Resource Guide

Becoming a Medicare Fee-For-Service Provider: What CBOs Need to Know

Aging and disability community-based organizations (CBOs) are generally well positioned to become Medicare Fee-for-Service (FFS) providers, providing benefits covered under Medicare Part B. Many factors contribute to this opportunity, including the long-standing experience CBOs have in delivering health and wellness programs, care transitions and care coordination services that can be readily enhanced with an appropriate clinical wraparound structure to meet Medicare requirements. CBOs also have an existing customer base from which to build and grow viable programs and services for the Medicare FFS program.

Benefits of Becoming a Medicare Provider

The substantial benefits for CBOs that come with becoming a Medicare provider include:

- **A reliable source of revenue** that can help CBOs sustain the valuable services they already offer, including evidence-based disease prevention and health promotion programs. Typically, CBOs that are part of the Aging and Disability Networks have relied on the Older Americans Act, the Rehabilitation Act and other grant funding to operate these programs and services. However, these traditional funding sources do not sufficiently address the increased demand for home and community-based services that are resulting largely from a rapidly aging population. Reimbursement from Medicare can increase revenue and cash flow for CBOs if they effectively market their services and establish an adequate number of reliable referral sources to create volume.
- **Increased visibility and recognition** for CBOs in their communities, creating **new partnership opportunities**. By forging new partnerships with health care entities and successfully integrating their own services within the health care sector, CBOs can reach more people and make a greater impact on health outcomes in the communities they serve.
- **Retention of 100 percent of the revenue earned** from Medicare reimbursement, which may not be the case if a CBO is getting paid to deliver services through a Medicare provider that is billing for the same services.

Opportunities for CBOs to Provide Medicare Part B Services

It is important that CBOs interested in becoming Medicare providers learn about Medicare Part B to help determine which benefit(s) they are best positioned to offer. Medicare Part B covers physician services, office visits, screenings, therapies, preventive services, outpatient services, emergency care, ambulance services, medical supplies and durable medical equipment, and more. Table 1 provides a list of Medicare Part B benefits that CBOs can offer. The hyperlinks connect to resources that provide detailed information about the requirements for the specific benefit.

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Table 1: Medicare Part B Benefits that CBOs Can Offer

Chronic Care Management (CCM) Benefit		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
A service to help individuals living with two or more chronic conditions follow their medical care plan, practice preventive health care and more effectively manage their health.	Services are expected to last at least 12 months; billed as either regular or complex,[i] depending on the intensity and the clinical staff time spent providing services each month; 20 minutes per month for regular CCM; 60 minutes per month for complex CCM with a 30 minute add-on code as needed during any month.	Physician or qualified non-physician provider (Nurse Practitioner or physician)
Diabetes Self-Management Training[1] (DSMT) Benefit		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
Diabetes self-management education and support services (DSMES)[2] to help individuals manage their diabetes. The DSMT benefit cannot be the only Medicare Part B benefit that an organization offers and is often offered in conjunction with the medical nutrition therapy (MNT) benefit. Note: To earn Medicare recognition of a DSMES program, a CBO must first attain national accreditation from the American Diabetes Association or the American Association of Diabetes Educators and then send a copy of the accreditation certificate to the Medicare Administrative Contractor (MAC).	This benefit covers the following: up to 10 hours of service in the first year, comprised of one hour of individual training and nine hours of group training; two hours of annual follow-up training after the initial DSMT is completed.	Registered Dietitian
Medical Nutrition Therapy (MNT) Benefit		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
Nutritional and lifestyle assessment and dietary counseling to help individuals living with diabetes or chronic kidney disease, or those who have had a kidney transplant within three years, manage their conditions.	This benefit covers three hours of service and can be offered in conjunction with DSMT.	Registered Dietitian

1 This term was defined in the Balanced Budget Act of 1997 and is used by the Centers for Medicare & Medicaid Services (CMS) to describe "educational and training services furnished . . . to an individual with diabetes by a certified provider . . . in an outpatient setting." The services are offered "to ensure therapy compliance or to provide the individual with necessary skills and knowledge" to manage diabetes. DSMT programs must meet the National Standards for Diabetes Self-Management Education and Support (DSMES).

