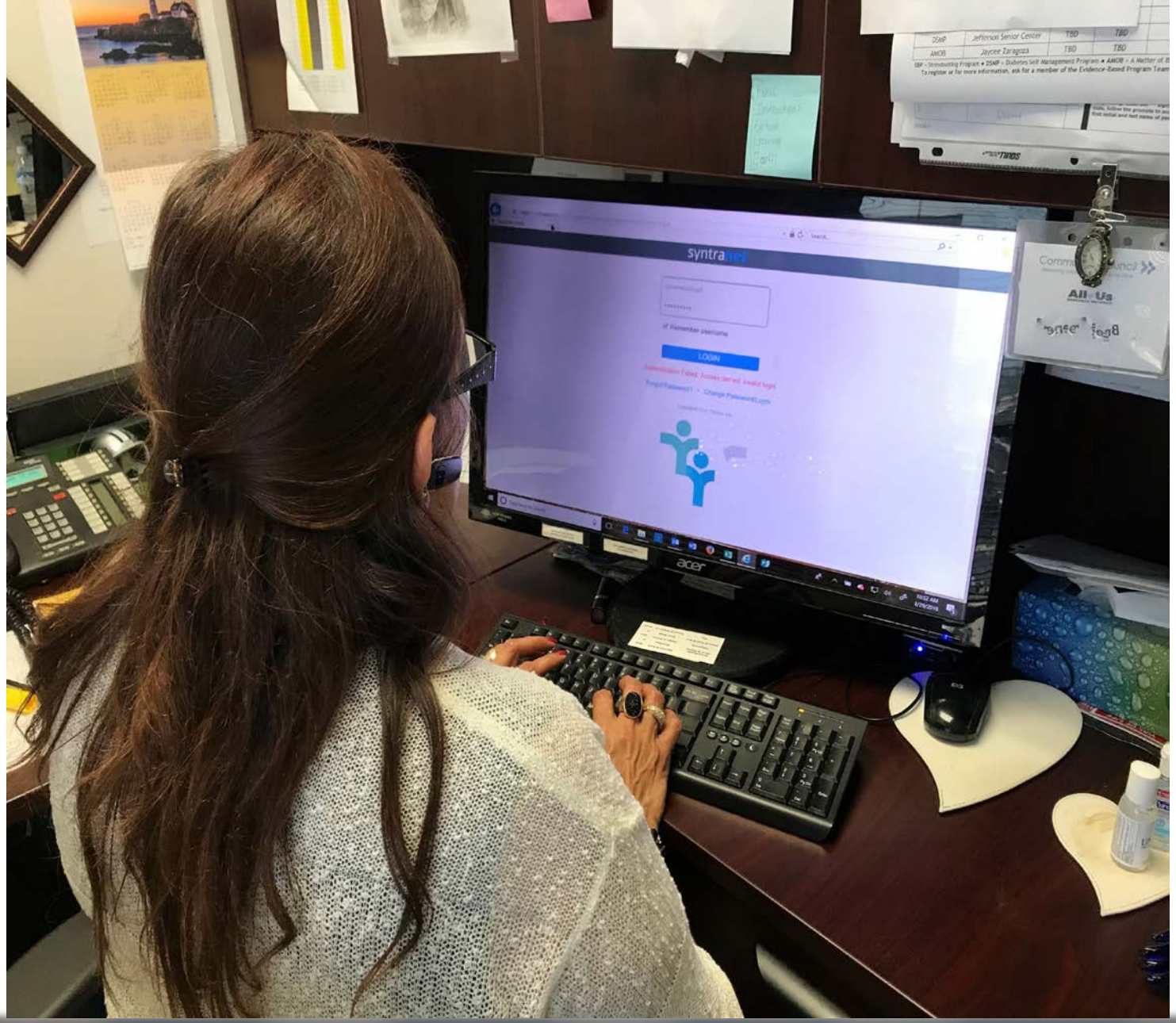
Dallas Area Agency on Aging
2-1-1 Information Referral Service
Healthcare Navigators
Healthcare Coalitions
Evidence-Based Programs
Youth Services & Programs
Economic Empowerment
Capacity Building
Convener
Fiscal Agent
Incubator

