ADVANCING ARTHRITIS PUBLIC HEALTH PRIORITIES
THROUGH NATIONAL ORGANIZATIONS (CDC-RFA-DP21-2106)

Arthritis Advisory Panel Design Session #5
Tuesday, July 11, 2023 – 10:00-11:30 A.M. ET

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Funding Attribution

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Design Sessions

May 9 **Screening Arthritis Pt's for QoL**

May 23 **Brief Advice / Counseling**

June 13 **Referral**

June 27 **Care Coordination**

July 11 **Reimbursement and Beyond**

July 25 **Evaluation**

Agenda

- Welcome and Agenda Review
- Reimbursement Discussion
- Reflections on Arthritis Model of Care
- Closing/Next Steps

Opportunities to Reimburse Screening, Counseling, Referral for Health Systems

Billing and Reimbursement for Comprehensive Arthritis Care

ADAM BURCH, DC, MPH

NH DEPARTMENT OF HEALTH & HUMAN SERVICES

CMS Pub. 100-04 Transmittal 10505 Change Request 12071

- AMA and CMS changed the qualification requirements for E&M Codes
- Effective Jan 01, 2021
  - 99201 – 99205 E&M New Patient, 99211 – 99215 E&M Existing Patient
    - 99201 dropped
    - Time Spent or Medical Decision Making
- Impacts
  - If total time spent is greater than medical decision making, time may be used to select the appropriate code

Documentation for time spent screening and counseling for physical activity

- Subjective
  - Relevant chief complaint where insufficient physical activity is a known risk factor
  - Annual well office visit
- Objective
  - Physical Activity Measurement using a research validated tool
    - Physical Activity Vital Sign
- Assessment
  - Secondary diagnosis of physical inactivity (Z72.3)
    - Attached to relevant primary diagnosis (arthritis, T2 diabetes, high blood pressure)
- Plan
  - Document time spent counseling in minutes
  - Documentation of patient education materials provided
  - Documentation of referrals made or goals set by patient

CMS Pub. 100-04 Transmittal 11708 Change Request 12982

- Creation of CPT Codes G3002 and G3003
- Effective Jan 01, 2023
  - G3002 – Chronic Pain Management 30 Minutes, G3003 – Each Additional 15 minutes
    - Provided by a Physician or other qualified health care professional
      - Must have prescribing privileges to qualify
    - Time increments are per month not per encounter
- Impacts
  - Can be combined with E&M codes to reflect that managing patients with chronic pain effectively can require greater amounts of time spent with patients than the 99211 – 99215 codes can account for

Documentation for time spent for treating chronic pain

- Subjective
  - Chief complaint related to chronic pain
    - Osteoarthritis, Rheumatoid Arthritis
- Objective
  - Physical Activity Measurement using a research validated tool
    - Physical Activity Vital Sign
  - Pain and disability measurement using a research validated tool
    - PROMIS Physical Function, PROMIS Pain Interference
- Assessment
  - Primary Diagnosis related to chronic pain
    - Secondary diagnosis of physical inactivity (Z72.3)
- Plan
  - Document time spent counseling in minutes
  - Documentation of patient education materials provided
  - Documentation of referrals made or goals set by patient

3rd Party Payers for both set of Codes As of Jan 01 2023

- 99202 – 99205 & 99211 – 99215 E&M Codes
  - Medicare
  - Medicare Advantage
  - Medicaid – NH verified, other states would need verification
  - Commercial Insurance – NH verified, other states would need verification
- G3002 & G3003
  - Medicare
  - Medicare Advantage

Sample Patient Encounter #1 Inactive Adult without diagnosed OA

- 48 YO female patient, sedentary job, elevated cholesterol, elevated blood pressure, follow up appointment for ER visit CC of angina
  - 27 minutes spent with patient related to recent ER visit
    - History of present illness, focused exam, patient education on angina and elevated risk of heart attack and stroke
  - 13 additional minutes spent counseling on the benefits of physical activity related to controlling cholesterol and reducing blood pressure
- As long as all elements are documented accordingly the most appropriate time based code for E&M including physical activity counseling is 99213. Based on the previous Medical Decision Making model the most appropriate code would be 99212.

