CENTER FOR ADVANCING HEALTHY COMMUNITIES | NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS — Promoting Health. Preventing Disease.

National Association of Chronic Disease Directors
Arthritis Advisory Panel Design Session #5 – Reimbursement mechanisms to support the arthritis care model
July 11, 2023 @ 10:00 a.m. ET

Notes and Summary Document

- Meeting recording
- Additional information: Please visit the private Advisory web page for a link to the recording from today, summary documents and additional information

Participants:

34 Total Participants (including presenters and facilitators)

Project Overview:

The National Association of Chronic Disease Directors (NACDD) Arthritis Portfolio, Centers for Disease Control and Prevention (CDC) and other key partners are working to develop an arthritis care model that supports innovative efforts that enhance healthcare provider awareness, knowledge, and skills in promoting physical activity as an effective, drug-free way to relieve arthritis pain, improve function, and limit arthritis progression.

Design Session #5 Objectives:

- Explore referral mechanisms to support the arthritis care model
- Assess implications to arthritis care model pathway
- Engage in peer-to-peer sharing, learning, and networking

I. Presenters:

A. Welcome
- Lisa Erck, NACDD

B. Reimbursement mechanisms to support the arthritis care model
- Dr. Adam Burch, New Hampshire Department of Health and Human Services
  - Billing and reimbursement for comprehensive arthritis care
- Jennifer Raymond, AgeSpan
  - Opportunities to reimburse care coordination, health coaching, and AAEBIs
- Tim McNeill, Freedman's Health
  - Opportunities to reimburse care coordination, health coaching, and AAEBIs

C. Reflections on Arthritis Model of Care
- Shalu Garcha, NACDD

II. Discussion Summary:

A. Billing and reimbursement for comprehensive arthritis care

1. Evaluation and Management (E&M) Codes
   - Provider needs to show documentation for time spent screening and counseling for physical activity
     - Relevant chief complaint where OA is a known risk factor
     - Physical activity levels (e.g., PAVS)

        - Secondary diagnosis of physical inactivity (Z72.3) that is attached to relevant primary diagnosis (e.g., arthritis)
        - Document plan (e.g., counseling, patient education, referrals made)
2. New Medicare Codes (G3002 – face to face for first thirty mins, and 3003) as of Jan 2023. For more details, please review [CMS web-cast]
    - Chronic pain management codes
    - Billed on monthly encounter rate
    - Can be combined with E&M codes
    - Qualified provider is physician or qualified health care professional (HCP that can prescribe)
3. For Chronic Pain and G codes
    - Need chief complaint of chronic pain
    - Chronic care codes: Pain must be assessed with a validated tool (e.g., PROMIS, visual analog, other tools recommended in CMS guidance.) Physical activity code - PAVS if PA is a recommended strategy for assessment
    - Primary diagnosis related to chronic pain and secondary diagnosis of physical inactivity
    - Plan is to document time spent (counseling, patient education, referrals)
    - Chronic pain codes can only be billed by prescribers, so they are inaccessible to ancillary staff in a team-based approach for the immediate future as these codes are intended to reduce opioid overuse by chronic pain patients.
        - Arthritis care model should support the reimbursement of non-physician based ancillary staff for counseling.
4. The average time providers typically spend with a single patient depends on how provider is reimbursed, contract structure (e.g., fee for service), who insurer/payer is (e.g., Medicaid/Medicare) and other factors.
    - EIM dedicated resources to help people document and bill around PA assessment and counseling
        - Exercise is Medicine coding and billing tips (Note- this will likely need to be updated with new chronic pain codes)
        - PA alliance has also done extensive work with physical activity related CPT codes

B. <u>Opportunities to reimburse care coordination, heath coaching, AAEBIs and beyond</u>

1. Discussion on health systems developing contractual relationships with community care hub and/or CBOs to assist with counseling and referral process.
    - Statewide community care hub (e.g., AgeSpan) links many CBOs together that provide various evidence-based interventions. This model provides a single point of contact for health care providers and health systems that in turn provide access to many services.
2. Demonstration pilot should consider using algorithms to identify patients who may benefit from PA counseling/referrals. This increases the volume of eligible patients and reaches patients who may have fewer access points with the health care system. Additionally, pilot should consider identifying patients at need and doing direct contact and outreach to at-risk individuals. If adequate screening tools are used regularly, clinical decision support algorithms can identify appropriate patients and standing orders that are already approved by the providers can automatically generate the referral.
3. One of the biggest challenges we face is that our providers, care managers, patients and others don't necessarily know that community-based programs exist Additionally, many of these programs are funded to deliver care and lack funding for marketing their program or community engagement. Perhaps we should consider targeted ads (e.g., Facebook) for a national CBO (e.g., YMCA) to direct potential patients to check out evidence-based programs provided by organization.

