Partnership to Align Social Care

A National Learning & Action Network

Timothy McNeill, RN, MPH
Co-Chair
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Co-Designing A Social Care Delivery System

Leading the Way on Aligning Health and Social Care

Partnership to Align Social Care

A National Learning & Action Network

Building Sustainable CBO Network Capacity

Envisioning an Ideal State

Partnership to Align Social Care

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Health Systems

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Concert Health

CBOs

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Aging & In-Home Services of Northeast Indiana, Inc.

Bay Aging

Camden Coalition of Healthcare Providers

Community Catalyst

Denver Regional Council of Govt

Detroit Area Agency on Aging

Houston AAA/ADRC & Houston Health Department

Mid-America Regional Council

Ohio Association of AAAs

Partners in Care Foundation

Spectrum Generations

YMCA of the USA

Associations/Other

Rush University Medical Center

AHIP

AMA

American Academy of Family Physicians

American Hospital Association

Health Care Transformation Task Force

SNP Alliance

USAging

Epiphany LLC

Freedmen's Health

Gravity Project

Independent Living Systems, LLC

Manatt, Phelps & Phillips, LLP

Social Current

Administration for Community Living*

CMS, Center for Medicare & Medicaid Innovation*

Independent Living Research Utilization

Office of the National Coordinator for Health Information Technology (ONC)*

**Federal Liaisons*

Partnership Workgroup

- Three (3) Current Workgroups
  - Community Care Hub Workgroup
  - Billing and Coding Workgroup
  - Contracting Workgroup
- One (1) planned new Workgroup
  - Technology: Looking for best practices to align data sharing requirements for technology vendors capturing HRSN data and outcomes

SDOH Regulatory Landscape

Regulatory Environment for SDOH

- Several recent policies are highlighting the role of SDOH and Health Related Social Needs that impact the Medicare and Medicaid programs.
  - CMMI Strategy Refresh
    - ACO funding to address SDOH
  - CMS Proposed Hospital SDOH Screening requirement
  - CMS Physician Fee Schedule changes
  - NCQA SDOH HEDIS Measures
  - Medicaid
    - 1115 Waiver Authority
    - In Lieu of Services / Enhanced Care Management

NCQA SDOH HEDIS Measures

- NCQA has proposed a new required HEDIS measure regarding SDOH

- Will apply to NCQA accredited Health Plans: Medicare Advantage Plans, Special Needs Plans, Medicaid MCOs
  - Measure requires reporting the percentage of members screened for SDOH
  - Percentage that screen positive and receive a referral to obtain an intervention to address identified health-related social needs

Hospital Social Needs Screening and Intervention

- CMS announced a proposed requirement for 2023 that hospitals screen Medicare beneficiaries for unmet social need and deploy interventions to address identified needs.
- Key screening requirements:
  - Food insecurity
  - Housing
  - Transportation
- Voluntary reporting CY2023 with Mandatory reporting CY2024
- FY2024: Payment adjustment based on reporting of homelessness