Sample Patient Encounter #2 Inactive Adult with diagnosed OA

- 73 YO male, bilateral knee osteoarthritis, hypertension, T2 diabetes, not a surgical candidate for bilateral knee replacement surgery, worsening of diabetes symptoms, medication adjustments needed, recent diabetic neuropathy symptoms reported.
  - 45 minutes performing a comprehensive medication review, reviewing recent laboratory work, cholesterol management, A1c levels, elevated risk of diabetic foot ulcers leading to foot amputation, referral to podiatry, referral to a Diabetes Self-Management Education Specialist, modification of prescriptions
  - 30 additional minutes discussing chronic pain, how poorly managed T2 diabetes can increase average daily pain levels, long term risks of pain medication usage, non-pharmacological pain management strategies and the role of low intensity physical activity in reducing average daily pain levels
- The most appropriate coding would be 99215-25, G3002

Medicare Reimbursements for Sample Patients 1 & 2

- Sample Patient #1 for a Non-Facility Medicare Provider in NH
  - Not including physical activity component
    - 99212 - $57.86
  - Including physical activity component
    - 99213 - $92.06
- Sample Patient #2 for a Non-Facility Medicare Provider in NH
  - Not including pain management component
    - 99215 - $182.13
  - Including pain management component
    - 99215-25 - $182.13
    - G3002 - $81.70

Opportunities to Reimburse Care Coordination/ Coaching/ AAEBIs

Jennifer Raymond, JD, MBA

AgeSpan

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Choices for Life's Journey






AAEBI Reimbursement Strategies

Partnerships, Payors, and Policy

Jennifer Raymond

Chief Strategy Officer

July 11, 2023

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)**

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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

the healthy living Center of Excellence

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Payors: Health Care Contracting

- **Medicare/Medicaid plan: Evidence based programing, including all AAEBI**
- **Medicaid ACOs: Nutrition (and Physical Activity)**
- **Medicare Advantage: Falls Prevention and Management / Physical Activity**

SWH
SENIOR WHOLE HEALTH

Lawrence General Hospital

Harvard Pilgrim Health Care

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Payors: Health Care Contracting

- HLCE Single contract for all regions/programs
- 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
- HRSN/SDOH screening
- Health care payor approves plan
- Reimbursement tied to completion outcomes
- Some tired to 1115 Medicaid Wavier

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Policy: HCBS Medicare Waiver

- 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

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Let’s learn together

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Timothy McNeill, RN, MPH

Freedman’s Health

Health Coaching and Chronic Care Management CPT code Overview for Evidence-Based Program Delivery

Timothy P. McNeill, RN, MPH

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Chronic Care Management Codes

Chronic Care Management – 2023 National Rates

CCM

- G0506: Chronic Care Management Care Plan (1 time per annum) = $59.26
- 99490: First 20 minutes (Non-complex) = $60.15
- 99439: Each subsequent 20 minutes (Non-complex) = $45.46
- **Rate for 1 hour (Non-complex) = $151.07 per patient per month**
- 99487: Complex Chronic Care Management (60 Minutes) = $127.18

Collaborative Care Management Business Model – 2023 Rates

- Every patient with a mental health diagnosis is eligible
- Care coordination activities that addresses mental health counts for CoCM
- Any type of mental illness qualifies to include depression or anxiety disorder. The diagnosis does not have to be a serious mental illness to quality
- Must establish a registry of patients with mental health comorbidity
- There must be monthly coordinating with a consulting psychiatrist
- 99492: Initial Collaborative Care Visit (70 Minutes/mo.) = **$143.69**
- 99493: Subsequent CoCM per month (60 minutes/mo.) = **$136.57**
- 99492: Each additional 30 minutes/mo. = **$55.37**

Care Management Rates for FQHCs

- FQHCs use different codes for care management services. There is a flat rate for FQHCs and the rate does not vary by geography.
- Rates

HCPCS Code	Description	Rate
G0511	General Care management (20 minutes/month)	**$77.94**
G0512	Psychiatric Collaborative Care (70 minutes the firs month; 60 minutes/subsequent month)	**$146.73**

- There is no provision for additional calendar month billing for FQHCs (one fixed flat payment per month)
- CMS Policy Link: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center

ASPE Analysis of CCM/TCM Utilization

- ASPE Report on the 2019 utilization of CCM and TCM by eligible Medicare beneficiaries:

Exhibit 2: Medicare FFS Beneficiaries Receiving CCM or TCM Services in 2019

Category	CCM	TCM
Total Medicare FFS beneficiaries with Part B coverage	35,598,051	35,598,051
Number of FFS beneficiaries potentially eligible for CCM or TCM	22,570,404	6,282,242
Percent of FFS beneficiaries potentially eligible for CCM or TCM	63.4%	17.7%
Beneficiaries with one or more CCM or TCM claims	882,728	1,078,580
Percent of potentially eligible beneficiaries with CCM or TCM claims	4.0%	17.9%

https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf

HEALTH CARE CONTRACTING

Addressing health related social needs (HRSN) through the integration of social care and medical care in a Primary Care First practice.

