Welcome to Day 3!
Engaging Healthcare Providers to Counsel on Physical Activity and Referring Patients to AAEBIs

Tracy Carver & Seema Rathor, Comagine Health
Engaging healthcare providers to counsel on physical activity and to refer patients to arthritis-appropriate evidence-based interventions.

Tracy Carver, Director of Community Engagement
Seema Rathor, Senior Improvement Advisor
By the end of the presentation, we hope you’ll be able to

• Identify strategies for state public health departments and national grantees to engage and partner with health systems and providers
• Better understand the role healthcare team members can play in counseling and referral
• Hear at least one best practice or theory to translate into practice
Why should healthcare leaders prioritize arthritis?

The burden of chronic disease in the US makes up nearly one fifth of the Gross Domestic Product (GDP), with diabetes, heart disease, and arthritis accounting for some of the highest direct and indirect costs among chronic diseases.

The United States spends nearly twice as much as comparable countries, while experiencing worse outcomes.

Source: Commonwealth Fund, 2020
Why should healthcare leaders prioritize arthritis?

• Arthritis is not seen as a high priority condition in a busy practice, despite its prevalence (23% of all adults; 35% among Medicare beneficiaries).

• Arthritis is a leading cause of disability in the U.S and a significant contributor to inactivity, increasing the risk of obesity, diabetes, and cardiovascular conditions.

• Arthritis is present alongside other comorbidities: heart disease (49%), diabetes (47%), and obesity (31%).

• Nearly half experience arthritis attributable physical activity limitations and one in four reporting severe joint pain.

Source: MMWR, 2017; CMS, 2018; CDC 2021
Role of the State Health Department

- Infrastructure investment across departments
  - Build or support the building and utilization of sustainable referral systems (Health Information Technology)
  - Support alternative payment models
  - Engage health system leadership
  - Provide technical assistance, learning opportunities and technology supports

- Align efforts with other chronic disease programs

- Work with state medical associations to amplify message and engage and educate providers

- Support local AAEBI program providers to establish sustainable models for program delivery and receiving referrals from healthcare providers
Alignment with Chronic Disease Interventions

DP18-1815 and DP18-1817 Cooperative Agreements

- 1815 Category A:
  - Prediabetes Screening, Testing and Referral
- 1815 Category B:
  - Track and monitor clinical measures
  - Team based care
  - Link Community Resources and Clinical Services that support systematic referrals
- 1817 Strategy A.1: Bi-Directional E-Referral
- 1817 Strategy A.8: Electronic Health Record

Quality Measures for Alignment

- Patient Centered Primary Care Home
- Value based payment
  - e.g. CPC+ (sunsetting); Primary Care First
Report to the Oregon Health Authority: Recommendations for increasing physical activity counseling and clinical linkages

- Develop guidance on decision support processes and tools for health care providers to assist with identifying patients with arthritis who would benefit from physical activity.
- Develop guidance, tools and templates for health systems to leverage Health Information Technology in Oregon to promote physical activity counseling and bidirectional referrals to AAEBIs.
- Document and promote best practices for AAEBI programs and health care providers to use to empower and engage people with arthritis to participate in self-management programs and physical activity.
- Empower AAEBI program partners and healthcare champions through facilitating and supporting partnerships and program capacity.
Understanding the role of Care Teams
Aligning the workflow

• The approach must reflect the reality of competing demands within a practice.
• Aligning workflows and decision support tools with other chronic conditions can reduce the burden on care teams.
• Helping practices understand and integrate appropriate billing codes and modifiers to cover the time spent counseling and referring will help strengthen sustainability within the care process.
• Utilizing team based care members
Role of healthcare providers and teams

1. Assess physical activity levels for adults with arthritis
2. Counsel patients on options for low-impact physical activity
3. Refer patients to physical activity
Assess
Assess physical activity levels for adults with arthritis

Point of Care Assessments:
• Annual Wellness Visit assessment questions
• Chart scrubbing for other types of visit such as preventive or follow up visit

Retrospective EMR queries and reports:
• Using registry for outreach calls
• Population Health tools
Counsel
Counsel patients on options for low-impact physical activity

• Provider Tools
  • Evidence-based guidelines and protocols
  • Provider education and training
  • Collateral to share with patients
  • Decision support tools
  • Automatic referrals/opt-out default referrals
  • Motivational Interviewing (all staff)
Refer
Refer patients to physical activity

- Internal referral- setting up referral in EMR
- Identify local community resources accepting referrals
- Uni-directional /Bi-directional referrals
- Auditing and feedback on referral rates
Resources and tools

- Exercise is Medicine’s Health Care Providers’ Action Guide
- Osteoarthritis Prevention and Management in Primary Care Toolkit
- Comagine Health Tools:
  - Annual Wellness Visit Toolkit
  - Chronic & Principle Care Management Implementation Guidance
  - Quality Improvement 101 Tools
Thank you!