2 This term refers to the ongoing process involved in supporting individuals with diabetes to increase their knowledge, skills and ability for self-care. It includes behaviors and activities to manage diabetes on an ongoing basis over time, beyond the scope of formal training and education.

Table 1: Medicare Part B Benefits that CBOs Can Offer *continued*

Health and Behavior Assessment/Intervention (HBAI)		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
A benefit established to address the behavioral, cognitive, emotional or psychosocial factors that affect the treatment or management of one or more physical health conditions. HBAI codes may not be used for treating or managing mental health conditions.	One hour for an individual assessment; while there is no national limit on the number of billable units for group services, the MAC has the discretion to limit services. Generally, up to 15 hours of group services can be provided annually if medically necessary.	Psychologist
Transitional Care Management (TCM)		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
Education and support services to help individuals transition from the hospital back to their homes and communities.	Offered over a 30-day period; services are billed according to complexity of need, moderately complex or highly complex;[ii] no time requirements.	Physician or qualified non-physician provider (Nurse Practitioner or Physician Assistant)
Psychiatric Collaborative Care Model (CoCM)		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
A model of behavioral health integration that provides 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 in the first month; 60 minutes per month in subsequent months; a 30-minute add-on code if needed during any month.	Physician or qualified non-physician provider (Nurse Practitioner or Physician Assistant)
Medicare Diabetes Prevention Program (MDPP) Expanded Model		
Description	**Length of Service/Billable Hours**	**Supervising Clinician**
A structured clinical intervention offered to individuals with prediabetes to prevent type 2 diabetes. The primary goal is at least five percent weight loss. The curriculum must be approved by the Centers for Disease Control and Prevention (CDC), and must be delivered by a recognized MDPP Supplier (an organization that has achieved CDC recognition and enrolled as a supplier).	Sixteen core sessions over six months in a group setting followed by less intensive monthly sessions to help participants maintain healthy behaviors. Services can continue for up to two years if an individual has been successful in losing weight. Note: The amount reimbursed depends on the percentage of weight loss. Providers must meet weight loss and activity targets to receive full reimbursement.	Provided by a health coach licensed as a recognized MDPP supplier

The benefits listed in Table 1 must be offered by or under the supervision of a qualified, licensed clinician when seeking Medicare reimbursement. Each benefit has unique requirements regarding which clinicians qualify to provide the services and what supervision is needed. For example, some benefits require the supervising clinician to be on site when the service is provided, while others require the clinician to be available, but not necessarily on site.

If deemed medically necessary by the supervising clinician, evidence-based chronic disease self-management education, falls prevention or other evidence-based health promotion programs can be offered as a component of the Part B services included in Table 1. The National Council on Aging (NCOA) has developed an online Community-Integrated Health Care Toolkit,[iii] which includes a section dedicated to Medicare Payment Opportunities[iv] to help CBOs learn

more about the benefits, as well as how evidence-based programs can be incorporated into a CBO's offerings. The "See It in Action" dropdown tab on that page provides examples of CBOs that are offering these services, including their successes, challenges and lessons learned.

Understanding the Basics of Medicare

Deductibles and Coinsurance

Three important terms for CBOs seeking to contract to provide Medicare Part B services are *deductible*, *coinsurance* and *copayment*. According to Medicare.gov, a deductible is "the amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay."[v] Coinsurance is "an amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20 percent)."[vi] A copayment is "an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug."[vii]

Medicare beneficiaries must pay an out-of-pocket deductible before Medicare Part B will begin covering their services. The deductible amount is established each year. In addition to the annual deductible, Original Medicare requires a coinsurance for Part B. Medicare pays 80 percent of the charges for the services provided, and the beneficiary is responsible for the remaining 20 percent. Medicare providers are expected to attempt to collect both the deductible and coinsurance. CBOs that become Medicare providers must follow all guidance provided by the Centers for Medicare & Medicaid Services (CMS) for the collection of beneficiary deductibles and copayments. Failure to do so can result in lost revenue and make it difficult or impossible for the CBO to reach the break-even point (the point at which profits are equal to costs). By establishing a process for billing the coinsurance, CBOs can increase revenue and reduce the break-even point, thereby increasing the likelihood of running a financially viable program for Part B services. CBOs may choose to work with subcontractors or clearinghouses to fulfill responsibilities for billing reconciliation and collection of payments.

