What's Current in Medicare Reimbursement for Evidence-Based Programs

March 3rd, 2021

FREEDMEN'S HEALTH

Expanded TeleHealth Opportunities for CBOs

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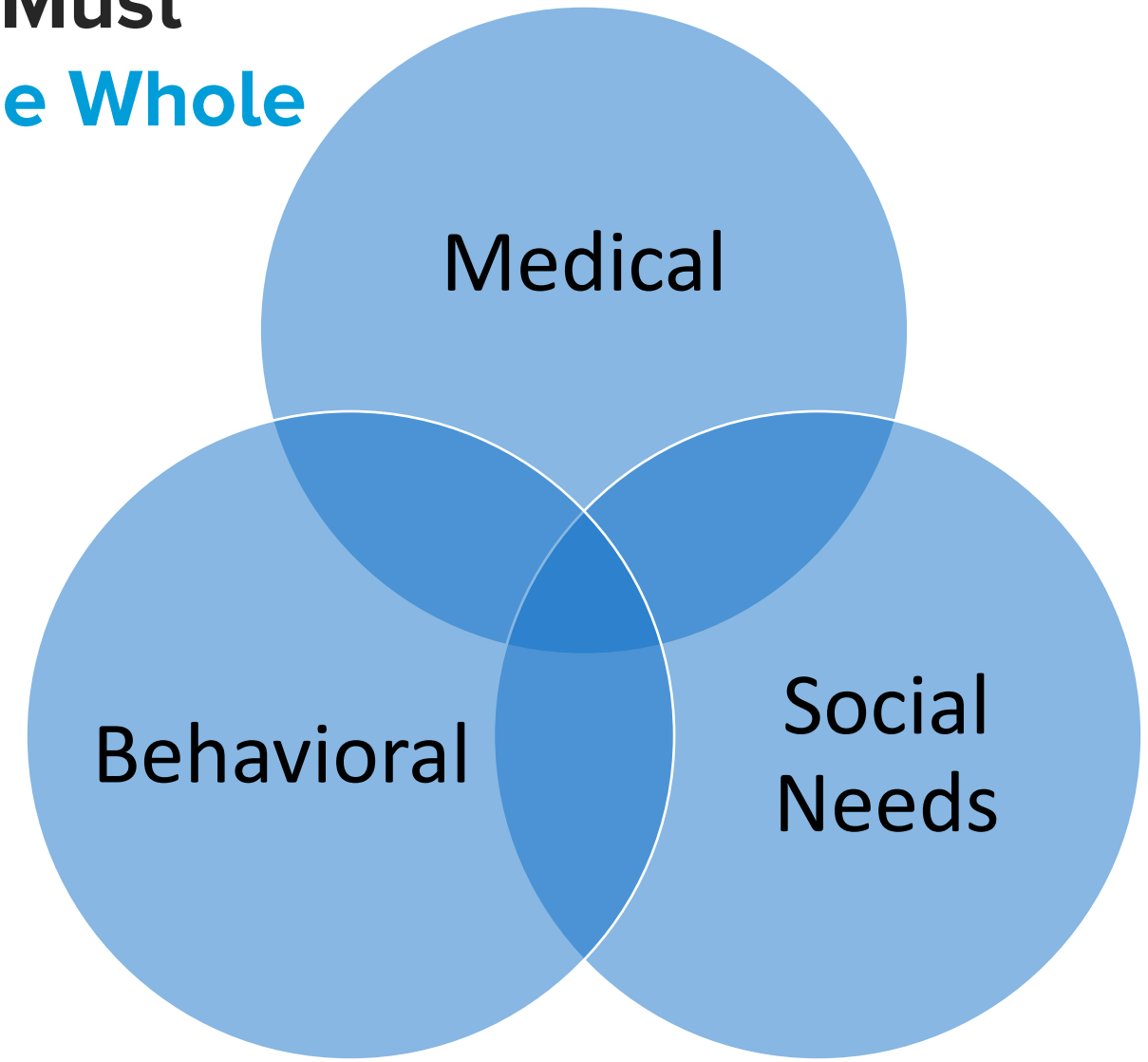
FREEDMEN'S HEALTH