  - Action Item: NACDD Arthritis Team will follow up with Comagine Health to review "3 touch campaign" model used by National DPP program delivery partners. This model could be applied to AAEBIs.
4. There is still a large delta between the work that community-based organizations do and the work that they get paid to do. Much of allied health professionals time is not tied to any contract/billing. There needs to be a re-examination of salaries (e.g., CHW) to reflect their value. Additionally, model needs to make financial sense to all parties involved including CBO. Texas A&M has done some work on creating cost calculator for CBO reimbursement
   - Some RNs are leaving profession and moving to health coaching
   - CHW salary study by UMass students
   - Mass Association of CHW salary statement
   - In many states, there is a path to CHW certification based on work experience. This has been incredibly helpful in recruiting CHW with lived experience in the communities we serve
5. Health coaching and CCM codes have had some substantial changes over the years.
   - These are time-based codes, but billing can occur under supervision, with ancillary staff that isn't co-located with provider, and doesn't have to be face-to-face
   - CCM codes (2023 national rates) are not face-to-face with billing provider; adaptations to fit in with busy primary care provider. Codes – G0506, 99490, 99439, 99487
     - Action item: NACDD will work with Tim M to review presentation that was done with the community-based provider and health care organization around health care contracting. This presentation helps to show what they outsourced to community-based provider as well as the business model. Additionally, NACDD will work with Tim to review sample memo used to document in lieu of services.
     - Action item: NACDD will work with Tim M to review current health coaching guidance.

III. Key take-aways

1. Arthritis care model should explore and support non-physician based ancillary staff and other allied health staff to be reimbursed for screening, counseling, and referral services. It will be important to look to team-based care and other allied health staff who can assist with screening, counseling, and referral pathway. Model should explore allied health billing and additional opportunities for collaboration.
2. Arthritis care model should address patient concerns with time allowable.
3. There is an opportunity to ensure that cost structure includes community engagement, marketing/outreach, administration costs and other necessary items needed to make the business case and cover administrative overhead.
4. Reimbursement codes (e.g., E+M codes) in a fee per service model could be difficult. There are a substantial number of patients that need screening, counseling, and referral services to increase physical activity and reduce pain and improve physical function. The arthritis care model and the implementation guide need to account for as many models as possible in a wide variety of office and payment systems (e.g., fee per service, value based).
5. Demonstration pilot should explore contracting with a community care hub to assist with screening, counseling, and referral model. Model should consider flexibility in contracting that allows care coordinator to make the decision on what is needed for patient and shifts the burden of outreach to the community care hub and/or CBO to reach patient. (Note- AgeSpan shared that referral

source with lowest volume is direct referrals from physician/healthcare provider to evidence-based program.)

6. Community based organizations (CBOs) that service Medicare beneficiaries, including Area Agencies on Aging, Centers for Independent Living, and Community Action Agencies, can work with ACOs receiving advance investment payments to address the holistic needs of beneficiaries. ACOs and CBOs can determine the best strategy to screen for and manage health-related social needs, such as food insecurity, housing stability, access to accessible transportation, and/or social isolation. Refer to roles for community-based organizations document for more information.

IV. Future considerations:

- Is there an opportunity for Advisory group to help grow partnerships to help increase funding for CDC Arthritis programs?
- Team should consider algorithms for reimbursement that can be used to triage patient into appropriate care. Tim McNeill might be able to assist with this aspect of the model.

V. Evaluation:

- **Poll Question**: In this design session, I had an opportunity to contribute my own knowledge and expertise to explore potential arthritis care model reimbursement mechanisms
    - 58% Strongly agree
    - 17% Agree
    - 25% Neutral
- **Poll Question**: In this design sessions, I had an opportunity to contribute tools, resources, and approaches to assist partners in providing reimbursement mechanisms
    - 58% Strongly agree
    - 17% Agree
    - 25% Neutral