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Reimbursement Strategy Discussion

Timothy McNeill, Freedmen’s Health
Jennifer Raymond, Elder Services of Merrimack Valley
Dr. Adam Burch, New Hampshire Arthritis Program
Timothy McNeill, Freedmen’s Health
Sustainable Alignment of CBO Interventions with Healthcare to Achieve Improved Clinical Outcomes

Timothy P. McNeill, RN, MPH
May 2021
Healthcare Must Address: The Whole Person

- Medical
- Behavioral
- Social Needs
COVID-19 Pandemic | Dramatic Changes to Health Policy

- March 13, 2020: Presidential Declaration of a National Emergency
- HHS Secretary issued a Public Health Emergency pursuant to section 319 of the Public Health Service Act
- Changes will stay in effect for the Duration of the Public Health Emergency
COVID-19 Pandemic: Some Groups are more Impacted than Others

The Freedmen’s Health Team is currently deploying statewide care innovation models in the following States and Regions—Maryland, Alabama, *Dually Eligible disproportionately impacted Health Equity Issues Present across Aged, Disabled, and ESRD Populations

![COVID-19 Hospitalizations Chart]

*Dually Eligible disproportionately impacted
COVID-19 Pandemic: Some Groups are more Impacted than Others

*53% of COVID-19 Hospitalizations are discharged to community
Duals and ESRD Population: Healthcare Demographics

- 12.2 Million People are dually enrolled in Medicare & Medicaid
- 41% have at least one mental health diagnosis
- 49% receive Long-term Services and Supports
- 60% have multiple chronic conditions

Blanket Waivers | Increase Adoption of Telehealth

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration’s aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS’s regional offices.

Flexibility for Medicare Telehealth Services

- Telehealth and Remote Patient Monitoring allowed without Geographic Restriction Nationwide
  - In-Home can be a delivery site
  - Example of Covered Services:
    - Medical Visits
    - Transitional Care Management
    - Chronic Care Management Services
    - Diabetes Self-Management Training (DSMT)
    - Medical Nutrition Therapy (MNT)
Specific Waivers to Address TeleHealth Adoption | Increase Access

- Telehealth: Real-Time, Two-Way Video and Audio Connection between the beneficiary and the provider
  - No Geographic Restriction
  - Services can occur in the home
  - Provider can be in their respective home

- Blanket Waivers for PHE
  - Waiver to allow Phone-Only (Audio) connection during the Public Health Emergency
  - Waiver to allow for not collecting co-pays for telehealth services during the PHE
  - Waiver to allow for use of non-HIPAA compliant platforms to conduct telehealth visits
    - Example: FaceTime
Are Blanket Waivers Permanent | What Happens After the Pandemic is Over?

- CY2021 CMS Physician Fee Schedule
- Makes Permanent the telehealth geographic waivers and expansion of telehealth for CY2021
- Even if the Pandemic is declared over before the end of CY2021, the waivers will stay in place
- CMS is seeking comment on the feasibility of permanent adoption of current waivers
Healthcare Digital Divide | Which Groups Have Access?

- Nearly half of people 65 years and older don’t own a video-enabled device like a smartphone
- Nearly 1 in 4 low-income patients lack the intern or data access necessary for a video visit
- Nearly 60% of those without a high school education don’t own a video-enabled device like a smartphone
- Some subsidized cell phone or low-cost programs have phones with limited broadband capability
Best Practices | Training and Support

The Freedmen’s Health Team is currently deploying statewide care innovation models in the following States and Regions – Maryland, Alabama, ...