Healthcare Must Address: The Whole Person



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
- CMS issues a series of COVID-19 Blanket Waivers: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf
- Changes will stay in effect for the Duration of the Public Health Emergency

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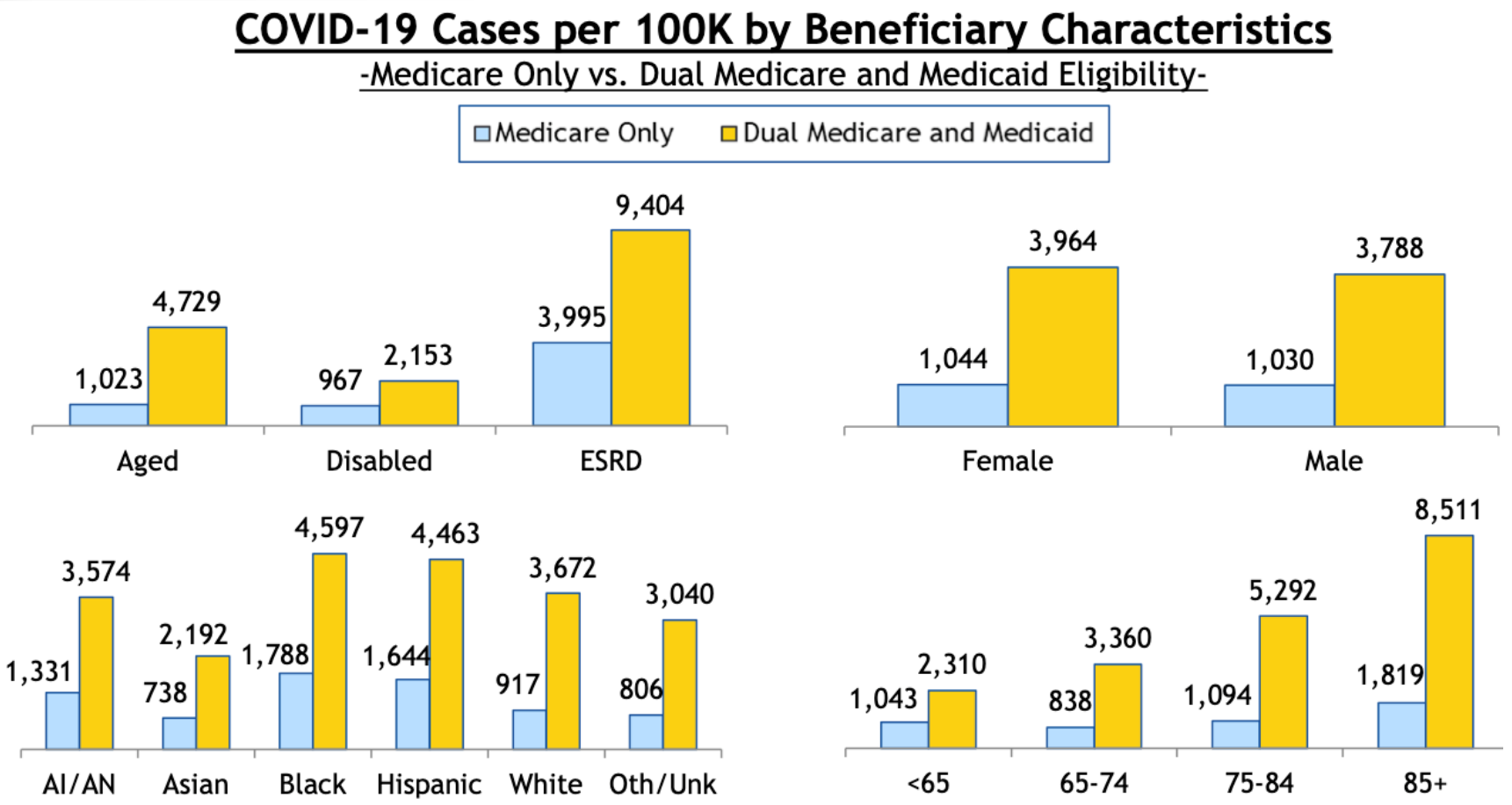
COVID-19 Pandemic: Some Groups are more Impacted than Others



