NWD PODCAST Episode 1

Supporting COVID-19 Challenges Through Care Transitions Partnerships

Final Transcript

Narrator 0:00

Welcome to the No Wrong Door podcast series brought to you by the Administration for Community Living. In this episode, we'll focus on ways ADRCs can support care transitions during the COVID-19 pandemic. Our featured speaker is Tim McNeill. Tim is a member of the No Wrong Door Technical Assistance Team.

Tim McNeill 0:23

"This is a very under-utilized service and was under-utilized before the emergency. And now the emergency just highlights the fact that it's needed now more than ever."

Narrator 0:26

This presentation highlights how the pandemic has created opportunities to build partnerships among aging and disability networks and healthcare entities. And now, let's hear from our featured speaker, Tim McNeill.

Tim McNeill 0:56

Great, thank you so much. It's a pleasure to speak with everyone today. So I'm going to go through a little bit of additional information about some of the blanket waivers. So the Department of Health and Human Services issued some blanket waivers through the Centers for Medicare and Medicaid Services that went into effect retroactive to March one, these waivers will stay in place for the duration of the public health emergency. And so these waivers allow additional flexibility for hospitals to expand the care delivery outside of the four walls of the hospital. So that includes things such as nationwide telehealth to include telehealth services in the home and in the listing of services that CMS outlined that could be supported by telehealth. There's a specific listing for transitional care management to facilitate transitions from one acute care setting to a community setting for any Medicare beneficiary. What's important to note is that waivers apply to all Medicare beneficiaries across the country. And they're not specific to just persons with a diagnosis of COVID or suspected of COVID, or they don't have to be in a specific hot spot or a surge location. It's a blanket waiver that applies to everyone. Now, one of the reasons that this is particularly important, especially related to this call, it's because what hospitals have begun to see is that their traditional pathway to use post-acute care, whether it be institutional rehab facilities, skilled nursing facility, long-term care

setting, home health agency, there's been a disruption in that pipeline. And a lot of the disruption as you've seen and even I'm sure in your local markets, the COVID-19 mortality rates in skilled nursing facilities is extraordinarily high. And as a result, there has been a lot of disruption in that, in that pipeline. So that there's access to those services are not what they were prior to the COVID-19 public health emergency. As a result, hospitals are having a much harder time discharging patients to those facilities, whether those facilities are not willing to take them because they may suspect they'd been exposed to COVID-19 while they're in the hospitals, or even we're hearing reports where beneficiaries are saying that they are fearful to go to a skilled nursing facility because of the high mortality rate. And they'd rather have a community option. Well, we think that the aging and disability resource centers across the country could serve as a vital resource to those health systems that are looking and as well as beneficiaries that are looking for an alternative pathway to receive services in the community. And to the extent we can facilitate those as part of a transitional care model. Now, the waiver allows for full reimbursement of those services, too, particularly if those are supported via telehealth. And even when that's delivered in the home as an alternative site where care could be delivered.

Narrator 4:06

Tim went on to highlight how ADRCs can facilitate community-based support for the most vulnerable populations during the pandemic.

Tim McNeill 4:15

So the potential impact on the age and disability network is that higher risk populations, there's consideration to expand the services for them, but we serve those higher risk populations – older adults, persons with disabilities, persons with preexisting mortality or preexisting conditions, persons living in institutional settings, whether it be skilled nursing facilities, assisted living facilities, congregate, group homes, all of those sites are higher risk. And so persons returning to those settings may need additional support that could be best delivered by a community based organization or network that's facilitated. The No Wrong Door System could be the access point for those hospitals, healthcare providers to serve beneficiaries. And now that there's expanded telehealth, that also can trigger reimbursement that makes the entire model fully sustainable. Although the blanket waivers apply to Medicare fee for service, we're also hearing that Medicare advantage plans and other commercial payers are facing the same challenges. So if that supply chain for post-acute care is disrupted in a market, it's not just impacting Medicare, Medicaid, it's also impacting Anthem, Blue Cross Blue Shield, United healthcare, and all of their members. In fact, we received reports from one of the large payers that during the height of the pandemic in certain markets, their case managers could not reach their members. And there were members that are members outreach saying that they had no access to services, and they literally had their case managers going to the grocery store to buy supplies to FedEx to their members, because there were no other ways to get them services. Well, those same case managers could have accessed their local ADRC that could have facilitated those services instead of spending an inordinate amount of time and resources that

were disproportionately used or having case managers do shopping, they could have spent those resources with their ADRC that could have facilitated those services. So when thinking about this approach, really think about it as a multi-payer model where we could be working with health systems, institutional settings, skilled nursing facilities to facilitate services that could be billed to Medicare, Medicare advantage and commercial payers to address high need services such as transitions to community settings, as well as comorbidities that have been heightened by this public health emergency to include things such as social isolation, loneliness, depression, all of those compounding factors are, are impacting the population. And there's a clear line to reimbursement to make those fully sustainable.

Narrator 7:04
Next, Tim elaborated on transitional care management and chronic care management as it relates to billing requirements.

Tim McNeill 7:13

I just wanted to highlight for those of you that follow the billing requirements for transitional care management and chronic care management. The rules changed January one, which was prior to the COVID-19 public health emergency that allows for transitional care management and chronic care management to both be billed for the same beneficiary during the same month. And that rule change was made specifically because this is a very underutilized service and it was under-utilized before the emergency. And now the emergency just highlights the fact that it's needed more than ever. So partnerships that could be developed between health systems, ADRCs, and other community organizations to deliver these services has great potential, particularly as hospitals begin thinking about hospital without walls and other initiatives that they may encounter.