Anticipated Increase in HRSN Screening Expected 2023

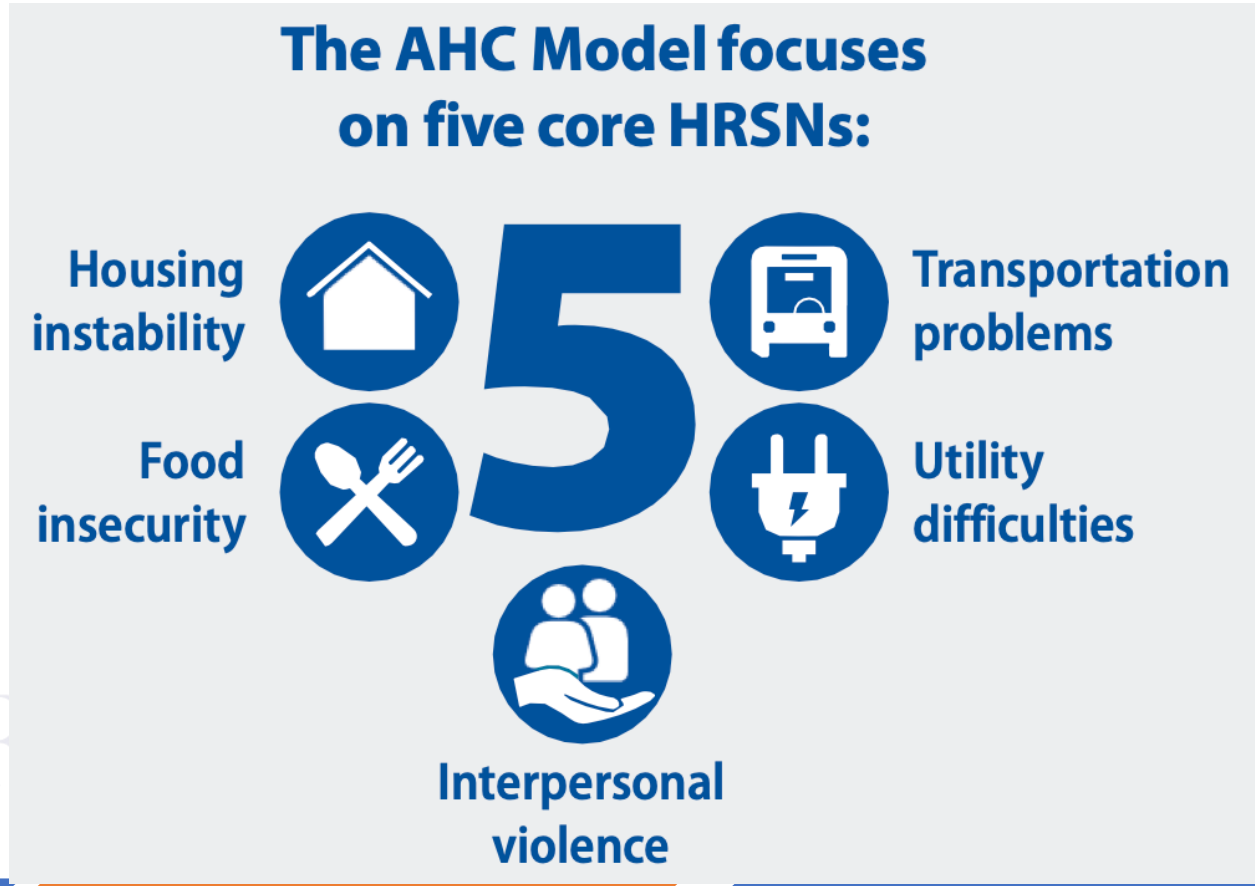
- There are numerous reports of Health Plans, Health Systems, and Providers mobilizing efforts to rapidly Expand HRSN screening to meet performance metrics beginning January 2023
  - NCQA – Social Need Screening and Intervention (SNS-E)
  - Joint Commission Requirements to Reduce Health Care Disparities
  - CMS IPPS Rules
  - MIPS Rule
  - MSSP ACO CY2023 Rule Changes
- Expected Outcome of increased screening: Increase volume of To coincide referrals to CCHs/CBOs to address HSRNs and data to show the outcome of referrals.

AHC Demonstration outlines the impact of increased screening Accountable

Model Overview

- The Accountable Health Community (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by addressing health-related social needs (HRSNs).
- Bridge organizations are required to screen all community-dwelling Medicare and Medicaid beneficiaries.
- **<u>482,967</u> Medicare/Medicaid Beneficiaries** successfully screened using an evidence-based SDOH screening tool