TIMELINE

CDSMP/DSMP Started (III-D/TMF-QIN)	**2010**
DSMT Accreditation (AADE)	**September 2012**
Medicare Classes Started	**March 2013**

Medicare 101

- Why Did We Become Medicare Provider for DSMT?
- MNT Must Be Part of the Service Delivery
- Steps Taken to Become Medicare Provider
- Costs
- Recruitment of Participants
- Paperwork/Documentation
- Billing
- Quality Assurance


syntranet
LOGIN
acer
All Us

Integrated Technology Platform

- Pilot Program/Thrasys
- Paper to Electronic System
- SyntraNet and Implementation
- Front/Back Office Function
- Physician Follow-Up

Blair, Kelly

Newgent, Sheena × | Goldwire, Hank × | Bence, Anya ×

Enter Patient Name

Bence, Anya (Female) Age [redacted] Speaks English

(170)549-2388 PCP LEACH, CHARLES, (650)449-1000 ID 910[redacted]0[redacted]3

(752)145-3231 HCP N/A Contact N/A Allergies

Insurance HICN 92000006

Medicare CARE M100002 Effecti

Current Case C-[redacted]03[redacted]0 (Day 395) Owner Lovell, Angela Acuity Unspecified Team DSMT/MNT Team

Program Medical Nutrition Therapy Day 395 Status Open Pending Enrollment

Existing Cases... (1)

Case Management | Patient Information | Clinical Summary | Calls | Uploaded Files | Charge Capture | Workshops

- Case Summary
- Calls
- Documents
- Correspondence
- Contacts

Documents

Date Range 1M 3M 6M 1Y ☑ Any Date

Add Documents

Select a visit to document...

New Visit

Drag a column header and drop it here to group by that column

	Name	Type	Status	Last M	Entered	Entered By	Signed	Signed By	Visit
×	Consent Form	Advanced Care Planning	Signed	07/26/2	07/26/2017	Blair, Kelly	07/26/2017	Blair, Kelly	03/14
	MNT Group Encounter	MNT Documents	Signed	04/26/2	04/26/2017	Lovell, Angel	04/26/2017	Lovell, Angela	03/14
	Nutrition Assessment	MNT Documents	Signed	04/18/2	04/18/2017	Lovell, Angel	04/18/2017	Lovell, Angela	03/14
	Referral Form	Advanced Care Planning	Signed	04/25/2	04/17/2017	Morren, Lind	04/25/2017	Morren, Linds	03/14

Benefits and Challenges

- Sustainability
- Offering Class in Community Location/Convenience
- New Funding Stream
- MNT Classes after DSMT Classes

- Recruiting/Scheduling
- Determining who Qualifies for MNT or DSMT
- Don’t Expect the Big Bucks to Roll in all at Once
- Timely Physician Signatures
- Lack of Healthcare Driven Referrals

Questions?

The Role of Quality Assurance in CBO/Health Care Partnerships

- Dana Eidson, Executive Director, Southern Alabama Regional Council on Aging, Dothan, AL
- Christine Tardiff, Chief Operations Officer/ VP Clinical Services, Elder Services of the Merrimack Valley, Lawrence, MA
- Tim McNeill, Independent Healthcare Consultant

