Aging and Disability BUSINESS INSTITUTE

Connecting Communities and Health Care

n4a

advocacy | action | answers on aging

ASA

American Society on Aging

Using Medicare Physician Billing Codes to Support CBO Partnerships & Address SDOH

Part of the Aging and Disability Business Institute Series- a collaboration of n4a and ASA

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The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

www.n4a.org/businessinstitute

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Partners and Funders

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

Funders:

- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation

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ACL Business Acumen Grants

- Learning Collaboratives for Advanced Business Acumen Skills (n4a)
  - Organize and conduct 3-5 topically-based action learning collaboratives to address "next generation" issues; and to provide targeted technical assistance to networks of community-based aging and disability organizations.
    - Trailblazers Learning Collaborative
    - Health Information Technology Learning Collaborative
    - Medicare Advantage Learning Collaborative
  - Create knowledge and capture insights through these collaboratives to incorporate into future curriculum for national dissemination.

Trailblazers Learning Collaborative

- Purpose:
  1) Develop comprehensive strategies for approaching and engaging different health care payers and providers
  2) Develop and test "road maps"
- 2 work groups – Health plans and health systems

About Physician Fee Schedule Codes Relevant to CBO Partnerships

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What codes/programs can foster provider-CBO collaboration

Service Description	HCPCS/CPT Code	National Rate
Transitional Care Management (TCM)	99495 99496	$166.50 $234.97
Chronic Care Management (CCM) Complex CCM	99490 99487	$42.17 $92.98
Advanced Care Planning	99497	$86.49
Collaborative Care Management	99492 99493	$162.18 $129.38
Cognitive Functioning Assessment & Plan	99483	$263.81

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TCM Benefit Overview

- Transitional Care Management –
  - 30-day intervention to provide coordinated care management over 30-days when transitioning from one of the following clinical settings:
    - Acute Inpatient Hospitalization
    - ED Observation
    - Skilled Nursing Facility
    - Mental Health/Behavioral Health Inpatient facility

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TCM Requirements

- Patient contact within 48-hours of discharge (phone or other methods)
- Face-to-face visit within seven (7) or fourteen (14) days
  - Claim can be submitted on the date of the face-to-face visit
- Interventions to address identified needs, over the course of 30 days
- Cannot be provided during the same month as Chronic Care Management (CCM)

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CCM Benefit Overview

- Eligibility – Medicare Beneficiary with 2 or more chronic conditions that are at-risk of deterioration
- Services: Non-face-to-face interventions to address the medical, behavioral, or social needs that impact health outcomes
- Provider Entity must have provided a qualifying service in order to bill for CCM
  - Transitional Care Management Visit
  - Level 3 Office Visit
  - Level 3 Home Visit
- Requires EHR, 24/7 access to info/care

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CCM Billing

- Billing
  - Billed once per calendar month
  - Requires a person-centered plan
  - CCM vs Complex depends on the level of complexity of the interventions, changes to the care plan
  - Documentation must reflect the intervention provided, outcome of the intervention, state of the person-centered plan based on outcomes observed

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CCM Implementation Elements

- Incident To Rules
  - Rules allow for CCM/Complex CCM/CoCM to be delivered under General Supervision requirements
  - Rules allow for Provider to outsource the services to a third-party entity
- CBO can be a third-party entity contracted to deliver CCM
  - Contract defines the relationship and financial terms
- Services can include, but no limited to:
  - CDSMP programs
  - Navigation and Care Coordination
  - Assistance with securing social services
    - Waiver/Medicaid/SNAP benefits, etc.