The CMS Medicare Claims Processing Manual[viii] outlines the requirements for Medicare providers collecting beneficiary payments.

Medigap Policies

Medicare allows beneficiaries to purchase a Medigap policy to cover the deductible and 20 percent coinsurance under Medicare Part B. In addition to billing Medicare, CBOs that become Medicare Part B providers are responsible for collecting the Medigap policy information from Medicare beneficiaries and billing the Medigap plan for the 20 percent coinsurance, in addition to billing Medicare. Medicare beneficiaries who have Medigap policies are not responsible for paying the coinsurance.

Dual Eligibles

Medicare beneficiaries who are also enrolled in a Medicaid program because they meet their state's income and asset qualifications (where applicable) are commonly referred to as a "dual eligibles" or "duals." This includes individuals under the age of 65 who qualify for Medicare due to a disability, as well as those who are age 65 or older. Medicare covers 80 percent of the approved charges, and Medicaid is mandated to cover the remaining 20 percent coinsurance for Medicaid-approved services. Some duals are enrolled in FFS Medicare and have their Medicaid benefits covered by a state-sponsored Medicaid managed care plan program. Under these circumstances, the managed care organization (MCO) is required to pay the coinsurance on behalf of the Medicaid program. As Medicare and Medicaid often have different provider credentialing and payment policies, CBOs must ensure they understand the coordination of benefits requirements between the two programs.

A CBO that serves as a Medicare provider is responsible for billing the Medicaid program or the Medicaid MCO for the 20 percent coinsurance for duals. To deliver and be paid for services, CBOs must be part of the Medicaid MCO's network. Medicaid agencies may also require CBOs to complete the local Medicaid provider registration process in order to bill under FFS. It is not the responsibility of the Medicare beneficiary to pay the coinsurance if they have Medicaid coverage.

Duals tend to have high rates of chronic disease and multiple conditions, as well as behavioral health and long-term services and supports needs. They are considered a high-risk or vulnerable population due to their complex clinical needs, compounded by health-related social needs that impact their health outcomes. Duals commonly encounter barriers to health care access and are one of the highest cost groups for Medicare and Medicaid. CBOs are generally well qualified to serve duals because CBOs can identify and effectively address the social determinants of health (SDOH), such as income, housing, social support, food security and health literacy.

Enrolling as a Medicare Provider

Becoming a Medicare provider is a two-part process that involves obtaining a **Provider Transaction Access Number (PTAN)** and a **National Provider Identifier (NPI)** from CMS. The PTAN is a Medicare-only number issued once a CBO becomes a Medicare provider. The NPI is a 10-digit unique identifier for health insurance providers developed by CMS to comply with the national Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions. Organizations providing Medicare services and each qualified clinician whose services will be billed to Medicare must obtain a unique NPI.

Obtaining a PTAN

- It is recommended that CBOs apply online through the CMS online Provider Enrollment, Chain and Ownership System (PECOS)[ix] electronic portal (an alternative to the CMS-855 paper-based enrollment process). Note: At least one qualified clinician with an NPI must be listed on the application. Refer to the "Obtaining the NPI" section if the clinician does not yet have an assigned number.
- PECOS allows organizations to enroll, view their enrollment status and edit their applications.
- The PTAN must be used to authenticate a provider when contacting the MAC for information or using self-help tools, such as the internet portal. A MAC[x] is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims for Medicare FFS beneficiaries.

Obtaining an NPI

There are two types of NPI, which are described below:[xi]

Organizational NPI for Medicare providers (such as CBOs). The organizational NPI will be assigned in the approval letter that the MAC issues for the PTAN.

Individual NPI for qualified clinicians (e.g., a CBO's medical director or Registered Dietitian). Each qualified clinician providing Medicare services must obtain a unique NPI:

- NPIs for qualified clinicians are issued through the National Plan and Provider Enumeration System (NPPES)[xii] online portal. A paper application is available only upon request by calling (800) 465-3203. The NPI follows the clinician over a lifetime (similar to a Social Security Number) anywhere the provider practices in the U.S.
- Each clinician's NPI must be linked to the Medicare provider entity's PTAN, a process that requires the submission of additional forms.
- A clinician's NPI may be linked to multiple organizations.
- The NPI must be on every claim submission.
- While the time it takes to obtain an NPI can vary, the process generally takes about 10 days.

