Telehealth Lunch & Learn Webinar Series: Session 4

Remote Patient Monitoring:
Medicaid New Rules & Pediatric Asthma Project
May 15, 2018
MEDICAID REMOTE PATIENT MONITORING OVERVIEW

Monchel Pridge
Health Policy Analyst

Dr. Tiffany Wedlake
Managed Care Physician Advisor

Tuesday, May 15, 2018
Agenda

I. Definition and Prescribing RPM
II. Preauthorization Requirements
III. Coverage Information
IV. Billing Information
V. Questions
VI. For More Information
I. Definition and Prescribing RPM

What is RPM?

• Remote Patient Monitoring (RPM) uses digital technologies to collect health data from individuals and transmit it securely to health care providers.

• Data is monitored daily by providers.

• Health care providers then use the transmitted information for assessment, recommendations, and interventions.
Who Prescribes RPM

Providers that may prescribe RPM include:

• Home Health Agencies
• Hospitals
• Clinics
• Federally Qualified Health Centers
• Managed Care Organizations
• Health Professionals (Physicians, Nurses, and Physician Assistants)
When to Prescribe RPM

Providers should order RPM when:

- RPM is medically necessary to improve chronic disease control.
- Patient has excess hospital utilization (ED or Inpatient) due to poor disease control.
- RPM may reduce potentially preventable hospital utilization (ED or Inpatient).
Currently, RPM is approved to target the following medical conditions:

- Diabetes Mellitus (Type 1 and 2)
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
Other Requirements

• Individuals must be enrolled in Medicaid.

• Individuals must consent to RPM.

• Individuals must have an internet connection and the ability to use the monitoring tools in their homes.
Other Requirements

Individuals must have one of the following scenarios with the same qualifying medical condition as the primary diagnosis, within the previous 12 months:

- 2 admissions
- 2 ED visits
- 1 admission and 1 ED visit
**II. Preauthorization Requirements**

**Preauthorization Form**

<table>
<thead>
<tr>
<th>Section I: Patient Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Name</strong></td>
<td><strong>DOB</strong></td>
<td><strong>Medicaid Number</strong></td>
</tr>
<tr>
<td><strong>Home Address</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section II: Pay-to Provider Information**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Name</strong></td>
<td><strong>NPI</strong></td>
<td><strong>Medicaid Provider Number</strong></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
<td></td>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>

**Section III: Rendering Provider Information**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Name</strong></td>
<td><strong>NPI</strong></td>
<td><strong>Medicaid Provider Number</strong></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
<td></td>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>
II. Preauthorization Requirements

Preauthorization Form

SECTION IV: QUALIFYING CONDITIONS
For qualifying condition, mark 1 and circle corresponding ICD10(s). Both qualifying events should have same primary qualifying condition but may have different ICD10s.
Example: COPD, ICD10: J44.1 and J44.9.

☐ Diabetes Mellitus
   ICD-10:

☐ Chronic Obstructive Pulmonary Disease (COPD)
   ICD-10:

☐ Congestive Heart Failure (CHF)
   ICD-10:

SECTION V: QUALIFYING EVENTS
Please mark 1.

☐ Recipient had 2 hospital admissions within the prior 12 months with the same qualifying medical condition as the primary diagnosis.

☐ Recipient had 2 emergency department visits within the prior 12 months with the same qualifying medical condition as the primary diagnosis.

☐ Recipient had 1 hospital admission and 1 emergency department visit within the prior 12 months with the same qualifying medical condition as the primary diagnosis.

SECTION VI: ATTESTATIONS AND SIGNATURE (Please initial all that apply.)

____ Patient is not getting similar service from another provider.

____ Patient is felt to be at high risk for repeat hospital utilization and this monitoring will reduce the risk.

____ Patient has the ability to utilize the monitoring equipment and has stated a willingness to do so at the requested frequency every day.

____ Patient is not residing in a hospital, nursing facility, or other medical or psychiatric institution.

____ The ordering provider, if not the rendering provider, has (or will) alerted the service provider to the monitoring values which require immediate notification. (Home Health Agencies only)

__________________________________________
SIGNATURE (Physician, Physician Assistant, or Nurse Practitioner)

__________________________________________
DATE

MARYLAND
Department of Health
RPM Episodes

RPM referrals may cover an episode of up to 60 days of monitoring.

Individuals may receive two episodes of RPM during a rolling 12-month period.
RPM Episodes

Authorization limits apply across provider types.

For example, an individual cannot receive two episodes of RPM from a home health agency and two episodes of RPM from another provider during a rolling 12-month period.
RPM Rates

The reimbursable rate for RPM is $125 per 30 days of monitoring and is all-inclusive.