- Assess the persons access to devices to support Telehealth
- Determine if a caregiver or aide can assist with telehealth utilization
- Determine if there are local programs that can support access
- Do not assume that everyone is proficient using video applications
- Provide training for participants prior to implementing a service
- Utilize online training programs
  - Example: AARP
Crosswalk to Services | Increase Adoption of Telehealth

- Chronic Care Management (CCM)
- Collaborative Care Management (CoCM)
- Diabetes Self-Management Training (DSMT)
- Health and Behavior Assessment and Intervention (HBAI)
- Medical Nutrition Therapy (MNT)
- Transitional Care Management (TCM)
- Medicare Diabetes Prevention Program (MDPP)
## EBPs as a Component of Medicare Services

<table>
<thead>
<tr>
<th>Part B Service</th>
<th>EBPs That Can Be Incorporated Into the Care Plan</th>
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<tbody>
<tr>
<td><strong>CCM</strong></td>
<td>• Fall Prevention Interventions</td>
</tr>
<tr>
<td></td>
<td>• CDSMP</td>
</tr>
<tr>
<td></td>
<td>• Chronic Pain Self-Management Program (CPSMP)</td>
</tr>
<tr>
<td></td>
<td>• Enhanced Wellness</td>
</tr>
<tr>
<td></td>
<td>• Health Coaching</td>
</tr>
<tr>
<td><strong>CoCM</strong></td>
<td>• PEARLS</td>
</tr>
<tr>
<td></td>
<td>• Healthy IDEAS</td>
</tr>
<tr>
<td><strong>DSMT/MNT</strong></td>
<td>• DSMP</td>
</tr>
<tr>
<td></td>
<td>• Diabetes Prevention Program (DPP)</td>
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<tr>
<td><strong>HBAI</strong></td>
<td>• Arthritis Management Support</td>
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<tr>
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<td>• CDSMP</td>
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<tr>
<td></td>
<td>• Chronic Pain Self-Management Program (CPSMP)</td>
</tr>
<tr>
<td></td>
<td>• HIV Positive Self-Management (PSMP)</td>
</tr>
<tr>
<td></td>
<td>• Cancer Thriving and Surviving (CTSP)</td>
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### CPT/HCPCS Code List for Care Management

<table>
<thead>
<tr>
<th>Care Management Codes CY2021</th>
<th>CPT/HCPCS Code</th>
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<tbody>
<tr>
<td>TCM Moderate complexity 14 days</td>
<td>99495</td>
</tr>
<tr>
<td>TCM High complexity 7 days</td>
<td>99496</td>
</tr>
<tr>
<td>RPM initial setup</td>
<td>99453</td>
</tr>
<tr>
<td>RPM monthly monitoring</td>
<td>99454</td>
</tr>
<tr>
<td>RPM interactive communication w/Pt or caregiver</td>
<td>99457</td>
</tr>
<tr>
<td>CCM - Initial Plan of Care</td>
<td>G0506</td>
</tr>
<tr>
<td>CCM every Calendar month</td>
<td>99490</td>
</tr>
<tr>
<td>CCM Non-Complex ea. additional 20 min</td>
<td>99439</td>
</tr>
<tr>
<td>Complex Chronic Care Mgmt</td>
<td>99487</td>
</tr>
<tr>
<td>CoCM - Initial</td>
<td>99492</td>
</tr>
<tr>
<td>CoCM - Ongoing</td>
<td>99493</td>
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</table>
CBO Led Care Transition Model: Coordination of Medical + SDOH

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
<th>National Rate</th>
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</thead>
<tbody>
<tr>
<td>99496</td>
<td>Transitional Care Management 7-day discharge</td>
<td>$247.94</td>
</tr>
<tr>
<td>99497</td>
<td>Advanced care plan 30 min</td>
<td>$86.98</td>
</tr>
<tr>
<td>G0444</td>
<td>Depression Screening</td>
<td>$18.41</td>
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<tr>
<td>G0506</td>
<td>CCM Initial Plan</td>
<td>$63.52</td>
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<tr>
<td>99490</td>
<td>Chronic Care Management 20 min</td>
<td>$42.22</td>
</tr>
<tr>
<td>99439</td>
<td>Chronic Care Management non-complex additional 20 min X 2</td>
<td>$75.78</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>$534.85</td>
</tr>
</tbody>
</table>
SDOH Intervention Example **Food Insecurity with Fall Risk**

1. **Arthritis Diagnosis + Fall Risk + Food Insecurity**
2. **Clinical Team Refers for SDOH Intervention**
3. **Closed-Loop Referral between Healthcare and CBOs**
4. **CBO completes SDOH + STEADI assessment/Plan**