Key Components

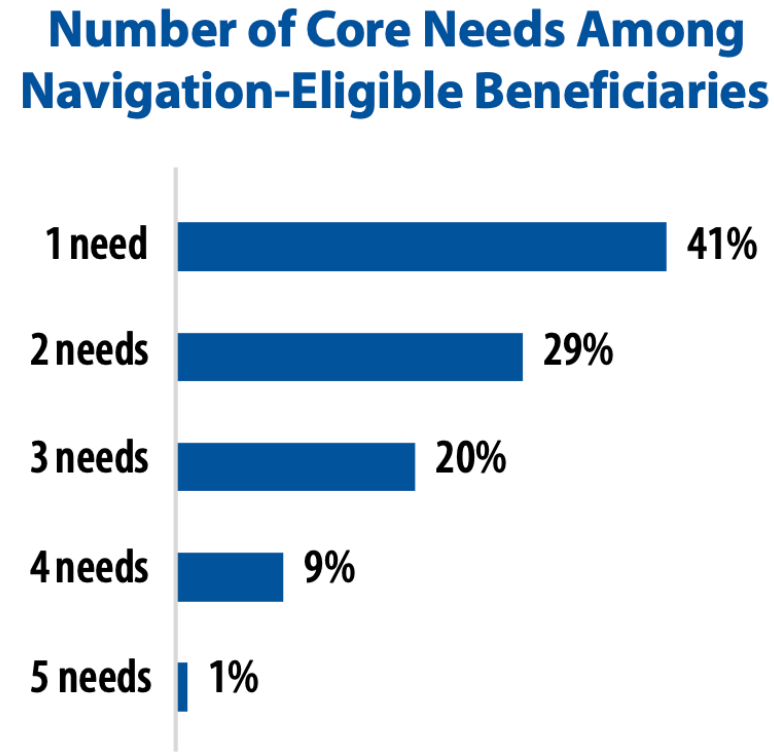


Accountable Health Community Model Findings

Evaluation

- More than half of navigation-eligible beneficiaries reported more than one core need.
- Food insecurity was the most commonly reported need (median prevalence of 69% across bridge organizations).
- Fully 74% of eligible beneficiaries accepted navigation, but only 14% of those who completed a full year of navigation had any HRSNs documented as resolved.
  - **Referrals without interventions**
- ***Key Finding: Identifying need without a targeted intervention strategy will not have sustainable success in addressing identified needs.**
- Evaluation Link: https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt-fg

Significant Need Among the Population



Future State: Community Network Hubs in Every Market

Community Integrated Health Network Model

Consumer

Care Team Referral Source

Common Access Point/Single Sign-On

CBO Evidence-Based SDOH Screening

SDOH Person-Centered Plan: Combining Multiple CBO Resources

CBOs Blend & Braid Resources
Public + Private + Philanthropy

Closed-Loop Outcome Reporting

Care Team

CMS Proposed Rule

Proposed Rule

Available:

- Release Date: July 13, 2023
- Comments period closed on September 11, 2023
- Final Rule expected to be released by November 1, 2023
- Final Rule will take effect on January 1, 2024

Key Sections Addressing Health Equity

- Proposed Rule Changes:
  - Social Determinants of Health (SDOH) Risk Assessment
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)
- Final Rule applies to Original Medicare Part B
- MA Plans and Special Needs plans must cover all Part A and Part B services
  - MA
  - SNPs (D-SNP, C-SNP, FIDE-SNP, HIDE-SNP)

Social Drivers of Health Risk Assessment

Proposed Rule for Health-Related Social Needs Screening

- “we [CMS] are proposing to establish a code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an E/M visit.”
- We are proposing a new stand-alone G code, GXXX5, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.
- SDOH risk assessment refers to a review of the individual’s SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.

Billing Code for HRSN Screening

- We [CMS] are proposing GXXX5 to identify and value the work involved in the administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit.
- Rate?
  - Relative example: CMS pays for a depression screen performed by a physician once per year.
  - CPT Code for Depression Screening
  - Medicare

Community Health Integration (CHI) Services

Community Health Integration Billing Codes

- We are proposing to create two new G codes describing CHI services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner.
- We are proposing that CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit.

Initiating Visit Requirement

- We propose that the CHI initiating visit would be an E/M visit (other than a low- level E/M visit that can be performed by clinical staff) performed by the billing practitioner who will also be furnishing the CHI services during the subsequent calendar month(s).
- The CHI initiating visit would serve as a pre-requisite to billing for CHI services, during which the billing practitioner would assess and identify SDOH needs that significantly limit the practitioner's ability to diagnose or treat the patient's medical condition and establish an appropriate treatment plan.

Use of Auxiliary Staff such as CHWs

- The subsequent CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initiating visit.
- The same practitioner would furnish and bill for both the CHI initiating visit and the CHI services, and CHI services must be furnished in accordance with the “incident to” regulation at § 410.26.

CHI vs CCM

- We would not require an initiating E/M visit every month that CHI services are billed, but only prior to commencing CHI services, to establish the treatment plan, specify how addressing the unmet SDOH need(s) would help accomplish that plan, and establish the CHI services as incident to the billing practitioner's service.
- This framework is similar to our current requirements for billing care management services, such as chronic care management services.