Example: If a physician monitors a qualifying diabetic patient for 60 days with RPM, the physician will be reimbursed $250 total for the episode.
RPM Rates

The all-inclusive rate covers:

- Equipment installation

- Educating individuals about how to use the equipment

- Daily monitoring of the information transmitted for abnormal data measurements
RPM Rates

The rate does NOT cover:

- RPM Equipment
- Upgrades to RPM Equipment
- Internet Service for Individuals Who Qualify for RPM
RPM Codes

HCPCS Code S9110 is reimbursable for RPM for the following provider types:

- Clinics
- FQHCs
- Hospitals
- MCOs
- Physicians
- Nurse Practitioners
- Physician Assistants
Revenue Code 0581 is reimbursable for Home Health Agencies ONLY.
Managed care organizations (MCOs) in the HealthChoice program may have different preauthorization requirements and reimbursement than the FFS system.

Please contact the MCOs about their specific RPM requirements.
## MCO Note

<table>
<thead>
<tr>
<th>MCO</th>
<th>Provider Information Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health of Maryland</td>
<td>1-866-827-2710</td>
</tr>
<tr>
<td>Amerigroup Community Care</td>
<td>1-800-454-3730</td>
</tr>
<tr>
<td>Jai Medical Systems</td>
<td>1-888-524-1999</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>1-877-806-7470</td>
</tr>
<tr>
<td>Maryland Physicians Care</td>
<td>1-800-953-8854</td>
</tr>
<tr>
<td>MedStar Family Choice</td>
<td>1-800-905-1722</td>
</tr>
<tr>
<td>Priority Partners</td>
<td>1-800-895-4998</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>1-877-842-3210</td>
</tr>
<tr>
<td>University of Maryland Health Partners</td>
<td>1-800-730-8543</td>
</tr>
</tbody>
</table>
VI. For More Information

Resources

Visit the RPM page on the MDH website: https://mmcp.health.maryland.gov/Pages/RPM.aspx

- RPM Transmittals
- RPM Preauthorization Form
- Link to the RPM regulations in COMAR

Home Health Providers: Tia Lyles
(410) 767-1448 or tia.lyles@maryland.gov

All Other Providers: Monasha Holloway
(410) 767-1737 or monasha.holloway@maryland.gov

MARYLAND Department of Health
For More Information

Visit the RPM page on the MDH website:
https://mmcp.health.maryland.gov/Pages/RPM.aspx

• RPM Transmittals
• RPM Preauthorization Form
• Link to the RPM regulations in COMAR

Home Health Providers:
Tia Lyles
(410) 767-1448
tia.lyles@maryland.gov

All Other Providers:
Monasha Holloway
(410) 767-1737
monasha.holloway@maryland.gov
Feasibility Pilot: Developing a Program to Foster a Child’s Self-Management of Asthma
Agenda

Remote Patient Monitoring (RPM) of children with asthma:
• Strategies
• Benefits and Metrics to Date
• Considerations for deployment under the current Medicaid RPM rules
Pediatrics at Home Background

We are a comprehensive provider of home based services, inclusive of home health, infusion and durable medical equipment serving the central corridor of Maryland and Washington, D.C.

Why Asthma?

• Second leading cause of admissions to Johns Hopkins Children’s Center
• Traditional home care model has not worked for this population, but we have the expertise of providing care in the community
• Perhaps a mobile platform could increase access to where the patient is, as well as engage in self-management
• Found a vendor that was willing to commit and collaborate on a pediatric-specific technology
The Team

Susan Huff, RN, MSN
Senior Director, Pediatrics at Home
Program Principal Investigator

John Adamovich, MHA
Administrator, Business Development and Innovation
Program Manager