**Action Plan:**
- **CPT/HCPS**
  - G0506
  - 99495
  - 99496
- **CPT/HCPS**
  - 97802 x 3
  - 99490
  - 99439 x 2

**Claim Submission with payment to CBO for intervention. Total Avg Collection = $296.27+**

**Referral Status Outcome to Provider**

**Fall Prevention Program + Chronic Care Management Services**
SARCOA: Fall Prevention Examples from the Field

• CBO Location: Dothan, Alabama

• Currently contracted with a Major Health insurer to serve high-risk health plan members across the State as a Network Lead Entity (NLE)

• Health plan submits a report of members with high utilization including a recent ED visit or Hospital admission for a fall

• CBO receives the electronic referral and conducts outreach to member

• CBO Member engagement + Interventions
  • Assess for Fall Risk
  • Health Plan trained CBO to screen for Bone Density (Current Osteoporosis HEDIS Quality Measure)
  • Reduce fall risk in the home
  • Enroll in a Fall Risk Reduction Program (Tai Chi)
  • CBO receives reimbursement (per member per month payment model)
Value Add: CBO Helps Health Plan Improve Clinical Quality for Bone Density Screens
The Freedmen's Health Team is currently deploying statewide care innovation models in the following States and Regions – Maryland, Alabama.

Timothy P. McNeill, RN, MPH
Direct: 202-344-5465
Email: tmcneill@freedmenshealth.com
Jennifer Raymond, Elder Services of Merrimack Valley
AAEBI Reimbursement Strategies

Partnerships, Payors & Policy

Jennifer Raymond, JD, MBA
Elder Services of the Merrimack Valley and North Shore (Massachusetts)
Our Role in the Aging Network

Largest AAA in Massachusetts, serving 28 cities and towns (and hundreds of communities within them)

Serve over 40,000 older adults annually

450+ employees and 450+ volunteers

40+ programs

Home of Statewide contracting network for evidence-based programs (Healthy Living Center of Excellence)
Partnering for sustainability: Our Statewide Network

80+ member provider network, including:

• AAA/ASAPs
• COAs
• ILCs
• Multicultural Organizations
• Faith Based Organizations
• YMCA
• Housing
• Community Health Centers
Partners: Creating a Value Proposition for Network Members

- Common mission and goals
- Ongoing workforce training and technical assistance
- Convenor of health care partners
- Referral streams = full workshops
- Centralized website
- Grant/funding expertise
- Reimbursement for program delivery
Payors: Health Care Contracting

- Medicare/Medicaid plan: Evidence based programing, including AAEBI
- Medicaid ACOs: Nutrition
- Medicare Advantage: Falls Prevention and Management / Physical Activity
Payors: Contract Reimbursement

- HLCE Single contract for all regions/programs
- Executed Contract: EBPs and AAEBIs, including disease management, pain management, and physical activity
- Four-pronged referral approach
  - Registry of high risk members identified through internal analytics
  - GSSC (Geriatric Support Services Coordinator) referrals
  - Referrals from case/care managers and other SWH providers
  - Self-Referral
- Reimbursement tied to completion outcomes
Policy: 1915 HCBS Medicare Waiver

- Approved in 2019
- Covers all evidence-based programs, including in person, group and remote delivery
- Allows community-based organizations who contract with AAAs to bill for EBPs
- Direct Service Waiver
- Reimbursement based on program participation
Jennifer Raymond, JD, MBA
Elder Services of the Merrimack Valley and North Shore

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978-946-1298
Dr. Adam Burch, New Hampshire Arthritis Program
STRATEGY 2 RESOURCE FOR STATES

Adam Burch, DC, MPH

NH Healthy Lives
PREVENT • PROMOTE • PROTECT
SOME ASSEMBLY REQUIRED

• Clinical terminology
  ○ ICD, CPT, SOAP, HEDIS, UDS, physician, provider, allied health, force multiplier

• Insurance terminology
  ○ Eligible, allowable, timed, bundled, supervised

• EHR terminology
  ○ Form, field, table, event, trigger, flag, report

• Sales tactics
  ○ Option attachment, pacing, reciprocity, damaging admission, common enemy, understatements, hypnotic language patterns

• Public Speaking
  ○ Vocal variety, tone, timbre, cadence, pauses, fillers, mirroring, nonverbal ques, positioning, props
PHYSICAL ACTIVITY

