Community Care Hub
National Learning Community

Network Expansion Track Meeting

July 13, 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"

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.”

Agenda

- Welcome
- ACL Updates
- ECHO Session: Transforming Billing and Coding – Working with Medicare Advantage Plans
  - Q&A
- Case Study Presentation
  - Group Discussion
- Closing

Older Americans Act Proposed Rule – Input Needed

- ACL seeks input on proposed updates to the regulations for most of its Older Americans Act (OAA) programs.
  - Last substantial update to most OAA program regulations was in 1988
- The 60-day comment ends August 15, 2023, and ACL is looking for input from aging and disability networks and those served by OAA programs.
- Instructions for submitting comments can be found here.

Community Care Hub Billing and Coding Mechanics Session #5

July 13, 2023

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Disclaimer

"Project ECHO® collects registration, participation, questions/answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to inform new initiatives.“

Overview of the ECHO Learning Framework can be found at:

- https://hsc.unm.edu/echo/what-we-do/about-the-echo-model.html

Community Care Hub Billing and Coding
An ECHO Initiative

Learning Objectives for Today's Session

- Increase participant knowledge of opportunities to contract with Medicare Advantage Plans.
- Increase participant awareness of Special Supplemental Benefits for the Chronically Ill(SSBCI) and Supplemental Benefits.
- Determine opportunities for CCHs/CBOs to contract with Medicare Advantage Plans
- Increase understanding of the value that community-based organizations (CBOs) bring to Medicare Advantage Plans.
- Identify ways that CCHs/CBOs can utilize existing billing codes in a contract negotiation with a health plan.

Today's ECHO Session

Time	Session Topics
5 minutes	Recap of topics covered in Session #4
10 minutes	SSBCI and Supplemental Benefits Overview
5 minutes	MA Plan Contracting Cycle
30 minutes	Western New York Integrated Care Collaborative / Independent Health Plan
10 minutes	Discussion/Questions for Presenter
25 minutes	Anonymized Case Study/Group Discussion and Problem Solving
5 minutes	Summary, Wrap-Up, Planning for Next Session

ECHO Session #4 Summary

- Session #4 of our ECHO series on Billing and Coding.
  - Overview of value-based contracting.
  - Role of CBOs in the value-based contracting cycle.
  - Role of CCHs/CBOs designing sustainability and reducing the total cost of care in a value-based contract model.
- Michigan Region IV AAA / Colmar Health Presentation
  - Home-based primary care practice serving high-risk, homebound patients.
  - Clinical practice outsources Chronic Care Management, Transitional Care Management, and Collaborative Care Management to the CBO.
  - CBO is fully integrated into the clinical delivery model and the financial model with a trajectory moving towards shared risk.

CMS Rule Changes for Medicare Advantage Plans

- CMS Announced Medicare Advantage Plan requirement changes to increase plan flexibility to tailor services to the needs of the beneficiary:
  - Proposed Ruling released in two parts
    - December 27, 2017
    - February 1, 2018
  - Final Policy Released
    - April 2, 2018
  - CMS Guidance Memo Released
    - April 27, 2018

2019: Expanding Health Related Supplemental Benefits

- The previous regulations limited supplemental MA plan benefits to health-related services.
  - There were specific limitations on supplemental benefits that include daily maintenance.
- This requirement prevented some plans for designing supplemental benefit packages that included non-skilled services that could reduce readmissions or improve health outcomes.

2019 Re-interpretation of the Supplemental Benefit

- "Under this reinterpretation, CMS would allow supplemental benefits if they are used to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."

Supplemental Benefits Defined

- AUTHORITY TO WAIVE UNIFORMITY REQUIREMENTS.—The Secretary may, only with respect to supplemental benefits provided to a chronically ill enrollee under this sub- paragraph, waive the uniformity requirements under this part, as determined appropriate by the Secretary.

CMS Guidance to Health Plans on SSBCI Benefits

Meals	Food and Produce
Transportation for Non-Medical Needs	Pest Control
Indoor Air Quality Equipment and Services	Social Needs Benefits
Complimentary Therapies	Services Supporting Self-Direction
Structural Home Modifications	General Supports for living
Homemaker Services	Personal Care Aide (PCA)

MA Plan Expenditures

- Medicare Advantage Plans must meet the 85% Medical Loss Ratio requirement
- 85% of annual premium collections must be spent on claims + quality improvement activity
- Expenditures that fall below the 85% threshold must be returned to Treasury
- 15% remaining = administrative costs, marketing, profits, etc.
- Goal – move to the 85% of the spending