Aging and Disability BUSINESS INSTITUTE

Alabama AAA's Accreditation

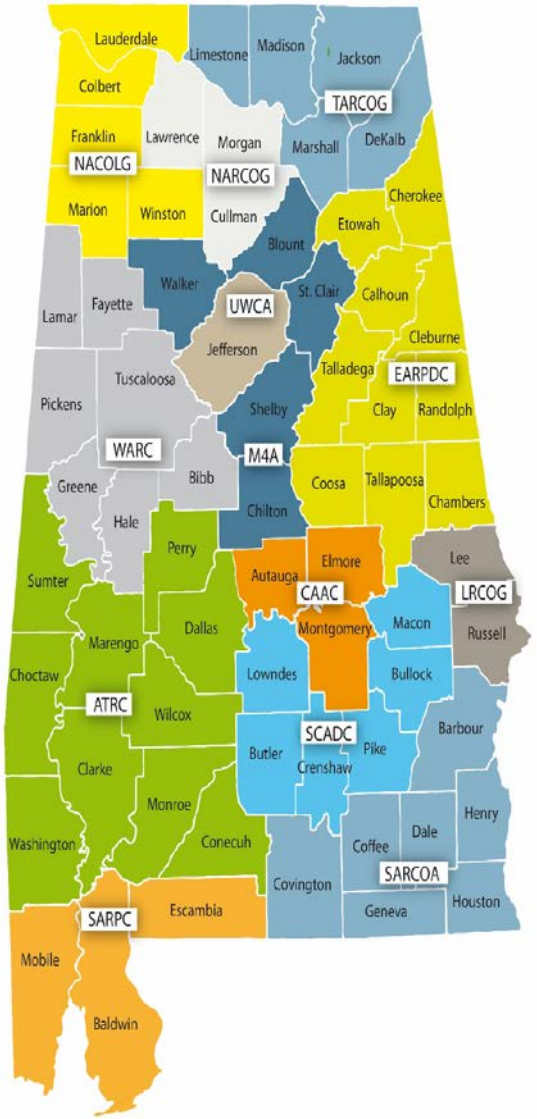
April 2018

SARCOA
healthy • active • home

13 AAAs

Alike but different

- 3 Independents
- 9 Planning Commissions
- 1 United Way
- Staffs: 25-80
- MW Slots: 261 - 1,205
- Case Mgt Costs vary 100%



[redacted]

Why NCQA Accreditation?

- LTSS Managed Care coming to Alabama Medicaid Waiver program
- Quality, consistency, improved processes
- Looking to the future
  - *Health plans recognize NCQA*

Integrated Care Network (ICN)

- October 2018 implementation
- Legislation adopted in 2015
- Original RFP released in August 2017
- Procurement delayed until further notice, Oct 2017
- Alabama Medicaid regrouped January 2018
    - PCCM model
- Projected RFP date April 2017

NCQA Accreditation

Case Management for Long-term Services and Supports

NCQA Accreditation

- Our statewide AAA “strategy” for the coming ICN: Quality
- Began March 2017
- Previous SUA Director and state Medicaid Agency secured “No Wrong Door” funding to include ADRC as entry point
- Engaged consultant for facilitation & technical assistance
- One AAA was funded as the lead for the project
- Fifteen month project….initially…..now 21 months

Redesign

Technology

Data requirements

New Assessments

New Care Plan

Predictive Modeling

Risk Stratification

Medication Review

Case Management

Person-Centered Care Planning

Care Transitions

Expanded Assessments

Staffing

ICN requires "Care team led by nurse and social worker"

Licensed Social Workers
RN's

Documentation

Everything must be documented.

Policies and Procedures, Processes, etc

Survey

Periodic surveys will become part of the new norm

[redacted]

Technology

- SARCOA managed and customized the technology platform
- Care planning and monitoring-new care plan model
- Assessments- added 12 new assessments, expanded existing MW assessment
- Quality metrics for quality improvement
- Data analysis: care transitions, population assessment

Technology Challenges

- Bringing 7 remaining AAAs into case management software system
- Customizing software system to include NCQA standards including 12 new assessments
- AAA implementation on new process and assessments
- Risk stratification and predictive modeling
- Integration with state system to prevent duplication

New Case Management Model

- Increased work; increased staffing requirements; increased staff turnover
- Expanded Assessments
- Care Transitions – change in care setting requires a contact; also prevent unplanned; identify problems
- Person-centered Care Plan with goals and preferences
- Care plan reviewed by social worker and RN (ICN)
- Medication review (ICN)

Policies and Procedures

- Largest group effort; took many months, many rounds of talks
- Understanding of Standards, Elements and Factors
- Standards were assigned to committee members to develop and document P&Ps

[redacted]

Training

- Person-Centered Care Planning/Thinking training resources are limited
- Conducted two rounds of PCP training
  - First with representatives from each AAA
  - Second with all CM, ADRC staff from each AAA
- Training committee has assembled a uniform training repository for use statewide

Statewide Accreditation

Advantages

- Consistency in network
- Shared responsibilities
- Shared costs
- Greater knowledge
- Larger resource pool

Disadvantages

- Slower
- Weak links
- No single authority
- Communication
- Disagreements

[redacted]

Lessons learned

- This is a marathon. Understand the commitment.
- More communication.
- More committees (shared responsibility).
- Get all AAAs involved in policies and procedures.
    - Parallel groups

Status

- Group 1 – Survey begins in July and August
- Group 2 - Survey begins September
- Group 3 - Survey September and October
- Group 4 – Survey October

- All site visits occur by December 31, 2018.