Incident To Requirements

- For purposes of assigning a supervision level for these “incident to” services, we are proposing to designate CHI services as care management services that may be furnished under the general supervision of the billing practitioner in accordance with
- § 410.26(b)(5). General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service (§ 410.26(a)(3)).

Types of Services covered under CHI

- Specifically, we are proposing that SDOH(s) may include but are not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when they significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the CHI initiating visit.
- Since Medicare payment generally is limited to items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury, the focus of CHI services would need to be on addressing the particular SDOH need(s) that are interfering with, or presenting a barrier to, diagnosis or treatment of the patient's problem(s) addressed in the CHI initiating visit.

Time Based Billing Codes

- GXXX1 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit:
- GXXX2 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1).

Principal Illness Navigation (PIN) Services

Proposed Service Definition

- For CY 2024, we are proposing to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected **to last at least 3 months**, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.

Target Populations

- Examples of serious, high-risk diseases for which patient navigation services could be reasonable and necessary could include cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

Intervention Defined

- Proposed Principal Illness Navigation (PIN) Service Definition
- PIN services could be furnished following an initiating E/M visit addressing a
- serious high-risk condition/illness/disease, with the following characteristics:
- One serious, high-risk condition expected to last at least 3 months and that
- places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;
- The condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

Auxiliary Personnel operating Incident To the Physician

- The subsequent PIN services would be performed by auxiliary personnel incident to the professional services of the practitioner who bills the PIN initiating visit. The same practitioner would furnish and bill for both the PIN initiating visit and the PIN services, and PIN services must be furnished in accordance with the “incident to” regulation at § 410.26.
- We would not require an initiating E/M visit every month that PIN services are billed, but only prior to commencing PIN services, to establish the treatment plan, specify how PIN services would help accomplish that plan, and establish the PIN services as incident to the billing practitioner’s service.

ASPE Analysis of CCM/TCM Utilization

- ASPE Report on the 2019 utilization of CCM and TCM by

Exhibit 2: Medicare FFS Beneficiaries Receiving CCM or TCM Services in 2019

Category	CCM	TCM
Total Medicare FFS beneficiaries with Part B coverage	35,598,051	35,598,051
Number of FFS beneficiaries potentially eligible for CCM or TCM	22,570,404	6,282,242
Percent of FFS beneficiaries potentially eligible for CCM or TCM	63.4%	17.7%
Beneficiaries with one or more CCM or TCM claims	882,728	1,078,580
Percent of potentially eligible beneficiaries with CCM or TCM claims	4.0%	17.9%

https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf

Learning Collaborative

Learning Collaborative Timeline

- Application release: Week of October 23, 2023
- November 2023: Community-Clinical Team participants identified
- December 2023: Pre-learning session and overview of the CHI codes and concepts of Multi-Payer Alignment of APMs to drive Health Equity (HCP-LAN HEAT Guide):
  - Reference: HCP-LAN HEAT Guide: *Advancing Health Equity through APMs, Guidance for Equity-Centered Design and Implementation*
  - Available: https://hcp-lan.org/workproducts/APM-Guidance/Advancing-Health-Equity-Through-APMs.pdf
- January 2024: Learning Collaborative Launch

Learning Collaborative Market Example – Houston, Texas

- The Community organizes a set of relevant stakeholders that are interested in improving health equity, using a multi-payer alignment approach.

Health System: Baylor St. Luke's Medical Center, Memorial Hermann-Texas Medical Center	**CCH/CBO: Houston Health Department/UT Health Sciences CCH – CATCH, Houston Health Foundation**
Healthcare Provider: Baylor St. Luke's MSSP ACO, Memorial Hermann ACO, Ibn Sina	**Person with lived experience: AAA Advisory Member/Health Department Advisory member from the community**
Health Payer: United Healthcare, Elevance Amerigroup, Medicare	

Learning Collaborative Market Example – Priority Issue

- The community clinical team reviews the data regarding Disparities-Sensitive Measures in their community.
- Each member of the Community-Clinical Team is respected and given equal power in participation.
- After a review of the relevant data from **State and local health department resources, health system utilization data, healthcare provider data, and health payer data**, the community-clinical team determines that the most relevant **disparity sensitive condition impacting their community is diabetes**.