Timeline

- The contract capture cycle is a key aspect of working with a MA plan.
- MA plan benefits must be submitted as part of their bid proposal
- Bid proposals deadline for CY2024– June 5, 2023.
- Preparation for the next year's bid generally begins when open enrollment begins for the upcoming year.
- CY2024 Plan year benefits would be included in the bid package submitted by June 5, 2023
  - All bids must be certified by a plan actuary
  - Changes to the bid cannot occur after submission

Contracting Cycle – Best Practices

- Plan and CBO should work collaboratively to develop the SSBCI offering.
- Process would begin early in the bid preparation process
- Collaboration between the health plan and the CBO would occur each year to define the SSBCI benefits in the next bid package
  - *Be aware that once the bid package is submitted, the plan only has the option of adding vendors to provide the defined service, unless the plan defined the vendor in the bid package.
  - Once the benefit is defined, all consumer facing marketing materials must meet CMS requirements
  - Continuation of services must be coordinated with the plan – denial of benefits

Key Items to Consider

- Health plan coverage area generally exceeds the coverage area of a single CBO.
- Once the bid package is submitted, the plan only has the option of adding vendors to provide the defined service, unless the plan defined the vendor in the bid package.
- Once the benefit is defined, all consumer facing marketing materials must meet CMS requirements
- Continuation of services must be coordinated with the plan – denial of benefits

V-BID

- Medicare Advantage Value-Based Insurance Design Model
  - The Medicare Advantage (MA) Value-Based Insurance Design (VBID) model will be **extended for calendar years 2025 through 2030**
  - MAOs in the model will be **required to offer supplemental benefits to address health-related social needs** in at least two of three health-related social needs areas: food, transportation and housing insecurity and/or living environment.
  - The model will introduce a new flexibility for MAOs **to address health-related social needs in socioeconomically disadvantaged areas**, using the Area Deprivation Index (ADI), to direct benefits to enrollees in underserved communities.

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Project ECHO

Western New York Integrated Care Collaborative / Independent Health Plan

Innovative Partnership between Community Care Hub and Medicare Advantage

Speakers

NIKKI KMICINSKI

- Executive Director
- Western New York Integrated Care Collaborative (WNYICC)

JANICE HERBOLD

- Manager, Implementation of Medicare Products
- Independent Health

Independent Health

- Independent Health is a regional not-for-profit healthcare plan headquartered in Buffalo, NY that serves the eight counties of Western New York.
- Independent Health was founded in 1980 and serves nearly 400,000 members across a variety of medical insurance products including approximately 65,000 Medicare Advantage plan members.
- We are nationally recognized for providing award-winning customer service, dedication to quality health care and unmatched relationships with physician and providers.
- To learn more about Independent Health, go to www.independenthealth.com.