[redacted]

What’s Happening at SARCOA?

SARCOA

Area Agency on Aging

SARCOA

healthy · active · home

[redacted]

Development Focus

- Reach new populations
- Integrate with healthcare
- Increase SARCOA capacity
- Diversify funding

Diabetes Education

- AADE Accreditation for Diabetes Self-Management Training
- Medicare Provider Number
- In process for obtaining CDC Diabetes Prevention Program Recognition; currently in Pending status.

Health Plan Care Management

- One year pilot
- 10 staff - Previous CCTP staff plus 5 new ones
- One of Plan's first questions….

  NCQA Accreditation?
- Working under delegation which involved a pre-delegation assessment

Chronic Care Management

and Transitional Care Management

- Contract with one large physician group
- Work with about 40 patients per month and growing
- CCTP staff

Generations Personal Assistance

- Private Pay Program, began Jan 2017
- Slow growth, monthly average of 7 individuals during first year

Generations
PERSONAL ASSISTANCE

[redacted]

The Role of Quality Assurance in CBO/Healthcare Partnerships

Christine Tardiff, RN, MSN
COO/VP Clinical Services ESMV

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

AGENDA

- Who we are – why we pursued accreditation
- Healthcare (RN) perspective on QA
- Benefits of Accreditation
- Challenges
- Lessons learned
- Cultural/ Organizational buy-in

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Elder Services of the Merrimack Valley (ESMV)

- **Largest AAA in Massachusetts**
- **Serve over 25,000 older adults annually**
- **250+ employees and 375+ volunteers**
- **40+ programs**
- **$70 million annual budget**
- **Home of Statewide contracting network for evidence-based programs (Healthy Living Center of Excellence)**
- **Consultant and partner in n4a Aging and Disability Business Institute**
- **Evidence-Based Leadership Council Member**

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Why Accreditation??

- Increased number of contracts with Health Systems
- Increased focus on outcomes and accountability
- Mechanism to help bridge the gap between multiple LTSS providers
- Tool that would help us demonstrate the quality of the work in a language health systems could understand
- Leverage our current Quality Assurance Program and systems
- Proactive approach to thinking about future contracting requirements

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Quality Assurance in Health Care

- **Policies and Procedures that promote the best possible patient outcomes, evidence based**
- **Focus on standardized systems, processes, outcomes, patient satisfaction**
- **Hospitals are ranked according to outcomes**
- **Reimbursement tied to outcomes**
  - **Value-based contracting**
  - **Pay for Performance (readmissions, falls with injury)**

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Benefits of Accreditation

- Provides a roadmap for improvement: Aligns our quality improvement efforts with our statewide designation as an Aging Service Access Point.
- Improves efficiency: Reduces errors and duplicated services.
- Integrates care: Helps improve communication between individuals, caregivers, providers, payers and other organizations coordinating care.
- Provides person-centered care: Standards focus on person-centered services, which can lead to better care, planning and monitoring.
- Supports contracting needs: Standards align with the needs of states, health systems and MCOs.
- Demonstrates capacity to be trusted partners in coordinating LTSS services by adhering to standardized, efficient high quality care and maintain compliance with National Standards .
- Increases our “marketability” to health care partners and creates consumer trust.

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Assessing Readiness

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Survey Challenges (Opportunities)

- **Fragmented documented processes – Development of standardized policies, procedures, documented processes**
- **Complex data collection and reporting – Development of Quality Reports**
- **Lack of data analytic capacity – Build internally (Data Quality Specialist)**
- **Moving from a culture of Quality Compliance to a culture of Accountability and Quality Improvement**

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

Lessons Learned

- **Develop a project plan and timeline and commit to it.**
- **Dedicate resources to the initiative**
- **Conduct a thorough gap analysis to determine areas of weakness and focus on improving those areas before your lookback period begins**
- **Utilize your NCQA resources (Best Practices Academy, assigned accreditation team)**