Note: AI/AN = American Indian/Alaskan Native

Disclaimer: All data presented in this update are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. COVID-19 cases are identified using the following ICD-10 diagnosis codes: B97.29 (from 1/1-3/31/2020) and U07.1 (4/1/2020 and after). Medicare claims and encounter data are collected for payment and other program purposes, not public health surveillance, so caution must be used when interpreting the data. For additional details on data limitations, please see page 2 of this data update and view the methodology document available here.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

FREEDMEN'S HEALTH

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

*CMS Medicare-Medicaid Coordination Office, Fact Sheet. March 2020. Available Online [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf]

Blanket Waivers | Increase Adoption of Telehealth

2/19/2021

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
    - 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

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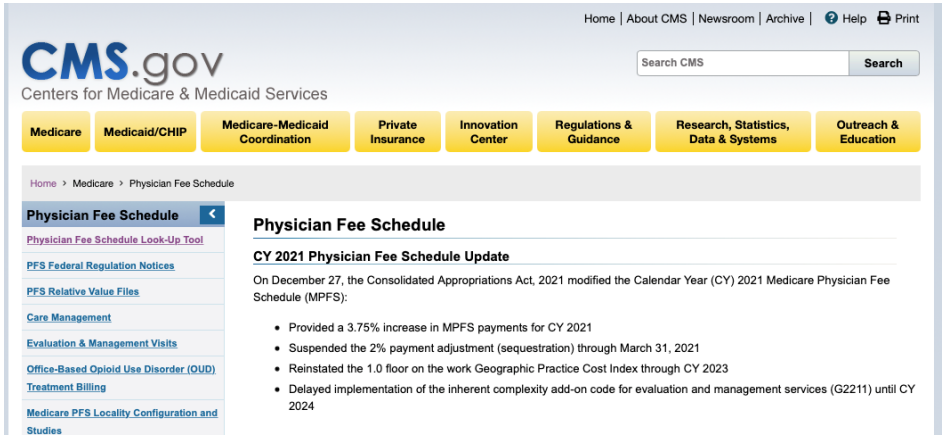
Are Blanket Waivers Permanent | What Happens After the Pandemic is Over?