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Current State

Fee For Service Billable Codes

Billing Code	Code Description	Summary Requirements
HCPCS G0506	Comprehensive Assessment & Care Planning	▪ Patient enrolled in person ▪ Systematic assessment & care planning personally performed by the billing provider ▪ Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit
CPT 99490	Standard CCM	▪ 20+ minutes of care management outside of office visits performed by clinical staff ▪ Care plan established and regularly reviewed
CPT 99439 (New in 2021)	Non-complex Add-on	▪ Additional 20 minutes of "non-complex" CCM ▪ Reportable up to 2x per month (after 99490)
CPT 99487	Complex CCM	▪ 60+ minutes of care management outside office visits ▪ Care plan created and/or significantly revised
CPT 99489	Complex Add-on	▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case

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INTEGRATED SOCIAL & MEDICAL CARE WORKFLOW

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In Lieu of Services / Health Coaching Codes

Community Care Hub Contracting Experience

- Oregon Wellness Network (OWN)
  - Statewide CCH contracted with CBOs across the State
  - OWN has a contract with Providence Health System to support hospital transitions for high-risk admissions
  - OWN is the largest provider of Diabetes Prevention Program (DPP) services using networks of CBOs in the State of Oregon
- Own has successfully secured one of the first ILOS contracts with a Medicaid Managed Care Plan in Oregon to provide HRSN screening and social care navigation to address identified needs.

Key Learnings from the CCH Contracting Process

- Defining the Services
- Billing Codes for the services
- Pricing proposal justification
- Cost Effectiveness justification
- Target population
- Data reporting requirements
- Working with Social Care Referral Platforms: Unite Us and FindHelp

Defining ILOS Services in a Proposal

- CCH proposed to provide the following services:
  - HRSN screening,
  - Reporting identified HRSNs, and
  - Providing social care navigation to address identified HRSNs.
- Oregon Health Authority (OHA) [Medicaid] advised that the activity of screening alone cannot be an ILOS service.
- Health Plan executed a contract with OWN but the HRSN screening/reporting has to be bundled with the social care navigation.
- The labor associated with completing the screen and documenting the screen is not a separately billable activity.

ILOS Services Action Steps

- Health Plan executed a contract with OWN but the HRSN screening/reporting has to be bundled with the social care navigation.
- The labor associated with completing the screen and documenting the screen is not a separately billable activity.
- OWN will work with referring providers that will identify persons that have a prescreen that is positive for HRSNs.
- Based on the pre-screen, OWN will complete a more comprehensive screen and immediately begin the care coordination process as a bundled activity.

Billing Codes for Proposed Services

- Medicaid Plan required the CCH to propose the codes to correlate with the service.
- CCH proposed the following CPT Codes:
- Category III codes for Health Coaching are listed as the following:
  - 0591T: Health and Well-being Coaching face-to-face; individual, initial assessment
  - 0592T: Individual, follow-up session, at least 30 minutes
  - 0593T: Group (two or more individuals), at least 30 minutes
    - Group participation in evidence-based programs
- Health plan accepted the Health Coaching Codes to quantify labor for providing social care navigation to address HRSNs.

Pricing Proposal Justification

- Health Plan requested a National Benchmark for the proposed price for the Health Coaching.
- CCH used the pricing for Medicare Chronic Care Management to provide a national benchmark for the price proposal.
- Challenge: The Health Coaching CPT codes have a 30-minute time increment and the CCM has a 20-minute time increment.