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey

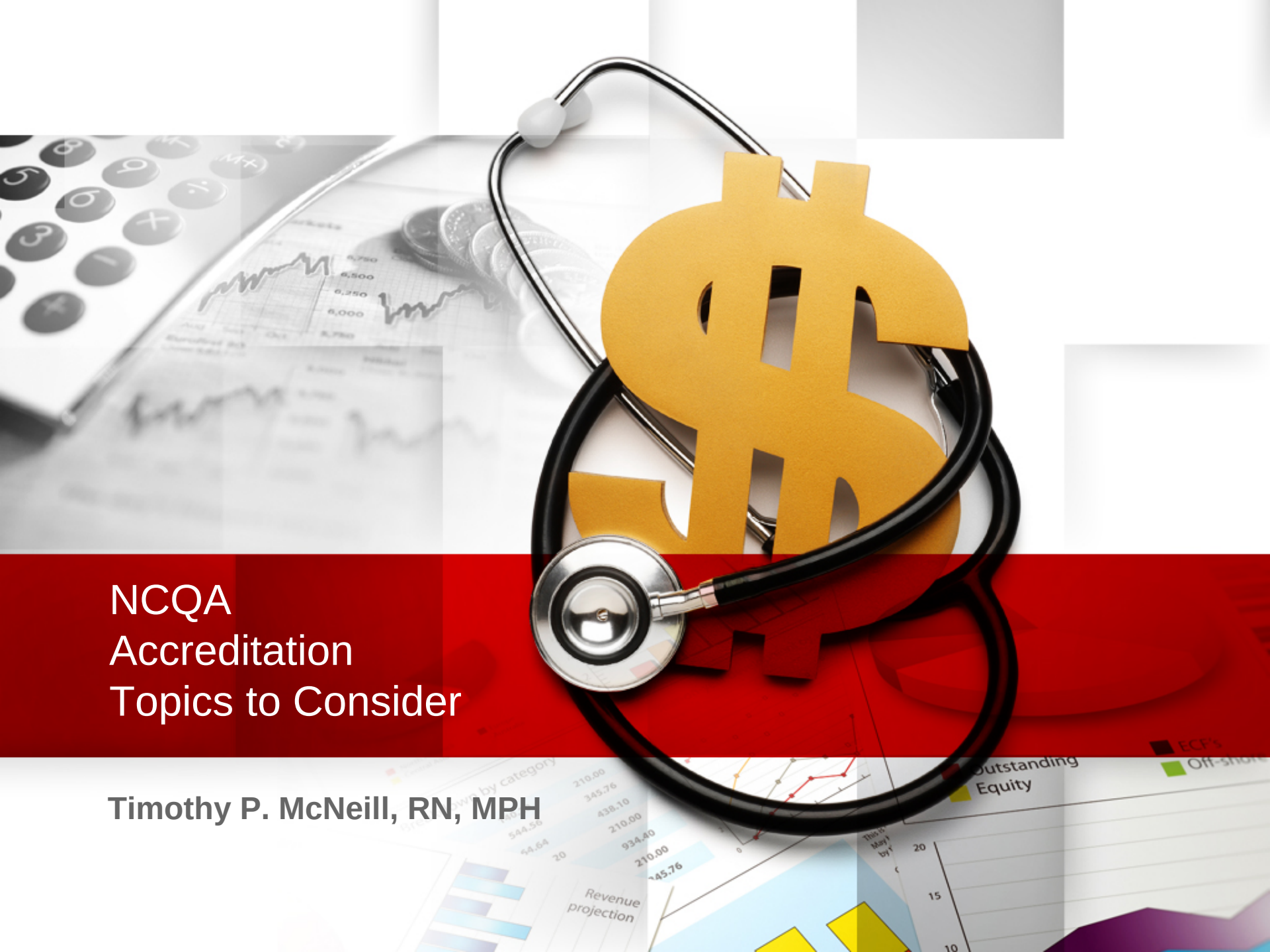
Cultural/Organizational Buy-In

- Heightened understanding and buy-in of Quality Improvement Process (Exec Leadership, Senior Leadership, Managers, Front Line Staff)
- Increased collaboration towards shared goals
- Real time modifications to the intervention/program based on data, outcomes
- Validation of intervention/program integrity

ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

Elder Services of the Merrimack Valley, Inc.