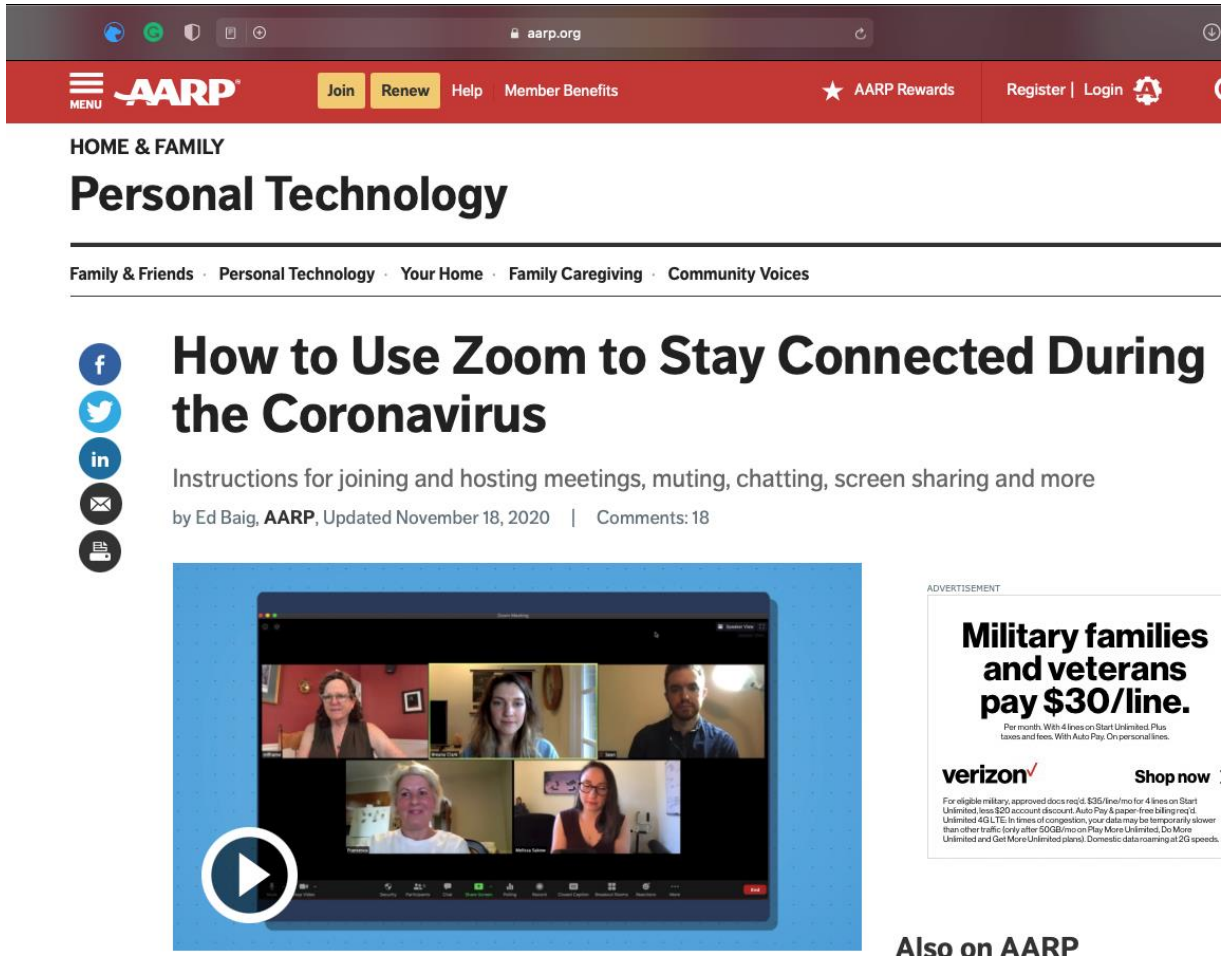
- CY2021 CMS Physician Fee Schedule
- Makes Permanent the telehealth geographic waivers and expansion of telehealth for CY2021
- Even if the Pandemic is declared over before the end of CY2021, the waivers will stay in place
- CMS is seeking comment on the feasibility of permanent adoption of current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

FREEDMEN'S HEALTH

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



- 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

Part B Service	EBPs That Can Be Incorporated Into the Care Plan
CCM	• CDSMP • Chronic Pain Self-Management Program (CPSMP) • EnhanceWellness • Health Coaching
CoCM	• PEARLS • Healthy IDEAS
DSMT/MNT	• DSMP
HBAI	• CDSMP • Chronic Pain Self-Management Program (CPSMP) • HIV Positive Self-Management (PSMP) • Cancer Thriving and Surviving (CTSP)

Transitional Care Management (TCM)

- 30-Day intervention to provide transitional support and care coordination for persons leaving an acute care hospital or skilled rehabilitation institutional setting
- Increased demand for care transitions during the Pandemic
- Early discharges
- Reduced demand for skilled nursing home / rehab care
- Increased requirements for support in the community after discharge
- Codes: 99495, 99496

Chronic Care Management (CCM)