Final Pricing Accepted

- Final Price Negotiation Accepted:
  - CCM National Rate for 20 Min (Non-Complex) = $60.15
  - CCH took the rate for 10 min and multiplied by 3
  - [$60.15/2] X 3 = $90.23 for 30 minutes of Health Coaching

Cost Effectiveness Justification

- CCH had to provide the Medicaid covered services that would be expected to be off-set by providing HRSN coordination In Lieu of Services.
- Proposal: The CCH will work with hospitals in the State to screen for high-risk members that have a recent acute care admissions or ED visit that is complicated by HRSNs.
- Social Care Coordination will be provided to address HRSNs and participation evidence-based programs to improve disease self-management capability. There is a reasonable expectation that over a five-year period there will be a subsequent reduction in utilization of the following Medicaid benefits:
  - ED Visits (Falls, Disease complications, chronic pain, etc.)
  - Inpatient Admissions
  - Reduced Inpatient Length of Stay
  - Reduced SNF Admissions
  - Reduced SNF Length of Stay

ILOS Justification Outline

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Health Coaching to Address HRSNs and improve Disease Self-management skills

In Lieu Of

Increased inpatient admissions, ED Visits, SNF admissions

Target Population

- Persons with Medicaid Coverage admitted to an acute care hospital or with frequent ED Visits with a chronic condition and have HRSNs contributing complications for their admission.
- Key HRSN – The inability to self-manage chronic conditions due to reduced health literacy, socioeconomic status, cultural factors, or other contributing issues.

Data Reporting Requirements

- CCH must report the following to the Medicaid Plan
  - HRSN Screening at the individual and aggregate level
  - Identified Needs
    - Reporting HRSNs with Z-Codes on Claims
  - HRSN trends based on the screening
  - Resources available to meet identified needs (Public, Private, Philanthropic)
  - Resolution of identified needs
  - Percentage of the population screened with multiple needs
  - Percentage of the population that have their needs resolved
- Key learning: The CCH must have control of their data to be compliant with the contract deliverables. If the CCH outsources control of the data, they put their contract at risk.

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Thank You

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Comagine Health

Tracy Carver and Theresa Kreiser

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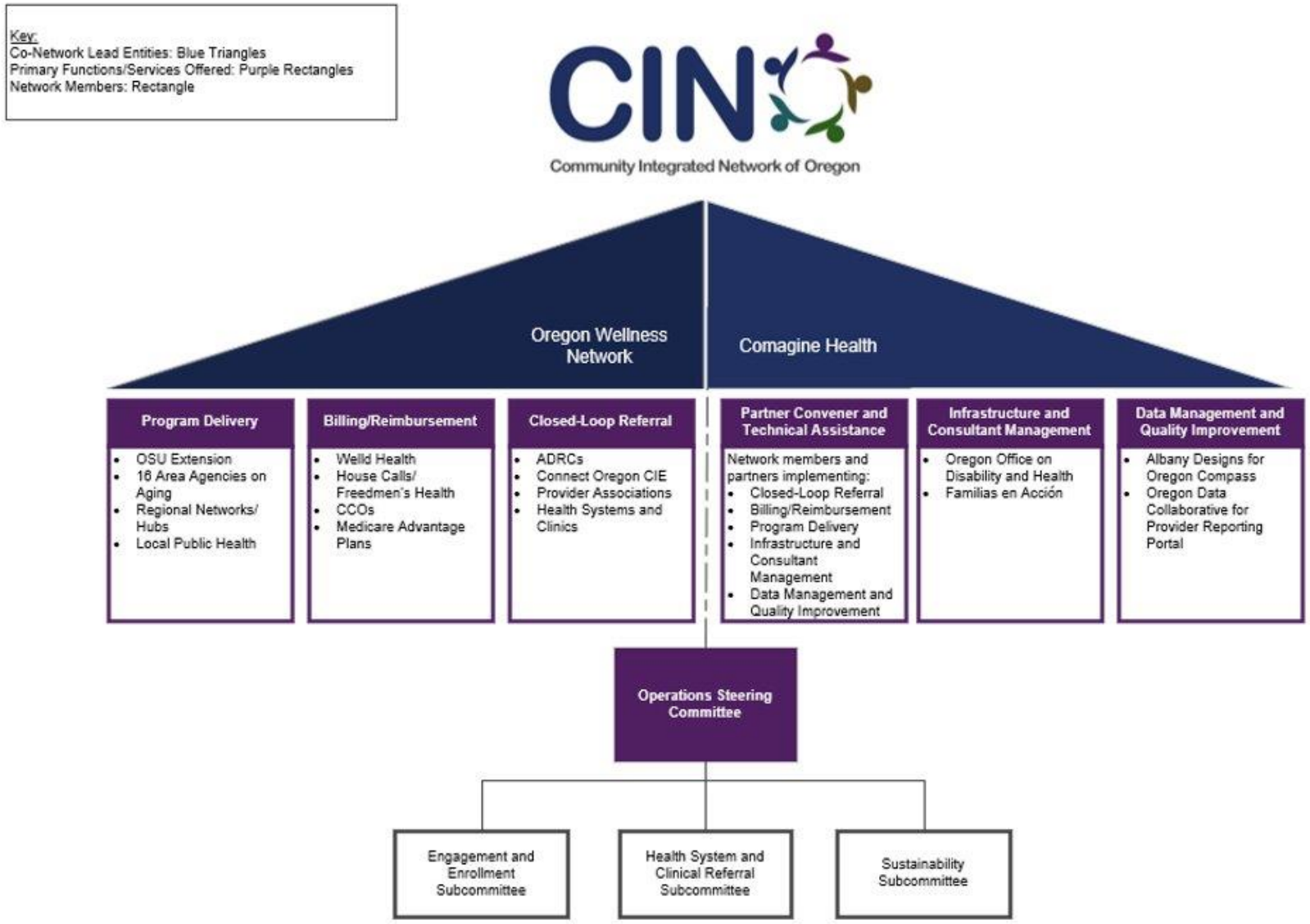
The Quest for Chronic Disease Self-Management Education Medicaid Coverage