Choices for a life-long journey



NCQA Accreditation Topics to Consider

Timothy P. McNeill, RN, MPH

About NCQA

- NCQA – National Committee for Quality Assurance
- 501(c) (3) not-for-profit organization
- Founded in 1990
- Accreditation program for managed care plans and program that support managed care plans

Medicare Advantage Plans

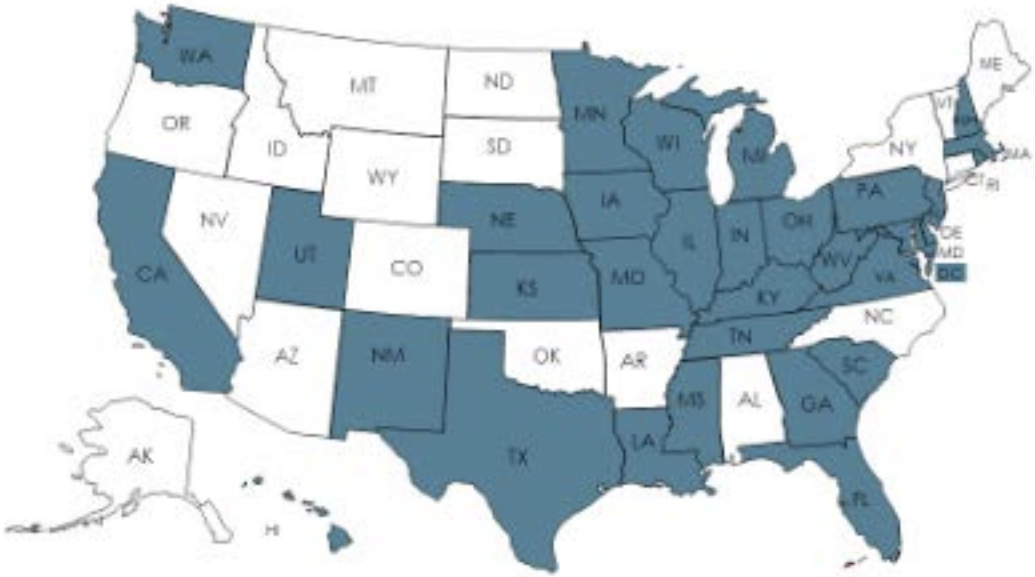
- Medicare Advantage plans must have an internal quality assurance program.
- Medicare Advantage plans are deemed to have satisfied the Medicare quality assurance requirements by receiving accreditation and having a periodic review and re-accreditation, from a private organization approved by CMS
  - NCQA
  - URAC
  - Joint Commission

Conditions of Participation

- In order for a health care organization to participate in and receive federal payment from Medicare or Medicaid programs, one of the requirements is that the program meets quality standards.
- These standards must cover all aspects of the organization
  - 42 States recognize NCQA Accreditation as meeting their requirements for Medicaid commercial plans
  - 33 Medicaid programs recognize or require NCQA Accreditation
  - Health plans that operate in the Health Insurance Exchange marketplace must seek accreditation

States Use of Accrediation

33 States Require or Recognize NCQA Health Plan Accreditation for Medicaid Managed Care (July 2016)



NCQA Long-term Services and Supports Distinction

- NCQA LTSS Distinction program provided NCQA-Accredited health plans that coordinate long-term services and supports.
- Program offers distinctions to organizations that meet requirements in areas such as conducting comprehensive assessments, managing transitions, performing person-centered assessments and planning and managing critical incidents.

NCQA Accreditation Programs

- Health Plan Accreditation
- Disease Management
- Case Management
- Case Management for LTSS
- Wellness & Health Promotion
- Accountable Care Organizations
- Managed Behavioral Healthcare Organizations

Should I Consider Seeking NCQA Accreditation?

- Do you intend to contract with a managed care plan in your market? Health System? Both?
- Do you want the health plan to delegate one or more of their core functions to your organization to provide on their behalf?
- Do you want the services of the plan to apply the cost of the contracted services to administrative expenses or towards their mandated MLR expense?

What is Your Contracting Strategy?