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Advance Care Planning Benefit

- Face-to-Face discussion with the patient and/or caregiver regarding end of life care.
- Can be provided by clinical staff under direct supervision.
- Requires a minimum of 30-minutes of time.
- Can be provided in outpatient and inpatient facility settings.
- Can be provided more than once. Requires documentation defining the reason to repeat the service
- Add-on service with other benefits
  - Part B Benefit
  - Annual Wellness Visit (AWV)
    - If Added on to AWV deductible and coinsurance do not apply
    - Requires billing modifier -33
  - E/M Service

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Advance Care Planning Benefit

- Items Addressed during the minimum 30-minute discussion:
  - Advance Directives
  - Living Will
  - Hospice Options
  - Financial Planning Assistance
  - Items of Importance:
    - Spouse/Children/Significant Other
    - Pets/What happens to them?
    - House/Apartment
    - Checking/Savings
    - Funeral, Burial, Memorial instructions
    - People to be notified of death
    - Bequest of personal items
    - Insurance

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Cognitive Assessment & Care Plan

- Eligibility: Any Medicare beneficiary with any level of cognitive impairment – of any cause.
- Services required
  - Assess function – ADLs/IADLs (Katz, Lawton-Brody)
  - Stage severity of cognitive impairment, using standard tools
  - Review and reconcile meds – i.e., Mini-COG , Dementia Severity Rating
  - Evaluate behavioral symptoms –i.e., depression, anxiety
  - Identify caregiver needs, social supports, etc.
  - Advanced care planning
  - Develop a person-centered plan
- Billing
  - Can be an additional service performed
  - Clinical staff can support the delivery, under direct supervision
  - Billing is not based on time
  - Can be repeated at intervals when there is a change in clinical status or caregiving needs

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Behavioral Health Integration

- Eligibility: Any Medicare beneficiary with a behavioral health condition (any condition including depression, anxiety, etc.)
- Care coordination, navigation, health coaching and other support services to address the health needs impacted by a behavioral health condition.
- Non-psychiatric codes ONLY
- Can be performed under General Supervision requirements and the service can be contracted to a third-party entity
  - CBO can be the third-party entity
- Billed once per calendar month
- If mental health services are required, then the mental health services are billed separately by a mental health provider

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Partners in Care Foundation Planning & Experience

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The Social Determinants Specialists

Our work serves as a bridge between medical care and what a person accomplishes in their own home.

We manage the gaps in non-medical care that affect a person's recovery and overall health.

We represent a California network of community-based organizations (CBOs)– Partners at Home.

The result is happier, healthier people cared for at lower expense in their own homes and communities.

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Why do this?

- A way to help healthcare pay for our services – especially care transitions
- New roles and relationships with providers
- Expand ability to address SDOH
- 2020 should bring more advantageous regulations and reimbursement for sustainability
- Can supplement Medicaid waivers with FFS Medicare funding

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W. M. Keck Foundation Grant

- Figure out how to use Chronic Care Management (CCM) and Complex Chronic Care Management (CCCM) codes to help pay for collaboration between physician groups and CBOs to improve health and SDOH for patients with 2+ chronic conditions
- Pilot to serve 200 people

W. M. KECK FOUNDATION

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Partnerships

- ACE Medical Associates
  - Co-founder on our board
  - Hospitalist group serving nearby Providence Holy Cross hospital
  - ACE considering postacute SNF & NP home visits to improve continuity of care after discharge
- Providence Holy Cross Medical Center
  - Contracts with ACE for inpatient hospitalist
  - Contracts with Partners for care transitions home coaching visits

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Process

- Weekly phone meetings
- Raise questions & investigate issues
- Create financial model that can be updated easily as questions are raised and answered
- Create workflows
- Create short explanatory summaries
- Work on partnerships

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Awesome Advisors

- Manoj Mathew, MD, SFHM, Co-Founder, ACE Medical Associates (hospitalist group)
- Tim McNeill, RN, MPH, Consultant and healthcare/CBO financing expert
- Martie Ross, JD, Managing Principal, Kansas City office, PYA Consulting
- Christopher Langston, PhD, CEO, Archstone Foundation

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Overarching issue: Relationships

- TCM & CCM codes underutilized
- Centralized approach makes sense for CBOs instead of one doctor at a time
- But relationships can be a barrier:
  - Patient with usual PCP and specialists – resist seeing unknown provider
  - Other docs can be protective of their patients
    - Don't want others "stealing" their patients
  - CMS pays the first claim for CCM in any month – we won't know if patients' regular docs are already doing CCM

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Issue 1: Who can bill for CCM?