Key Considerations for CBOs: Understanding the Responsibilities and Risks

A CBO can reap substantial benefits once it becomes a Medicare provider. However, taking on this role carries with it certain responsibilities and inherent risks, which a CBO must carefully contemplate to determine whether becoming a Medicare provider is right for its organization.

Consideration: Culture Change and Change Management

CBOs weighing their options for serving Medicare beneficiaries through the Medicare FFS system should determine how this new business would align with the CBO's mission, vision and goals. This shift involves a major undertaking—culture change—which will require adopting a different approach to service delivery.

If a CBO decides to become a Medicare provider, its board of directors, executive management team, staff and stakeholders should engage in a change management process, which will help the CBO prepare for and make changes needed to incorporate the new services within its organizational structure. A major component of change management is ensuring infrastructure capacity, including staff hiring, training and development to carry out essential operational and administrative tasks. Other change management functions include evaluating readiness, setting priorities, developing goals and action steps, and determining how and when a series of incremental changes will be made that will ultimately lead to a successful Medicare program for the CBO.

Several resources can help CBOs understand and prepare for the crucial change management process. A Framework of Change[xiii] from NCOA helps CBOs navigate the stages of organizational change that are required for CBOs to successfully implement Medicare Part B services. In addition, Assessment Tools[xiv] developed by the Aging and Disability Business Institute, which is administered by the National Association of Area Agencies on Aging (n4a), guide CBOs through the process of successfully preparing for, securing and maintaining partnerships with the health care sector. Among other components, the Readiness Assessment tool helps CBOs assess how ready their organizations are for change.

Consideration: Implications of Health Care Service Delivery

Medicare providers are responsible for delivering safe, effective and appropriate health care services based on the needs of each beneficiary. Therefore, if something goes wrong or if there is a poor outcome, a CBO that becomes a Medicare provider may be liable and face a malpractice claim. Prior to becoming a Medicare provider, a CBO should seek legal counsel to fully understand the implications of liability and malpractice, and to determine the appropriate amount of liability coverage it needs in the event of a lawsuit. CBOs should also develop written policies and procedures, as well as implement a quality assurance process to ensure that the correct action is taken at the appropriate time throughout the delivery of services.

Consideration: Billing and Filing Claims

Medicare providers must file claims with Medicare, as well as with Medigap or Medicaid agencies/plans as applicable. As a result, Medicare providers have a responsibility to develop appropriate billing processes, which should include asking beneficiaries about their insurance coverage and getting accurate insurance information. Many beneficiaries have insurance coverage beyond Medicare and providers must collect this information. Failure to create a process for identifying other payers is viewed as a violation of the CBO's provider agreement with Medicare.

Each time it files a claim with Medicare, the CBO is attesting that the services listed on the claim are accurate and were delivered to the beneficiary in accordance with established health care standards and Medicare billing policies. Federal law requires that providers submit medical record documentation to support claims for Medicare services upon request. If the services were not medically necessary, were rendered in a manner inconsistent with established standards, or were not rendered at all, the provider may be responsible for repayment of those claims or further penalties.

Consideration: Steering Clear of Fraud and Abuse

A pattern of inappropriate claims submissions may raise concern of fraud or abuse. *Fraud* is intentionally or knowingly providing false or misleading information, whereas *abuse* involves unintentional actions that result in unnecessary costs to Medicare. Examples of abuse include errors in coding on claims or billing for services that were not medically necessary or properly documented.

Federal laws govern Medicare fraud and abuse. A provider that violates these laws, including the owners and/or directors, could be subject to non-payment of claims, citations, fines, exclusion from all federal health programs and criminal or civil liability, depending on the extent of the activity. Therefore, CBOs seeking to bill Medicare must have a vigilant quality assurance program that monitors service delivery throughout the process, service documentation and billing accuracy. A robust quality assurance program and a comprehensive claims management system mitigates the risks that a CBO will face when choosing to become a Medicare provider.

