Community Care Hub
National Learning Community

Network Expansion Track Meeting

March 9, 2023

Introductions

- Please let us know who is here by sharing via chat:
  - Your name
  - Organization

- It's also helpful to update your name in Zoom to include your name, organization, and state
  - To change how your name appears in Zoom:
    - Go to "Participants" list and select the icon with 3 dots to the right of your name
    - Select "Rename"
    - Enter your name and organization and select "Change"

Agenda

- Welcome
- Billing & Coding ECHO Session Introduction
- Key Policy Issues and Best Practices for Interventions to Address HRSNs
- NCQA Presentation
  - Q&A
- Case Study Presentation
  - Group Discussion
- Closing

Logistics

- Recordings and meeting material
  - NLC meetings will be recorded and shared with NLC participants via email
  - Meeting material will be posted to the NLC technical assistance page
- Sound
  - Please keep yourself on mute unless speaking
- Use the Raise Hand function to engage
  - To raise your hand, click on the “Reactions” box and then click “Raise Hand.” You can also lower your hand by following the same process.
  - Please provide your name and organization when speaking
- Closed captioning
  - A live transcript of the meeting is available. To turn on closed captioning click on the upward arrow next to Live Transcript and select “Captions.” The captions option may also be available under the icon labeled “More.”

Community Care Hub Billing and Coding Session #1

March 9, 2023

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Why Is it Important to Understand Billing and Coding

- Billing and Coding is the language that healthcare professionals speak.
- If your organization cannot speak Healthcare Billing and Coding, **you cannot** effectively communicate with the rest of the Healthcare Industry.
  - An example we like to use is: If you're trying to do business in Latin America, your chances for success is better if you are speaking Spanish versus English. You have to be able to speak the language… the same goes for healthcare.
- Healthcare collectively refers to the following key groups:
  - Health Plans
  - Hospitals
  - Providers/Clinicians
- These are your primary audiences

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Today's ECHO Session

Time	Session Topics
10 minutes	Didactic presentation of key policy issues and best practices for interventions to address Health-Related Social Needs (HRSNs)
20 minutes	NCQA Presentation HRSNs HEDIS Measures and Billing and Coding Overview
10 minutes	Discussion/Questions for Presenters
5 minutes	Anonymized Case Study Presentation
30 minutes	Group Discussion and Problem solving for the issues presented in the case study
5 minutes	Summary, Wrap-Up, Planning for Next Session

Learning Objectives for Today's Session

- Increase participant literacy in billing and coding
- Increase understanding of the value that community-based organizations (CBOs) bring to health systems/plans
- Identify ways that CBOs can sustain activities used to address health-related social needs (HRSNs)

Speaker for Today's Session

Sarah Paliani, MPH

Ms. Sarah Paliani is Senior Research Associate at the National Committee for Quality Assurance (NCQA), where she supports measure development initiatives related to social determinants of health, health equity, and complications of diabetes. Recently, Sarah led the development of a new HEDIS measure assessing Social Need Screening and Intervention (SNS-E).

Sarah holds a Master's in Public Health from Columbia University Mailman School of Public Health, with a certificate in Health Promotion Research and Practice.

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Project ECHO

January 2023 Implementation of Quality Metrics for SDOH

Healthcare Actions to Implement New Quality Metrics

- Numerous Reports of Plans to rapidly Expand HRSN screening to meet performance metrics beginning January 2023
  - NCQA
  - Joint Commission
  - CMS IPPS Rules

2023 HEDIS® SDOH Measure

- The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, **and** received a corresponding intervention if they screened positive.
- **Percentage of members that screen positive and receive a corresponding intervention within 1 month of identifying a need**
- Key SDOH Categories
  - Food
  - Housing
  - Transportation

Joint Commission Health Care Disparities Requirements

- Effective **January 1, 2023**:
- Requirements:

1. Organization must designate an individual to lead activities to reduce health care disparities for the organization.
2. Organization must assess for health-related social needs and provide information about community resources and support services
3. Organization must develop a written action plan to address at least one of the health care disparities prevalent in the population.

CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule

- Key Rule Changes:
  - Hospital Commitment to Health Equity measure beginning with the CY 2023 reporting period/FY 2025 payment determination.
  - Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination
    - Housing Insecurity
    - Food Insecurity
    - Transportation Insecurity

Social Need Screening and Intervention (SNS-E)

Sarah Paliani, MPH, PCMH CCE (she/her)

Senior Research Associate, NCQA

Healthcare Effectiveness Data and Information Set

HEDIS® 101

A measurement set used by more than 90 percent of America's health plans.