Melissa Lantz-Garnish, RN
Monitoring Program Administrator
Program Clinical Lead

Michael Batista
Quantified Care, CEO
Program Coordinator

Leslie Poole, RRT
Pediatric Respiratory Therapist
Program Clinical Lead

Technology powered by
QuantifiedCare
Strategies: Environmental Scan

1. National, State and City Data

<table>
<thead>
<tr>
<th></th>
<th>USA</th>
<th>Maryland</th>
<th>Baltimore City</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Pediatric Population</td>
<td>74.1M</td>
<td>1.4M</td>
<td>133,560</td>
</tr>
<tr>
<td>Total Pediatric Asthma Population</td>
<td>6.2M</td>
<td>161,003</td>
<td>27,914</td>
</tr>
<tr>
<td>Lifetime Pediatric Asthma Prevalence</td>
<td>12.60%</td>
<td>16.40%</td>
<td>-</td>
</tr>
<tr>
<td>Current Pediatric Asthma Prevalence</td>
<td>8.40%</td>
<td>11.90%</td>
<td>20.90%</td>
</tr>
<tr>
<td><strong>Social Impact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Patient Missed School Days</td>
<td>10.5M</td>
<td>510,057</td>
<td></td>
</tr>
<tr>
<td>Missed School Days per Patient</td>
<td>1.69</td>
<td>3.17</td>
<td></td>
</tr>
<tr>
<td>Total Number of Caregiver Missed Work Days</td>
<td>84,000</td>
<td>4,080</td>
<td></td>
</tr>
<tr>
<td>Caregiver Missed Work Days per Patient</td>
<td>1.35</td>
<td>2.53</td>
<td></td>
</tr>
<tr>
<td>Cost of Productivity Loss per Year</td>
<td>$2.3B</td>
<td>$59.3M</td>
<td>$10.2M</td>
</tr>
<tr>
<td><strong>Medical Impact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Visit Rate (per 10,000 patients)</td>
<td>136.1</td>
<td>360.2</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Total Visits</td>
<td>18,520</td>
<td>5,514</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Cost per Visit</td>
<td>$685</td>
<td>$820</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Total Visit Cost</td>
<td>$12.1M</td>
<td>$4.5M</td>
<td></td>
</tr>
<tr>
<td>Hospitalization Rate (per 10,000 patients)</td>
<td>25.4</td>
<td>50.7</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations Total</td>
<td>2,976</td>
<td>792</td>
<td></td>
</tr>
<tr>
<td>Hospitalization Cost per Event</td>
<td>$5,403</td>
<td>$7,506</td>
<td></td>
</tr>
<tr>
<td>Hospitalization Total Cost</td>
<td>$16.1M</td>
<td>$5.9M</td>
<td></td>
</tr>
</tbody>
</table>

2. Survey and Focus Group of Target Population
Strategies: Pre-Deployment

Weekly meetings since fall 2015 led to a cycle of refinement:

- Clinical Workflow Development
- Data Gathering
- Technology Design Sessions
- Grant Identification and Writing
- Demos to Payors and Physicians
Strategies: Deployment

- Training
- Implementation
- Evaluation
- Outcomes
- Program Sustainability and Scalability
  – Funding
Coordinating Care with Technology

**Patient**
Remote Monitoring, Self-Management, Education

**MD Collaboration**
Primary Care Physicians, Specialists, Hospitalists

**Pediatrics at Home**
Primary Case Management

**Payors**
Reimbursement, Care Coordination
Benefits

• Increased Access: Bring Your Own Device
• Scalability of our clinicians
• Ability to:
  – get patients into PCP appointments
  – obtain up-to-date Asthma Action Plans
  – communicate via patient/caregiver preference
  – relay pertinent information to care team in near real time
  – proactively intervene before an issue becomes more serious
  – reinforce age appropriate medication education
  – provide supplies and facilitate refills
Outcomes to Date

- Ages 5-21
- Referred from JHCP Canton Crossing, East Baltimore Medical Center, and Remington
- Graduate at 90 days

Representative of April, 2017 through March, 2018 in an ongoing study

<table>
<thead>
<tr>
<th>Measure</th>
<th>Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>77</td>
<td>98% Priority Partners (Medicaid MCO)</td>
</tr>
<tr>
<td>Currently Enrolled</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Graduates</td>
<td>53</td>
<td>12 graduates are still checking in</td>
</tr>
<tr>
<td>Engagement</td>
<td>87%</td>
<td>Users engaging at least 4 times per 30 days</td>
</tr>
<tr>
<td>Reduction in High-Cost Utilization</td>
<td>80%</td>
<td>Pre/Post 90-day Comparison for ED Visit or Hospitalization</td>
</tr>
<tr>
<td>Reduction in High-Cost Utilization</td>
<td>53%</td>
<td>Pre/Post 180-day Comparison for ED Visit or Hospitalization</td>
</tr>
<tr>
<td>Patient/Caregiver Satisfaction</td>
<td>98%</td>
<td>Tests for Satisfaction and Technology Acceptance</td>
</tr>
</tbody>
</table>
Considerations with Medicaid

• Currently, this program is not reimbursable under Maryland Medicaid

• Goal: Work with Maryland Medicaid towards expanding coverage to include the care for children with asthma via a remote patient monitoring program
Q&As
Thank You!

Please complete the webinar survey coming to your inbox soon!

Or, click here