- Healthcare is a volume business
  - Hospitals (My ER as 4 min wait time compared with 6 min at my competitor)
  - Health Plans (Open Enrollment marketing blitz)
  - MLTSS / D-SNP
- Do you provide an advantage to the plan beyond your direct services?
- How will you monitor the ROI your services provides to the plan?
- Do you understand the competitive advantage of the health plan that you are negotiating with?

Determine your approach to the Health Plan

- If you want to be a provider:
  - Contact provider enrollment and define the services you wish to provide
  - Adhere to the provider enrollment procedure
- If you want to provide delegated case management services:
  - You will want to consider accreditation
  - Some plans will not consider contracting with organizations that are not accredited because it could negatively impact the health plan's accreditation
  - Determine your IT requirements

Know the Trigger Points for the Plan

- A MLTSS Plan that operates a D-SNP in your market
- A Medicare Advantage Plan with poor HEDIS performance
  - Which metrics are they trying to improve?
- A Health Plan that is seeking to divert high-risk members from SNF facilities
- A health plan with a high / low MLR
- Is the plan required to contract with designated entities for a specific period of time
  - ROI is critical for long-term success

What are HEDIS Measures

- **H**ealth **E**ffectiveness **D**ata and **I**nformation **S**et
- Tool Used to measure performance of health plans
- 90% of all health insurance plans use HEDIS to measure performance
- HEDIS is the Registered trademark of the National Committee for Quality Assurance (NCQA)

Why Measure Health Plan Quality

- HEDIS allows a consumer to use a independent, neutral criteria to directly compare health insurance plans
- All NCQA Accredited Health Plans must report HEDIS measures
- NCQA is contracted with CMS to accredit all Medicare Advantage and Health Insurance Exchange plans

Why are HEDIS measures important to MCOs

- HEDIS is one component of the NCQA accreditation process
- As an indicator of quality, HEDIS measures reflect the quality of care for the population
- Poor performance on HEDIS could negatively impact:
  - NCQA Accreditation status
  - New Member enrollment
  - Retaining current members
  - MCO Federal (MA) and State (Medicaid) contracts

Common HEDIS Measures

- Diabetes
  - Hgb A1C, Foot Screening, Retinopathy Screening, LDL, etc.
- Preventive Health Care
  - Colonoscopy Screening
  - Breast Cancer screening
- Immunizations
  - Flu, Pneumonia

How Many measures are there?

- HEDIS consists of 81 measures that cross 5 domains of care
- HEDIS Measures are updated annually
- New measures are introduced or modifications to current measures occurs at the annual update

Primary Data Source utilization

- Claims data is the primary data source for HEDIS
- Claims data provides a definitive source to validate that a service is provided
  - Examples
    - Breast Cancer Screening
    - All – Cause Readmissions

HEDIS Measures that CBOs could support

- All Cause Readmissions
- Prevention
  - Breast Cancer, Colorectal Cancer, Glaucoma Screening
- Comprehensive Diabetes Care
- Influenza
- BMI Assessment
- Fall Risk Management in Older Adults
- Advanced Care Planning for Older Adults

Fall Risk Management

- Two Components of Fall Risk Management Measure:
- *Discussing Fall Risk*. The percentage of Medicare-enrolled adults 65 years of age and older with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who report discussing falls or problems with balance or walking with the practitioner.

- *Managing Fall Risk*. The percentage of Medicare-enrolled adults 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who report receiving fall risk intervention from the practitioner.

All Cause Readmission

- 30-day readmission
- Numerator Description
  - At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date minus planned readmissions
  - “What are examples of planned readmissions?”
- Denominator Description
  - Acute inpatient discharges for commercial members 18 to 64 years of age and Medicare members 18 years of age and older as of the Index Discharge Date who had one or more discharges on or between January 1 and December 1 of the measurement year

ROI

- ROI = Return on Investment
- ROI should be part of a presentation to a MCO
- ROI calculation:

$$\frac{\text{Net Savings from Changes in Utilization}}{\text{Program Costs}} = \text{ROI}$$

ROI Interpretation

- ROI greater than 1 (>1): greater than expected savings
- ROI less than 0 (<0): less than expected savings
- ROI between 0 and 1: Results are small or inconclusive

- Example: ROI of 2: $2.00 in reduced healthcare expenses produced for every $1.00 invested