Allows for comparison of health plans across important dimensions of care and service

- Receive preventive services
- Manage chronic conditions
- Address behavioral health
- Coordinate Care
- Overuse/ Appropriateness

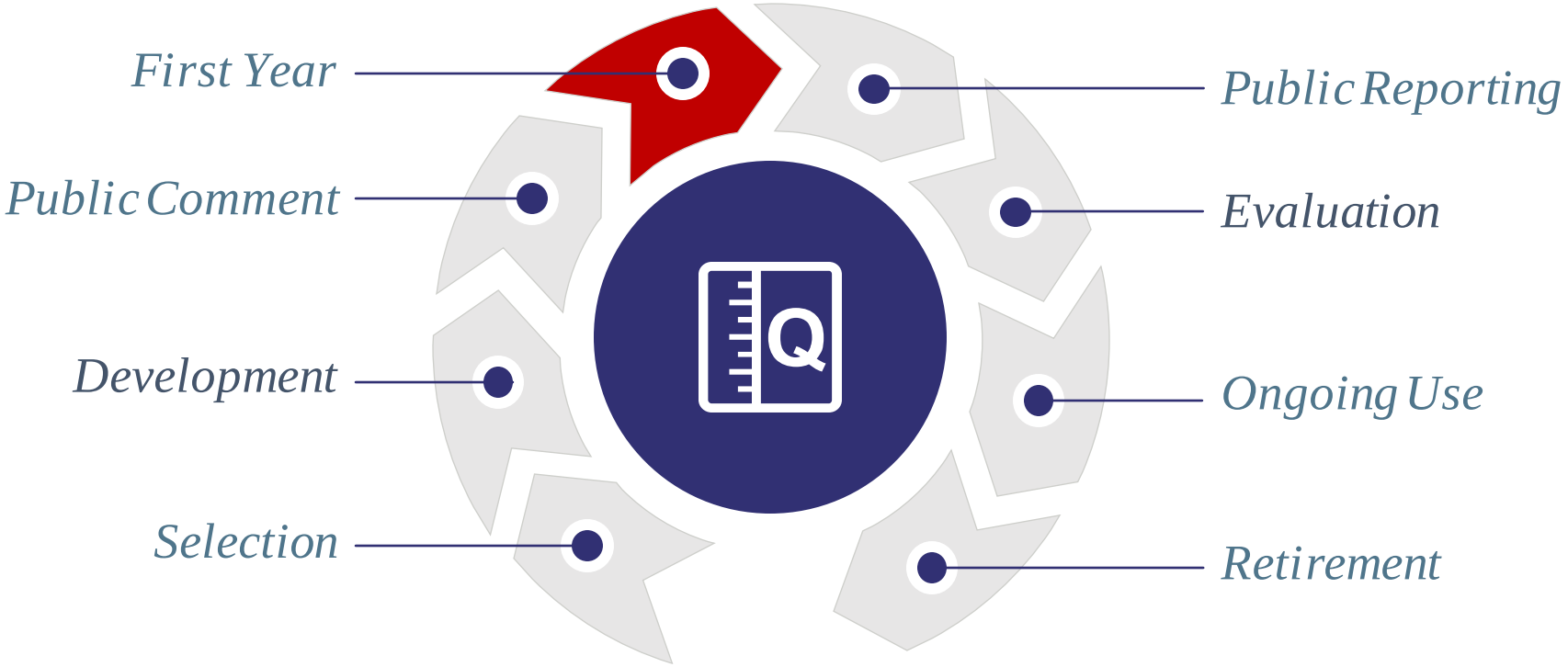
Advance health equity across all domains

Addressing Health Equity with HEDIS

Goals

- **Bring transparency** to inequities in health care quality.
- **Promote inclusive approaches** to measurement and accountability.
- **Address social needs** to improve health outcomes.
- **Incentivize equity** with benchmarks and performance scoring.

HEDIS Measure Development Process



Social Need Screening and Intervention (SNS-E)

Measure Specification

Measure Description

The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using a pre-specified screening instrument and, if screened positive, received a corresponding intervention.