- Can only bill for CCM based on existing (w/in 1 year) relationship (verified by billing) with patient.
  - Conflicting information about whether hospitalist inpatient visit counts
    - Medicare Administrative Contractor (MAC) in Maryland told Tim's group NO; Kansas MAC said YES to Martie's group
    - Regs specify types of encounter that qualify – ***Part B*** services including TCM, evaluation & management (E/M)
    - California MAC says "probably not" but try submitting a claim and see what happens.

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Issue 2: Transitional Care Mgt (TCM) to establish relationship for CCM

- TCM requires face-to-face (F2F) visit with provider (MD, NP, PA) within 7 days post-discharge for best reimbursement
- Partners' TCM program with Providence Saint John's Health Center
  - Patients resist going to unknown provider
  - Providers in the med group billed the wrong codes
  - Better results with coaching interventions
- Use post-discharge NP home visit for F2F TCM?
  - Not affordable given other work necessary for TCM

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Issue 3: Needs a certified EHR

- ACE Docs uses hospital's Epic system, so to bill for CCM, they need to find an EHR
- Different models – straight EHR vs. EHR bundled with CCM billing module
- Software companies evolving into providers – hard to compete with $20 CCM per patient per month including software, 24/7 call center, billing service, and CCM phone calls

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Issue 4: Working by the minute

- CBO staff not used to tracking minutes
- Need software that tracks minutes, but it needs to be part of usual workflow (counting minutes in the background)
- Rule of 8: 22-minute minimum to count for 30-minute billing requirement

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Sharing the work & the wealth

- These are all physician billing codes
- Gauge what work the CBO will do
- Determine fair share based on effort
- Look at costs liberally to get started – only include dedicated staff or hourly/consultants

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Building a business model

- Get correct reimbursement for each code from state's MAC
- Bill at 85% if delivered by NP or PA (vs. MD)
- Deduct 20% Copay
  - Calculate % of copays that will be collectible (Medicaid, supplement, or out of pocket)
  - Consider restricting population to those w/ Medicaid or Medicare supplement
- Deduct cost for billing service
- Model/proforma has assumptions that flow through to P&L – change once

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Building a business model

Revenue Assumptions								
Service	CPT Code	Max Fee Amount*	Fee minus co-pay	MD or NP	MD or NP %	5% bad debt	Billing	Net
PCHV - Established Patient -40 min F2F**	99349	$ 135	$ 108	NP	85%	$ 12	6%	$ 98
PCHV - New Patient Lvl 3--45 min F2F	99343	$ 136	$ 108	NP	85%	$ 12	6%	$ 98
PCHV - New Patient Lvl 4--60 min F2F	99344	$ 191	$ 153	NP	85%	$ 16	6%	$ 138
PCHV - New Patient Lvl 5--75 min F2F	99345	$ 232	$ 186	NP	85%	$ 20	6%	$ 168
CCM - Care Plan REVIEW	G0506	$ 67	$ 53	MD	100%	$ 7	6%	$ 57
CCM - Chronic Care Management	99490	$ 44	$ 35	MD	100%	$ 4	0%	$ 40
CCCM - Complex Chronic Care Management (60 min.)	99487	$ 99	$ 79	MD	100%	$ 10	6%	$ 85
CCCM - Complex Chronic Care Management (each add. 30 min.)	99489	$ 50	$ 40	MD	100%	$ 5	6%	$ 42
Advance Care Planning	99497	$ 90	$ 72	MD	100%	$ 9	6%	$ 76
Cognitive Assessment and Care Planning (CogACP)	99483	$ 278	$ 223	MD	100%	$ 28	6%	$ 237

* Per Noridian – California MAC; **PCHV=Primary Care Home Visit

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Building a business model - 2

- Project volume and growth rate
- Project ongoing retention rate for CCM (monthly drop-off)
- Project staff cost per intervention
  - Primary care
  - CBO
- Review interaction between Primary Care Home Visits (or TCM), CCM, Advance Care Planning, Cognitive Assessment & Care Plan

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Pilot model 1

- Population: 1915(c) Waiver clients aged 65+
- Waiver CMs offer & get consent for NP home visit to qualify for new Medicare service (CCM) and provides assessment & recent case notes to NP
- NP Primary Care Home Visit to establish relationship
- NP determines need/level – CCM or Complex CCM
- NP offers continuing home visits (no pressure)
- Partners provides Complex CCM for a month or two, then convert back to telephonic
- Considering specialized company for ongoing telephonic 20-minute CCM – depends on scale