Improving patient outcomes while getting reimbursed

NH Healthy Lives
PREVENT • PROMOTE • PROTECT
MINIMUM PHYSICAL ACTIVITY

• 150 minutes per week
  o moderate intensity
• 75 minutes per week
  o vigorous intensity PA
• CDC, AAFP, ADA, AHA, ACSM, ACS
BENEFITS OF REGULAR PHYSICAL ACTIVITY

- Decreased HbA1c, BMI & Systolic BP in DMII
- Decrease Systolic and Diastolic BP in HTN
- Decreased risk of DMII
- Decreased risk of CVD
- Decreased risk of cancer at additional sites
- Improved GAD-7 and PHQ-9
- Improved Cognition ages 6 and up
UDS MEASURES

• Weight Assessment and Counseling of Nutrition and Physical Activity for Children and Adolescents

• Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

• Preventative Care and Screening: Screening for Depression and Follow-Up Plan

• Controlling High Blood Pressure

• Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
PHYSICAL ACTIVITY SCREENING

• On average, how many days per week do you engage in moderate to strenuous exercise?

• On average, how many minutes do you engage in exercise at this level?
CURRENT EHR PHYSICAL ACTIVITY SCREENING
PROPOSED EHR PHYSICAL ACTIVITY SCREENING
WHY CHANGE NOW?

• CMS Pub. 100-04 Transmittal 10505 Change Request 12071
  o 99201-99205, 99211-99215 time based services
  o Effective January 01, 2021
  o Standardized in accordance with AMA CPT Editorial Panel recommended changes
  o Change mirrored by all NH insurers
HOW TO DOCUMENT FOR REIMBURSEMENT

- Screen patients using 2 question evidence-based tool
  - Is the patient under the recommended 150 min per week?
- Add ICD 10 diagnosis code Z72.3
- Record time spent counseling and referring in SOAP
  - ICD 10 code in Assessment section
  - Minutes spent counseling and referring in Plan section
- Bill for total time spent with patient in minutes E&M
COMMERCIAL INSURANCE

• Total number of minutes spent with patient dictates which E&M code you select

• For every documented 15 minutes spent in patient education increase billed amount by 1 level (99202 → 99203)
CALCULATING POTENTIAL REIMBURSEMENT INCREASE

• Select commercial insurance carrier and pull number of patient encounters with E&M codes 99201-99204, 99211-99214.

• Calculate average visit income

• Move each encounter up 1 category and recalculate
  
  ○ This represents enough minutes of patient education to push the total minutes spent not 15 minutes of patient education only
ANTHEM BCBS EXAMPLE

• 100 visits 99203 @ $152.20 per patient
• 75 visits 99204 @ $230.94 per patient
• AVI = ((100*152.20) + (75*230.94))/175 = $185.95
• Shift 99203 → 99204, shift 99204 → 99205
• AVI = ((100*230.94) + (75*290.79))/175 = $256.59

- Average revenue increase of $70.64 per patient screened, counseled and referred with documentation
MEDICARE/MEDICAID

• CMS form 224-14
  o Direct cost of services

• Market Basket Forecast
  o Used to determine future Prospective Payment System rates

NH Healthy Lives
PREVENT • PROMOTE • PROTECT
CAN I JUST USE THE EXISTING PHYSICAL ACTIVITY QUESTION?

• Insurance Audit
  o Legitimate time coding per new CMS guidelines
    ▪ Diagnosis code (Z72.3) Physical Inactivity ✓
      ✓ Recognized diagnostic criteria for diagnosis (150 minutes/wk PA) ✓
      ✓ Validated diagnostic tool ✗ (currently collect days per week)
    ▪ Treatment plan to address diagnosis
    ▪ Documentation of effort
  o Compare against other diagnosable conditions
    ▪ HTN, Obesity, DMII

NH Healthy Lives
PREVENT • PROMOTE • PROTECT
HOW MUCH WILL THIS COST?

• Initial Cost
  o NH Arthritis Program (CDC funding)

• Ongoing maintenance
  o No ongoing maintenance costs in excess of current upkeep

• Training
  o NH Arthritis Program (CDC funding)
  o Pfizer

• Implementation incentives, reimbursement increases
CREATE THE CAPABILITY NOW, IMPLEMENT LATER!

Waiting too long to make the EHR changes to plan for future implementation will result in loss of currently available funding to cover all of the implementation and training costs.