Six Indicators:

1. Food Insecurity Screening
2. Food Insecurity Intervention
3. Housing Screening
4. Housing Intervention
5. Transportation Insecurity Screening
6. Transportation Insecurity Intervention

Product Lines

Commercial, Medicaid, Medicare

Reporting Method

Electronic Clinical Data Systems

Exclusions

Hospice

I-SNP

LTI

Age Stratification

- ≤17
- 18-64
- 65+

Different Reporting Methods for HEDIS

Administrative Method: Transaction Data — *Enrollment, Claims, Encounter*

Hybrid Method: Administrative + Sample — *Manual Medical Record Review*

Survey Method — *CAHPS®, Medicare Health Outcomes Survey*

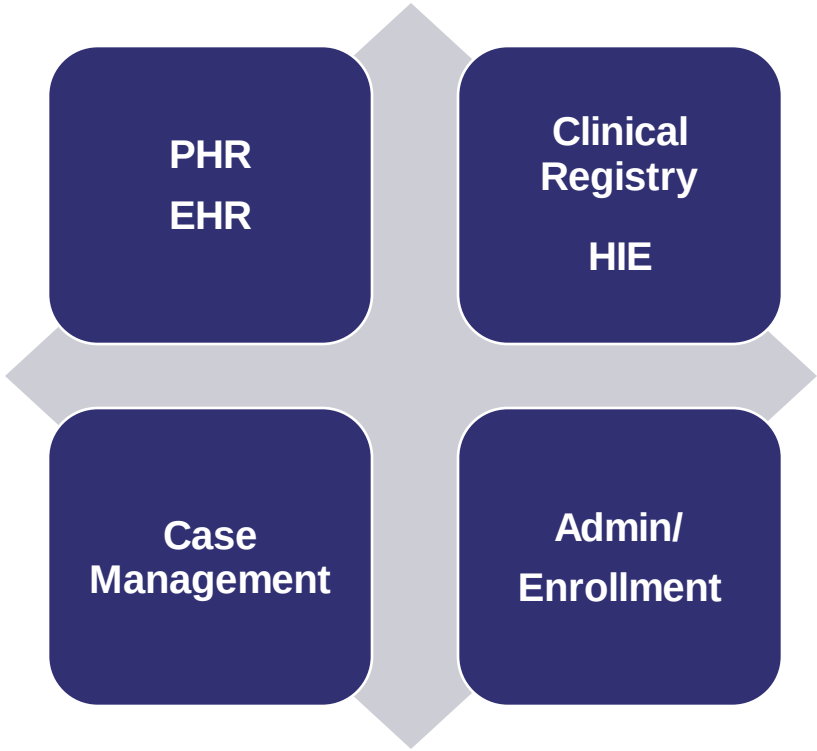
Electronic Clinical Data Systems Method — *Enrollment, Claims, Encounter, EHRs, Registries, Case Management*

Reporting standard for HEDIS

Electronic Clinical Data Systems (ECDS)

A **structured method** to collect and report **electronic clinical data** for HEDIS® quality **measurement** and for quality **improvement**

Organizations report each measure component **by source system.**



For more information on ECDS: http://www.ncqa.org/ecds

Gravity Project

Social Needs Electronic Data Standards

- A national public collaborative that develops consensus-based data standards involving social determinants of health (SDOH).

- NCQA's Social Need Screening and Intervention measure aligns with current Gravity Project data elements.

3 Screening Indicators (Food, Housing, Transportation)

Screening Indicators

Numerator: Members with 1+ documented result on food/housing/transportation screening

Denominator: Members 0+ continuously enrolled during MY

Screening Instruments (Documented via LOINC):

- Accountable Health Communities
- AAFP Social Needs Screening Tool
- Health Leads Screening Panel®1
- Hunger Vital Sign™
- PRAPARE
- Safe Environment for Every Kid (SEEK)
- We Care Survey
- WellRx Questionnaire
- Housing Stability Vital Signs™
- Comprehensive Universal Behavior Screen (CUBS)
- PROMIS
- USDA Food Security Survey

Mixing and matching allowed

Screening Example

Social Need Screening Questionnaire

Hunger Vital Sign *Food*	1. Within the past 12 months, you worried that your food would run out before you got money to buy more. (88122-7)	❑ **Often True (LA28397-0)** ❑ **Sometimes True (LA6729-3)** ❑ Never True (LA28398-8)	Positive
PRAPARE *Housing*	2. Are you worried about losing your housing? (93033-9)	❑ **Yes (LA33-6)** ❑ No (LA32-8)	Positive
Health Leads *Transportation*	3. In the last 12 months, have you ever had to go without healthcare because you didn't have a way to get there? (99553-0)	❑ **Yes (LA33-6)** ❑ No (LA32-8)	Positive

Cultural and linguistic adaptations allowed.