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Pilot model 2

- Population: Hospital discharges who:
  - A. Have no primary care home; or
  - B. Receive in-home coaching from Partners paid by Hospital
- Main partner is physician group that does home visits
  - They do the billing, etc.
  - They review care plans from care transition coaching
- In-home care transition coaching cost partially defrayed by TCM (under new rates) ***AND*** CCM (under 2020 regs allowing TCM & CCM or Complex CCM in the same month)
- Coach assessment determines ongoing need/level – no CCM, CCM or Complex CCM
- NP Primary Care Home Visit(s) provided only if requested
- Partners provides Complex CCM for a month or two, if needed, then convert to telephonic
- Consider specialized company for ongoing telephonic 20-minute CCM

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Looking to the future

- Big changes coming to make this easier and more financially sustainable (Tim will tell)
- Relationships are key
- This needs to start with someone close to patients/members/clients
- Ongoing coordination with PCP is essential – usually needs technology to support
- A lot of this is about the small print, so it takes longer than usual to get going
- Requires different approaches than CBO usual

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Tim McNeill: Alabama Experience & Upcoming Changes

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Alabama Experience

- Two (2) Area Agencies on Aging (AAAs) participated in the CMMI Community Care Transitions Program (CCTP)
  - Southern Alabama Regional Council on Aging (SARCOA)
  - Top of Alabama Regional Council of Governments (TARCOG)
- Shared learning from CCTP provided to all AAAs
  - Medicaid approved State ADRCs to complete assessments and initiate enrollment for Medicaid Wavier, when persons are transitioning from acute care hospitals
  - SARCOA providing care transitions and chronic care management services for Medicare Providers in APMs / MIPS
- 2018: Medicaid Long-Term Services and Supports implemented under Medicaid Waiver in Alabama
  - 1 Vendor: Senior Select Health Plan

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Alabama Current Contracts

- Alabama Medicaid secured "No Wrong Door" Funding to strengthen the Network of ADRCs across the State
  - Funding leveraged to secure NCQA LTSS Accreditation for each of the thirteen (13) Area Agencies on Aging
- NCQA LTSS Accredited AAAs have secured the following contracts:
  - Large Physician practice contracts with SARCOA for TCM/CCM
    - 80% of revenue paid to SARCOA for TCM/CCM services.
  - Senior Select Medicaid LTSS Plan / D-SNP
    - Delegated case management
    - Care transitions
  - Blue Cross Blue Shield of Alabama Medicare Advantage
    - In-person case mgmt. & Care transitions for high utilizers
  - Blue Cross Blue Shield of Alabama Health Insurance Exchange
    - In-person case mgmt. for high utilizers

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2020 Physician Fee Schedule changes (Proposed)

- TCM & CCM billing during the same month
- CCM billing options will include billing in 20 min increments (20/40/60)
  - Reduced requirement for significant changes to the person-centered plan
- New CCM code for persons with 1 chronic condition
- TCM & CCM billing rate increase (RVU)

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Business Institute LTSS Client Survey & Care Transition Survey

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How you can use the tool

- TEST LINK:
  - https://www.surveygizmo.com/collab/4414506/TLC-CM-Satisfaction-Survey
- Request to use the full survey:
  - eblair@n4a.org
  - Send names of case managers and name of program to customize
  - Send questions/response sets you would like to have ADDED
  - Beth will send the link to the live survey

Other products

- Care transitions outcomes and patient experience survey in final stage of word-smithing
  - Includes outcomes
    - Readmissions
    - ED use
    - Behavior change
    - Medications
    - Confidence in ability to self-manage chronic illness
- Care transitions standard "product" description for those just getting started

Questions & Answers:
Please Submit Using the “Questions” Box

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Please join us for future webinars in the Aging and Disability Business Institute Series

"Washington State's Health Home Model: A Home-Based, Person-Centered Approach to Improving Health Outcomes" – November 7

Learn more and pre-register here:
http://www.asaging.org/series/109/aging-and-disability-business-institute-series

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