Narrator 8:04

Another key area of opportunity is to support telehealth services.

Tim McNeill 8:09

So some of the opportunities include supporting telehealth services that has been the greatest response from physicians and the challenge of serving beneficiaries as CMS expanded yele-health, the ability to conduct telehealth visits. In fact monthly Twitter, online, social gathering for the American Academy of Family Physicians that I log into just to hear what family physicians are saying around the COVID-19 emergency. And one of the things that it's been a resounding discussion on at every meeting is how difficult it is to facilitate telehealth, particularly for their highest risk beneficiaries. And they cited things such as the inability of the beneficiary to access telehealth, their inability to manipulate the phone, lack of caregiver support, dementia, all of those factors that we face every day in serving the same population. And they have been unable to figure that, figure it out to the extent that those same Academy of Physicians could access their local ADRC to address all the myriad of things to include social determinants that’s impacting that population is a pathway. And now that could be fully

sustainable through reimbursement. So that includes transitional care management and care transitions efforts.

Narrator 9:33

Tim had another important insight on opportunities related to the VA health system...

Tim McNeill 9:39

Opportunities with the VA health system is another area that this pandemic has highlighted that there's more need for home and community-based services. As in numerous markets, veterans are afraid to go to veteran care homes because of high mortality rates for veteran care. So now the VA, I've heard that from the VA in DC, that there's the increased demand for home and community-based services, and they need a conduit to address the needs of those veterans.

Narrator 10:10

Tim talked about ways ADRCs can get started by looking at different payers or funding streams based on the population served in the area.

Tim McNeill 10:19

It's important to understand what would generally determine the payer mix in your market. So you want to know what is the mix of Medicare, Medicare advantage? What's the distribution of that? Where are those people getting services, as well as there's increasing opportunities for veteran services, as we see more people that are also contracting COVID in veterans' homes. And so understanding that mix, you could begin to stratify your opportunities based on the penetration of the payers and then looking at who's most impacted. So if there's Medicare beneficiaries is the dominant payer in your market, Medicare fee for service, and there's a large health system, that health system would be one entry point for the Medicare fee for service population. Let's say like I have relationships in my market like Louisiana, all of their ADRCs have relationships in the marketplace. If I have that relationship and it already exists with the health system, understanding next, what are the payers that, that health system serves? We have seen greater success when a health system and the community-based organizations go to the payer jointly where the health system says, this is my community partner for activities such as transitions. There's a greater likelihood that that payer would be very much interested because it shows the payer that community-based organization has a direct access line to their members through that hospital partnership.

Narrator 11:58

He continued on to recommend different ways to approach hospitals to initiate conversations about partnering -- one of the main things he highlighted here is their current focus on planning for COVID-19 surges and their need for more home and community-based services to support transitions of care.

Tim McNeill 12:17

So they don't have any preexisting relationship with the hospital. It is a challenging time for hospitals, many hospitals, just like skilled nursing facilities, are closed to visitors. So what we have found, most hospitals that are planning for surge as it relates to COVID-19 and everybody's working on plans, whether they have a surge currently coming or not. Cause I don't want to be caught without a plan in place, if there's a surge in their market, it usually is a multidisciplinary team that's organized to help develop that plan. So the discharge planning is just one component of that, but also infectious disease, the clinicians, all are part of that. And probably leading that effort is the clinical teams and the nursing teams with discharge planning, as well as administration, all supporting that effort. There's a huge focus on transitions to communities because of the inability to send to nursing facilities. So what we've seen and this rang true with Cincinnati, that was part of the n4a Business Institute webinar, their hospitals began organizing to figure out what was the plan B. There was an identified need for more home and community-based services. As they formed their committee, the AAA reached out and said, can we join the committee? Then they were invited in because they were seen as a resource with the most expertise in facilitating home and community-based services. So then once they're at the table, they can begin negotiating for how we can, how can we get integrated into the credit? In many communities, the concept of the ADRC and a No Wrong Door System, it's not something that most hospital administrators, clinicians are going to be adept that. That is something we're going to have to explain to them what that role is, what is the benefit and how we can facilitate those services that they may need, because they won't readily know how that fits in.

Narrator 14:27

Lastly, Tim spoke of ways that ADRCs can potentially leverage their relationship with the state to help them forge these new partnerships.

Tim McNeill 14:36

Since a lot of these services are going to occur at the local level, it is going to take implementation at the local level where that local ADRC, AAA, or CIL will be the implementation arm that could absolutely be facilitated by the state, particularly in markets where you have a health system, a health, a payer that operates in more than one market because their geographic region doesn't follow the same distinct lines that ours do. And so oftentimes we have a health plan or health payer that, that needs, will need to engage with multiple networks of community-based organizations to deliver services. Now, the state could play a role in coordinating those efforts to facilitate the monitoring of the services, as well as that coordination when people may be eligible for state level programs, whether it be Medicaid or Older Americans Act and so forth, then definitely the state could also be involved as well as tracking of outcomes. I think that the local agency should leverage that relationship with the state, as particularly when they work with a potential payer or health system that operates in multiple markets. We have seen great success with, with that. Ohio is one of those markets where the AAAs are very active working in collaboration with the state unit. And as they secured contracts with payers, they keep the state unit aware of those contracts. And also

particularly when it involves a beneficiary going into a Medicaid long-term service support model, coordinating with the State Unit on Aging to report quality and outcome metrics.

Narrator 16:26
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