3 Intervention Indicators (Food, Housing, Transportation)

Intervention Indicators

Interventions defined by Gravity Project Intervention Categories

- Assessment
- Assistance
- Coordination
- Counseling
- Education
- Evaluation of eligibility
- Provision
- Referral

Members who **received a corresponding intervention with in 30 days** of first positive screen

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Members with at least 1 positive result for food, housing, transportation

Defined in Gravity Project Value Sets

Examples of Interventions

Intervention type	Example
Assistance	Assistance with application to Homelessness Prevention program
Assessment	Assessment of barriers in inadequate housing care plan
Coordination	Coordination of care plan
Counseling	Counseling for readiness to implement food insecurity care plan
Education	Education about area agency on aging program
Evaluation	Evaluation of eligibility for a fuel voucher program
Referral	Referral to area agency on aging
Provision	Provision of home-delivered meals

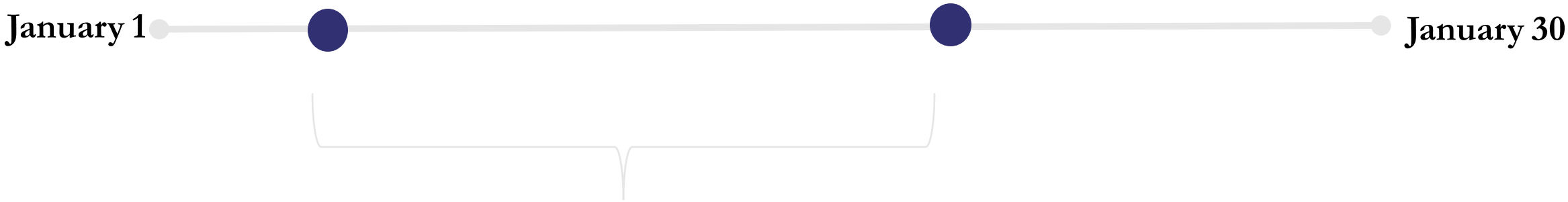
Captured via CPT, SNOMED, HCPCS codes

Food insecurity

Intervention Example

Positive Food Insecurity Screening Result (LOINC LA28397-0)

Referral to community meals service (SNOMED 713109004)



Referral must be placed within 30 days – closing the loop not yet required.

SNS-E Measure Timeline

MY 2023 HEDIS Publication

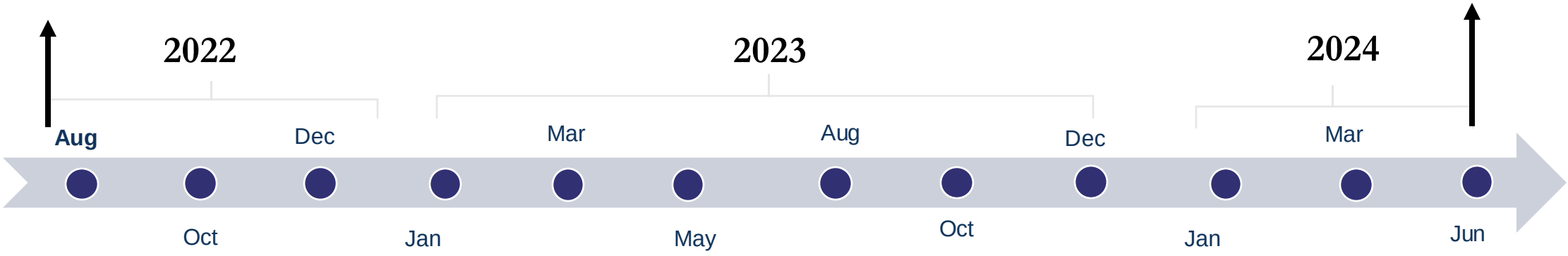
Final SNS-E measure specification released for MY 2023.

Measurement Year 2023

The period of time during which heath plans collect SNS-E data.

MY 2023 Data Reported

Plans submit SNS-E performance data from measurement year.



Each year, the new HEDIS volume is released the August prior to the applicable measurement year.

Thank you

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Project ECHO

Case Study Discussion

Anonymized Real World Case Example

- A DC Medicaid MCO has 100,000+ members. The MCO data reveals approximately 10,000 members have disproportionately high utilization.
- The population is difficult to engage through traditional call-center based case management models.
  - MCO Case managers report that the population, with significant HRSNs, are transient, often have wrong phone numbers, and frequent address changes.
- The health plan would like to determine the impact of HRSNs on this population.