Learning Collaborative Market Example – Priority Population

- Adults with diabetes
- Persons with gestational diabetes
- Persons with diabetes and multiple chronic conditions
- Persons with diabetes and functional impairments that limit their ability to perform activities of daily living (ADLs)
- Persons with diabetes and comorbid behavioral health or SUD conditions

- A secondary priority for the Houston Community-Clinical Team includes persons in the household that are at elevated risk of developing disease:
  - Childhood obesity
  - Persons with prediabetes

Learning Collaborative Market Example – Social Needs

- The Community-Clinical Team determined that the following factors are potentially impacting health outcomes for the priority population:
  - Health literacy
  - Limited disease self-management skills
  - Food Insecurity
  - Access to care
  - Access to medication
  - Lack of completion of relevant health screening and preventive health measures

Learning Collaborative Market Example – Multi-Payer Impact

- Priority Population Impacts Multiple Payers in the Houston Market:
  - Medicare (Original Medicare, Duals, MSSP ACO population)
  - Medicaid (Medicaid MCOs – Texas Star, Star-Plus plans, UHC)
  - Medicaid Waiver (Texas Star – Plus, UHC)
  - Special Needs Plans (United Healthcare)
  - Medicare Advantage (United Healthcare MA Plan)
  - Commercial Insurance
  - Uninsured (Texas Uncompensated Care Fund)

Health Equity Performance Measures

- The Community-Clinical Teams adopt at least one aligned health equity performance measure set, stratified by Race, Ethnicity, language and other characteristics, to assess health equity performance.
- Next the Community-Clinical Teams adopt a common methodology to measure the size of health disparities at baseline and then monitor month-to-month and and year-over-year changes.

Disparity-Sensitive Measure Selection

NQF#	Measure Title	Measure Description
575	Comprehensive Diabetes Care: HbA1c control (<8.0%)	The percentage of members 18 – 75 with diabetes who had HbA1c control (<8.0%)
630	Diabetes and elevated HbA1c – use of diabetes medications	The percentage of adult patients 18 – 75 with diabetes and an elevated HbA1c who are receiving diabetes medications
1902	Clinician/Group's Health Literacy practices based on the CAHPS Item set for addressing health literacy	The item set includes the following domains: communication with provider, disease self-management, communication about medications, communication about test results, and communication about forms.
272/274	Diabetes Short-Term and Long-term complications admission rate	Number of discharges for diabetes (short-term and long-term) complications per 100,000
285	Rate of lower extremity amputation among patients with diabetes	The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 population

Learning Collaborative Market Example – Root Causes

- Next, the Community-Clinical Teams work to identify all of the possible root causes that contribute to health disparities related to diabetes outcomes.
  - Social Determinants of Health (i.e., lack of safe, walkable communities that allow persons to maintain an exercise regimen)
  - Health-Related Social Needs (i.e., food insecurity or lack of access to recommended dietary choices that meet diabetes management guidelines)
  - Limited Health Literacy
  - Limited disease self-management capacity
  - Access to preventive health care services

Learning Collaborative Market Example – Intervention Model

- Evidence-based screening protocols for HRSNs,
- Z-code reporting of identified needs, reporting and monitoring identified needs (must include tracking of race, ethnicity, and geography)
- Deploying interventions to address priority social needs (health literacy, disease self-management capacity, food insecurity, transportation/access to care, etc.).
- Reporting HCPCS/CPT codes (CHI/PIN) to capture the labor related to addressing identified needs.
- Monitoring the outcomes of the interventions at the individual and population level.
- Regular review of the outcome data to determine the impact on health disparities.
- Gathering input from diverse stakeholders on suggested methods to drive improvement year-over-year.

Health Plan Benefits for Participation

- Improved HEDIS performance
- Improved CAHPS scores
- Increased collaboration with community to drive HEDIS measure improvement
- Health plan partnerships with community to define and implement programs to drive towards health equity goals
- Community partnerships to support NCQA Health Equity or Health Equity Plus Accreditation
- Improvement in Value-Based Contracting goals (internal goals or Medicaid required goals)
- Identification of additional resources (public/philanthropic) to meet member health needs

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Co-Chairs

June Simmons
Partners in Care Foundation
jsimmons@picf.org
818-837-3775 x101

Timothy P. McNeill
Freedmen's Health
tmcneill@freedmenshealth.com
202-344-5465

Project Director

Autumn Campbell
acampbell@Partnership2ASC.org
202-805-6202
@Partners2ASC