- A benefit for individuals with two or more chronic conditions expected to last at least twelve months or until death, who are at significant risk of functional decline, deterioration, acute exacerbation, or death.
  - To help individuals more effectively manage their health, reduce exacerbation of the disease, and improve their clinical outcomes.
  - An extensive array of services may be provided by phone, electronically, or in person, including phone calls to coordinate care with health care providers and community agencies.
  - Services expected to last a year/monthly billing
  - Simple or complex depending on time and intensity of services each month
  - Codes: G0506, 99490, 99439 (previous G2058 + 20 min), 99487

Collaborative Care Management (CoCM)

- A model of behavioral health integration to provide care management support to individuals who are receiving behavioral health treatment for mental health conditions, such as depression.
- Monthly services that may last up to 12 months or longer.
- 70 minutes of care management the first month; 60 minutes subsequent months; a 30-minute add-on code if needed during any month.
- Codes: 99492, 99493, 99494

Diabetes Self-Management Training (DSMT)

- Diabetes self-management education and support (DSMES) services to help individuals manage their diabetes.
- DSMT cannot be the only Part B benefit that an organization offers. It is often offered in conjunction with medical nutrition therapy (MNT).
- Must attain national accreditation from ADCES (Formally AADE) or ADA and send a copy of the accreditation certificate to the Medicare Administrative Contractor (MAC).
- Covers up to 1 hour of individual and 9 hours of group services first year; 2 hours of annual follow-up.
- Legislation introduced to increase expand services: *Expanding Access to DSMT*
- Codes: G0108, G0109

Medical Nutrition Therapy (MNT)

- Nutritional and lifestyle assessment and dietary counseling to help individuals with diabetes, chronic kidney disease, or those who have had a kidney transplant within three years manage their condition.
- Covers 3 hours of service.
- Can be provided with DSMT but not on the same day.
- No deductible or coinsurance requirements.
- Codes: 97802, 97804

Healthcare Transformation Must Address: Social Determinants of Health

- The Centers for Medicare & Medicaid site that SDoH interventions can be counted as a medical expense
  - https://www.cms.gov/newsroom/press-releases/cms-issues-new-roadmap-states-address-social-determinants-health-improve-outcomes-lower-costs#_ftn1

Codes Used by Some Managed Care Plans for CBO SDoH Interventions

- S5109: Home Care Training, All-inclusive (Care management, HomeMeds, and health promotion course)
- S5170: Home delivered prepared meal
- S9452: Nutrition Class, Non-Physician provider, per session
- S9445: Patient Education
- S9977: Meals, per diem
- S9986: Not medically necessary service, (used for social isolation intervention)

Documenting the Impact: Social Determinants of Health

- Future discussions of using Z-Codes in the risk calculation for health plan premium payment adjustments
  - Z59.0: Z59.9: Problem related to housing and economic circumstances, unspecified
  - Z59.91: Worried about losing housing
  - Z59.62: Unable to pay for utilities
  - Z59.65: Unable to pay for phone
  - Z59.66: Unable to pay for adequate clothing
  - Z59.69: Unable to pay for other needed items
  - Z59.4: Worry about finding affordable food; lack of adequate food and safe drinking water
  - Z72.4: Inappropriate diet or eating habits
  - Z59.64: Unable to pay for transportation for medical appointments or prescriptions

Technology Requirements: Examples from the Field

- HIPAA Compliant documentation systems
- Ability of CBOs to file claims
- CBO adoption of Industry Standard Code Set (CPT)
- Use of a Clearinghouse to file claims
- Medical Loss Ratio Requirements deter use of claims-based reimbursement models
- CBOs that overcame these challenges
  - Mid-America Regional Council Area Agency on Aging
  - Western New York Integrated Care Collaborative

Questions | Comments

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Thanks for joining today!

Register for upcoming events:

Office Hours with Sharon Williams:

- May 26th @ 1-2 p.m. ET - Navigating Opportunities to Advocate for Medicaid Payment for Evidence-based Programs in your State

- July 21st @ 1-2:00 p.m. ET - Navigating Network Partnerships

Conference:

- June 7-10th: Age+Action Virtual Conference