<u>Discussion Question #1</u>

- How could the MCO work with healthcare providers and CBOs to engage this population, if the MCO has limited impact using traditional call-center case management approaches?

Case Example: Discussion Question #2

- A DC Medicaid MCO has 100,000+ members. The MCO data reveals approximately 10,000 members have disproportionately high utilization.
- The MCO extends a value-based contract to a large health system and CBO, providing care transitions for hospital patients, for reporting HRSNs in the NCQA HEDIS format – for MCO enrolled members.

Discussion Question #2

- If the population are high-utilizers, how can a care transitions intervention be used to meet the MCO VBP contract requirement?
- How would the CBO care transitions team determine which hospital patients are enrolled with the MCO?
- Is there a HIPAA requirement that prevents the CBO care transitions team from providing care coordination for MCO patients?

Case Example: Discussion Question #3

- The MCO VBP contract aligns with the NCQA SNS-E HEDIS Measure
- The Health System and CBO must report data on each member according to the NCQA SNS-E HEDIS requirement
- Key points for consideration:
  - Completing an **Evidence-based Screen**
  - Deploying an intervention **within 1 month** of identifying a need

Discussion Question #3

- The health system is delegating the HRSN screening to the CBO providing Care Transitions. How will the CBO address the data reporting requirement?

Case Example: Discussion Question #4

- The MCO VBP contract provides payment for completing HRSN screening and separate payment for reporting interventions deployed within 1 month.
- The MCO will not provide startup funding for the CBO and the MCO reports that they have difficulty reaching the population so the MCO cannot guarantee volume.

<u>Discussion Question #4</u>

- What is the potential business opportunity and sustainability strategy for the CBO?
- What steps can the CBO take to assess financial viability of the project?
- How can the CBO assess if the project is viable to "invest"?

Case Example: Discussion Question #5

- The CBO Care Transitions team successfully implements the MCO VBP contract with one health system.
- The MCO requests expansion to another DC Hospital with high utilization of MCO members.

Discussion Question #5

- How can the CBO Care Transitions Team engage the second hospital?
- Is there a value-add benefit to the hospital to receive "free" care transitions services paid by the MCO?
- How will the CBO assess the financial viability of expanding to a second hospital, if the MCO will not provide startup capital?

Case Example: Discussion Question #6

- The MCO VBP contract provides payment for completing HRSN screening and separate payment for **reporting interventions** deployed within 1 month.
- The MCO does not pay for interventions, they only pay for reporting what interventions were deployed.

Discussion Question #6

- How can the CBO care transitions team utilize blending and braiding to address needs in the priority categories: Food insecurity, Housing, & Transportation?
- What happens if the CBO cannot "fix" the need or if the need extends beyond the care transitions period?

Case Example: Discussion Question #7

- During care transitions, the transitions coach has identified persons with Diabetes and Prediabetes.
- The CBO has a DPP, DSMT, and MNT program

Discussion Question #7

- Should the CBO incorporate a process to screen and refer persons to their other programs that they have a contract to perform?
- Is there a regulatory requirement that prohibits referring persons to other programs the CBO provides?
- Is there a HIPAA requirement that prohibits the CBO for assessing the person for other needs and making appropriate referrals?

Next Session

Session Topic	Session Speakers (Tentative)	Dates for Sessions
☑ Session #1 Introduction to Series - Billing and Coding Overview	NCQA: Sarah Paliani	March 9, 2023
Session #2 Billing and Coding Mechanics Part 1:	**Gravity Project – Sarah DeSilvey**	**April 13, 2023**
Session #3 Billing and Coding Mechanics Part 2:	Common Spirit – Ji Im	May 11, 2023
Session #4 Transforming Health Care Billing and Coding Part 1	Lakeland Health System, Michigan	June 8, 2023
Session #5 Transforming Health Care Billing and Coding Part 2	Independent Health Medicare Advantage Plan	July 13, 2023
Session #6 Summary - Break-out groups, Discussions on what was learned and ideas	United Healthcare	August 10, 2023

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Questions

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Upcoming Meetings & Events

- Peer Group Dialogue Meeting – March 23, 2023, 2-3pm ET
- Network Expansion Track Curriculum Meeting – April 13, 2023, 2-3:30pm ET
  - Theme: Z-Code reporting and CMS IPPS Hospital requirements

Update: April NLC All-Member Meeting – New Date TBD

Thank you!
Please contact
CommunityCareHubs@acl.hhs.gov
with any questions.

Administration for Community Living