Tracy Carver, Sr. Director of Community Health

Theresa Kreiser, Sr. Improvement Advisor

Community Integrated Network of Oregon



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Other folks to know!

- Community Integrated Network of Oregon (CINO)
- Oregon Health Authority (OHA)
- Health Evidence Review Commission (HERC)
- Value-based Benefits Subcommittee (VbBS)
- Evidence-based Guidelines Subcommittee (EbGS)
- OHSU Center for Evidence Based Policy
- Chronic Disease Self-Management Education (CDSME) Programs

Comagine Health's Role

- Writing and submitting initial HERC consideration letter (with feedback from CINO's subcommittees)
  - This letter was signed by 37 partner organizations across Oregon
- Coordinating public testimony
  - 12 written testimony submissions
  - 3 verbal testimony submissions
- Consulting with OHA and OHSU to inform the scope statement for the EbGS report
- Reviewing new scope and coordinating 2nd round of testimony

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Evidence Provided to HERC for CDSME coverage

Goal – To synthesize arguments related to HERC's 5 principles and ensure that the literature available is the most accessible and useful for the arguments we want to make to HERC.

5 principles for HERC consideration

1. Represents a significant burden of disease or health problem
2. Represents an important uncertainty with regard to effectiveness or harms
3. Represents an important variation or controversy in implementation or practice
4. Represents high costs or significant economic impact
5. The topic is of high public interest

40 studies total

- 25 studies regarding SMRC programming specifically
- 6 studies based on self-management programming generally (not necessarily SMRC programs)
- 11 studies ultimately decided were outside of scope

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Lessons Learned

- We are challenging the “norm” for how and what interventions are considered for coverage. This is a new type of intervention and approach for HERC to take in their traditional process.
- This work is as much new for HERC and OHA as it for our team
- “Know the process, respect the process.” -Dr. Lessler
- Be prepared to start, stop, sprint, and jog all at a moment's notice
- There is a balance for when and how to gather input from partners for collective action.
- Always register for public testimony.

New York Medicaid Reimbursement

- Over the past two years, the New York State Department of Health (NYSDOH) Arthritis Program and Office of Health Insurance Programs (OHIP) have been pursuing possible avenues for Medicaid reimbursement for the Chronic Disease Self-Management Program (CDSMP)
- **CDSMP is now approved in the NYS budget for adult Medicaid enrollees with a diagnosis of arthritis.**
  - Article VII, Part R of the NYS budget declares that CDSMP will be a covered benefit for NYS Medicaid enrollees, with a diagnosis of arthritis, when referred to the program by a healthcare provider.
  - This benefit is for adults with a diagnosis of any form of arthritis, not just osteoarthritis.
  - This coverage applies to all formats of CDSMP (in-person, virtual, and phone workshops).
- **It is expected that this benefit will take effect on October 1, 2023.**
- Over the next few months OHIP and partners will continue to work out details such as billing and coding.
- This mechanism will help to reach more New Yorkers with arthritis who would benefit from CDSMP but may have experienced barriers to participation due to social and health inequities and disparities.

Reflections on Arthritis Model of Care

Lisa Erck, MS and Shalu Garcha, MHA

Closing and Evaluation

Thank you!