Consideration: Compliance with HIPAA Requirements

A CBO that becomes a Medicare provider must comply with federal regulations, including HIPAA's privacy and security standards, which require that organizations put safeguards in place to protect consumer health information, which is referred to as protected health information (PHI).[xv] Personal, demographic, medical, mental health and insurance information are all considered PHI. Even a listing of an individual's disease self-management goals is considered PHI.

CBOs serving as Medicare providers must protect PHI at all times. Medicare providers are responsible for ensuring that all employees, contractors and subcontractors adhere to Medicare's standards regarding the privacy of patient information. HIPAA breaches can occur when PHI is lost, accessed without authorization or disclosed without permission and can result in a fine of up to $10,000 per occurrence. A breach caused by a failure of the provider's contractors or subcontractors becomes the liability of the provider that shared the data with the contractor or subcontractor. CBOs should also be cognizant of any consumer information protection regulations in their state and ensure they comply with those regulations.

Many organizations have obtained a HIPAA data breach insurance policy, which will cover all fines and penalties in the event of a data breach that occurs due to the fault of the organization or the organization's contractors or subcontractors. This HIPAA data breach insurance policy is commonly referred to as cyber insurance. A CBO considering becoming a direct Medicare provider should carefully review the cyber insurance requirements and seek legal counsel to develop a sound compliance program that addresses HIPAA and other key regulatory standards.

Consideration: Ebb and Flow of Funds

A CBO that operates as a Medicare provider must consider the ebb and flow of funds resulting from a FFS model. There is no guarantee that a CBO will receive a fixed amount of money each month. The reimbursement amount fluctuates from month to month, depending on the number of referrals, billable services and collections from Medicare for claims that have been paid. It can take up to 60 days for CMS to adjudicate a claim to determine if it is appropriate.

CBOs must maintain sufficient financial reserves to account for variances in cash flow. CBOs must operate the program, pay staff and continue to deliver services while they wait for reimbursements to arrive. To provide for consistent cash flow, CBOs should build their referral base so that they are generating and filing claims on a daily basis. CBOs serving as Medicare providers should also consider submitting claims electronically to reduce the turnaround time for payment and lessen the administrative burden on the CBO.

Consideration: Electronic Health Record and Practice Management System

Any CBO that is considering becoming a Medicare provider must consider adopting an electronic health record system (EHR) and an electronic practice management system. An EHR automates the documentation, storage and retrieval of health information. A practice management system streamlines and automates daily operational and administrative activities and generates reports.

Electronic health records are becoming mandatory for Medicare. In order to assist physicians, providers and hospitals to address the cost of these systems, the HHS Office of the National Coordinator for Health Information Technology (ONC) developed a set of "meaningful use" standards. Systems meeting the meaningful use standard are registered by the ONC

and published on their website. All IT standards and requirements for providers now and in the future will be based on the meaningful use standards. Therefore, CBOs planning to become a Medicare provider or partner with a Medicare provider must look into adopting a meaningful use certified system.

Using a practice management system can bridge front office (clinical) and back office (administrative) functions to make daily operations easier and more efficient. Having a practice management system in place helps CBOs process and monitor large volumes of claims and other clinical and performance reporting/tracking. Functions handled by practice management systems include scheduling, insurance authorizations, revenue cycle management and other related activities.

Forming a Partnership with a Medicare Provider

After weighing the benefits and considerations discussed above, if a CBO decides not to become a Medicare provider, it can opt to partner with one or more qualified Medicare providers to offer Medicare Part B services by entering into a contractual arrangement with one or more provider practices to deliver services. The contract should specify the scope of services, responsibilities of each organization, reporting requirements and payment rate/schedule. CBOs considering this model may want to refer to the Partnership Development section of NCOA's Community-Integrated Health Care Toolkit[xvi] for detailed information on partnership development with health care entities, including contract negotiations. CBOs may also access resources on a range of topics in partnering with health systems available through n4a's Aging and Disability Business Institute,[xvii] such as resources on defining your value and evaluating contracts. Table 2 outlines the advantages and disadvantages of this type of model.