Leading MCOs in the MLTSS Market

- Amerigroup
- AmeriHealth
- Centene
- Cigna Healthspring
- Molina
- United Healthcare

Risks DRIVE the MCO

- It is CRITICAL that you determine the risks to the MCO
- Risks will drive the decision making for the MCO
  - What their risks are
  - What population presents the most risk
  - Their ability to manage these risks
  - Your access to the population that presents the most risk
  - Your ability to mitigate risks for the MCO

MCO Attempts to shift risks

- Value-Based Payment Models are designed to shift the risk to the provider
- When a provider shares in the risk, they are financially motivated to improve outcomes and reduce costs
- Many large Payers are embracing VBP contract models and there will be growth in this area
- Recent mandates require alignment of payment incentives between Medicare and Medicaid programs

MLTSS Risks

- Many States are requiring that Medicaid MCOs adopt Value-Based Payment Models that align with Medicare VBP models
  - ACOs
  - Bundled Payment
- HCBS Risks
- Long-term Care Risks
  - Understand the markets and population that are at-risk

MLTSS Risks for LTC

- Medicare Part A covers SNF care under certain conditions
  - Beneficiary must have Part A
  - Must have a qualifying hospital stay prior to transfer to the SNF
    - Qualifying inpatient hospital stay is 3 days before SNF care is authorized
  - Services required for a medical condition that meets one of the following indications
    - A hospital-related medical condition
    - A condition that started while you were getting care in the skilled nursing facility for a hospital-related medical condition

Skilled Nursing Facility coverage (cont.)

- Medicare covers the cost of care for SNF care as follows
  - *Avg length of stay in a SNF is 20 days
  - SNF Readmissions likely occur between day 20 - 39

For Days	Medicare Pays for Covered Services	Beneficiary is responsible for the following
1 – 20	Full Cost	Nothing
21 – 100	All but a daily copayment	Daily copayment (2014 = $152/day)
Beyond 100	Nothing	Full Cost

How Payment Alignment is impacted by MLTSS

- Alignment of MLTSS and Medicare VBP models
  - Some States are now requiring MCOs to establish Medicaid and MLTSS Value-Based Payment models that align with Medicare VBP
  - This will require greater adoption of the following contract types:
    - Bundled Payment
    - ACOs
    - The possibility exists for LTSS ACO Networks that align with Medicare ACOs and Bundled Payment Programs

Application of the Concept

- Bundled Payment for Care Improvement Initiative & CJR
  - Target Population – Medicare Beneficiaries
  - Duals are included if they still maintain their Medicare benefit
  - Medicare Advantage plans are increasingly embracing Bundled Payment
  - Focus of Bundled Payment includes
    - Hospital Care
    - Post-Acute Care cost reduction
      - SNF

Alignment of Payment Incentives

- Incentives to reduce Medicare and Medicaid directly impacts providers that serve duals
- Reductions in Medicare costs and Medicaid costs can have a dramatic impact on the overall cost of care
- Medicare
- Medicaid (Medicare Supplemental Coverage)
- Managed Long-Term Services and Supports
  - Medicaid Waiver

Challenge for CBOs

- Understanding how your business brings value to the system
- Defining your return on investment (ROI)
- Implementing the required culture change to realize the opportunity
- Implement systems to drive change and document your impact
  - Continually reinforcing your ROI to your customer

Challenge for the MCO

- Conversion of MLTSS members to D-SNP
- Growing enrollment and maintaining members
- Managing risk of the population
  - Improving Quality Outcomes and containing costs
  - Working with providers that influence risk
- D-SNP provides an opportunity for the health plan to manage the Medicare risk (Part A / B + Medicaid Risk
  - FIDE: Fully Integrated Dual Eligible Plan
  - Greatest opportunity for profit
  - Investors in Medicaid plans like to see rising conversion rates

Defining Your Value Proposition

- Ability to identify high-risk members
- Ability to have direct influence on potential members
- Drivers of cost and quality metrics
- Targeting services to high-risk beneficiaries
  - Implementing supplemental benefits to drive down costs for targeted groups
  - Chronic Care Act
- Do you have a single service vs a regional/statewide delivery system?
- Data, Data, Data…

Questions

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- Direct: 202-344-5465
- Email: tmcneill@me.com

Questions?