Conclusion

CBOs are generally well positioned to offer Medicare services because they are experienced and trusted members of the community and can offer services that complement clinically driven practices that are targeted at improving health outcomes. Serving as a Medicare provider offers many opportunities for a CBO to develop, grow and sustain its programs and services. However, this decision should be weighed carefully because many responsibilities and risks are inherent to the Medicare provider role. For CBOs that decide to become Medicare providers, understanding these responsibilities and risks upfront can help ensure a high-quality, viable program and long-term fiscal sustainability.

Table 2: Advantages and Disadvantages of Partnering with a Medicare Provider

Advantages
Once a partner is identified, this model may not require as much startup time because the CBO doesn't have to go through the process of becoming a Medicare provider.
Any Medicare provider practices involved in the partnership can potentially offer a steady source of referrals.
There is potential to replicate this model by forming contractual agreements with other providers.
By not taking on the Medicare provider role, the CBO burden is less.
Disadvantages
The CBO might have less control over the programs and services delivered in this model.
Negotiating separate contracts with each Medicare provider can be time and labor intensive.
The CBO has to learn and adopt each Medicare provider's electronic health record.
Multiple contracts can increase administrative costs to manage and track services based on the needs of each provider.
The Medicare provider has an option to terminate the agreement with the CBO at any time.

Endnotes

[i] The Centers for Medicare & Medicaid Services, *Chronic Care Management Services*, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

[ii] The Centers for Medicare & Medicaid Services, *Transitional Care Management Services*, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf.

[iii] The National Council on Aging, *Community-Integrated Health Care Toolkit*, https://www.ncoa.org/toolkits/community-integrated-healthcare-toolkit.

[iv] The National Council on Aging, *Medicare Payment Opportunities*, https://www.ncoa.org/toolkits/community-integrated-healthcare-toolkit/#medicare-payment-opportunities.

[v] Medicare.gov, *Deductible*, https://www.medicare.gov/glossary/d.

[vi] Medicare.gov, *Coinsurance*, https://www.medicare.gov/glossary/c.

[vii] Medicare.gov, *Copayment*, https://www.medicare.gov/glossary/c.

[viii] The Centers for Medicare & Medicaid Services, *Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements*, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.

[ix] The Centers for Medicare & Medicaid Services, *Provider Enrollment, Chain, and Ownership System (PECOS)*, https://pecos.cms.hhs.gov/pecos/login.do#headingLv1.

[x] The Centers for Medicare & Medicaid Services, *What is a MAC*, https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.

[xi] The Centers for Medicare & Medicaid Services, *How to Apply,* https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/apply.

[xii] The Centers for Medicare & Medicaid Services, *National Plan & Provider Enumeration System*, https://nppes.cms.hhs.gov/#.

[xiii] The National Council on Aging, *A Framework of Change Stages of Organizational Change, Outcomes, and Key Decision Points For Successful Implementation of Medicare Part B Benefits*, https://www.ncoa.org/wp-content/uploads/A-Framework-of-Change_Stages-of-Organizational-Change_Final-Draft-002.pdf.

[xiv] The Aging and Disability Business Institute at the National Association of Area Agencies on Aging, *Readiness Assessment Tool*, https://www.aginganddisabilitybusinessinstitute.org/assessment-intro.

[xv] HIPPA Journal, *What is Considered Protected Health Information Under HIPAA?*, https://www.hipaajournal.com/what-is-considered-protected-health-information-under-hipaa.

[xvi] The National Council on Aging, *Community-Integrated Health Care Toolkit*, https://www.ncoa.org/toolkits/community-integrated-healthcare-toolkit.

[xvii] The Aging and Disability Business Institute at the National Association of Area Agencies on Aging, *Aging and Disability Business Institute*, https://www.aginganddisabilitybusinessinstitute.org.

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NCOA is a trusted national leader working to ensure that every person can age well. Since 1950, our mission has not changed: Improve the lives of millions of older adults, especially those who are struggling. NCOA empowers people with the best solutions to improve their own health and economic security—and we strengthen government programs that we all depend on as we age. Every year, millions of people use our signature programs BenefitsCheckUp®, My Medicare Matters®, and the Aging Mastery Program® to age well. By offering online tools and collaborating with a nationwide network of partners, NCOA is working to improve the lives of 40 million older adults by 2030. Learn more at www.ncoa.org and @NCOAging.