Independent Health®

Western New York Integrated Care Collaborative

Community Integrated Health Network: since 2016

WNYICC is the Community Care Hub of the Network

54 Network Members

2 Departments of Health

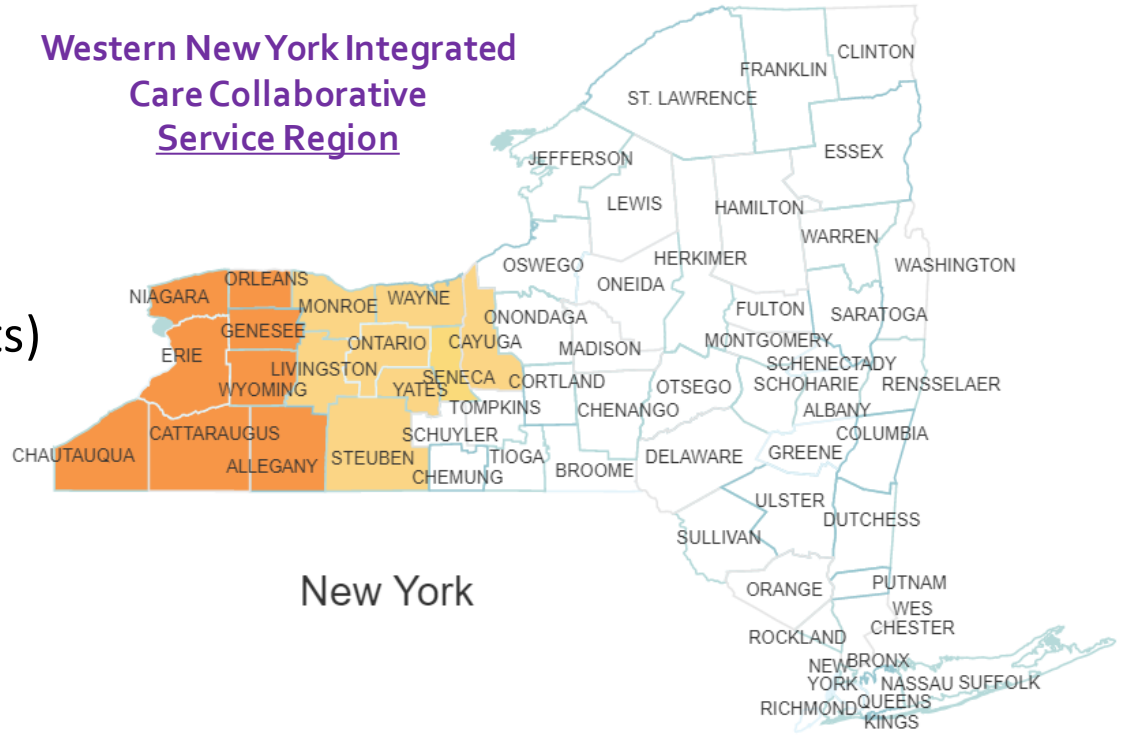
1 Independent Living Agency

8 Area Agencies on Aging (AAA)

43 Social Care Agencies (non-profits)

More information: wnyicc.org

Western New York Integrated Care Collaborative Service Region



Timeline of IH & WNYICC Partnership

2018

IH reached out regarding Diabetes Prevention Program

WNYICC also proposed the Diabetes Self-Management

2019

SSBCI Benefits approved by CMS; WNYICC proposed Meals Program to IH.

IH added Meals Benefit to launch in 2020 as Supplement Benefit.

2020

Meals Program launched;

WNYICC proposed Chronic Care Management (CCM) and Healthy IDEAS

2021

CCM/ Healthy IDEAS started as pilots;

Meals Program expanded and IH/WNYICC started meals file and letter

2022

CCM/Healthy IDEAS – new billing codes changed name to Community Health Coaching (CHC)

2023

Added Falls & Caregiver programs

WNYICC-IH Current Programs:

- Post-Discharge Meal Delivery
- Community Health Coaching
- Healthy I.D.E.A.S. Program
- Diabetes Prevention Program (DPP)
- Medical Nutrition Therapy
- Diabetes Self-Management Education and Support (DSMES)
- Falls Prevention
- Caregiver Support Program

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Benefit Types Summary

Types of Benefits	More information
Part B Benefits	Standard (Original)/Fee for Service) Medicare benefits
Supplemental Benefits	Benefits not otherwise covered under Medicare Part A or Part B and are considered primarily health related, the primary purpose of the item or service is to prevent, cure or diminish an illness or injury. Plan files these benefits with the Annual Bid. Plan uses rebate funds from Bid to pay for these benefits. Not limited to a clinical diagnosis
Uniform Flexibility Benefits	Reduction in specific cost sharing for certain conditions/criteria. Providing equal treatment of enrollees with the same health status or disease state ; Using some type of qualifier for eligibility
Special Supplemental Benefit for the Chronically Ill (SSBCI) Benefit	Limited by diagnosis; Otherwise not meeting needs of supplemental – not health related (i.e Personal Emergency Response System (PERS))
Program (not a benefit)	Using administrative, non-claims funds. Are not marketed to prospective members, fall under extension of care or disease management services.

Programs Contracted / MA Funding Mechanism

Program	Funding Mechanism for IH
Post-Discharge Meal Delivery Program	Supplemental Benefit
Community Health Coaching	Program, extension of IH case management
Healthy IDEAS	Program, extension of IH BH case management
Falls Prevention	Supplemental Benefit
Caregiver Support	Program, extension of IH case management
Diabetes Prevention Program	Medicare Part B Benefit
Diabetes Self-Management Training	Medicare Part B Benefit
Medical Nutrition Therapy	Medicare Part B Benefit (i.e. DM/CKD) & added Supplemental Benefit for any other diagnosis

Post-Discharge Meals Program

Meals Program Benefit Summary

Home Delivered Meals

Participants receives 14 days of meals (2 meals per day) upon discharge from at least 1 overnight stay in an acute care facility.

- Automatic referral to Registered Dietitian for Nutrition Counseling

Eligibility: Independent Health (IH) Medicare Advantage member

- 4 specific plans – 35,000+ beneficiaries

Referrals: WNYICC receives Member file from IH weekly → Daily ADT alerts from HEALTHeLINK (Regional Health Info Org) → WNYICC sends Letter File to IH → IH Mails letters to eligible members → Members call IH to enroll

Billing Codes: S5170 HCPC code "Home Delivered prepared Meal"

- IH developed Modifiers for Modified, Alternate (frozen), and Rural rates

Program Outcomes in 2022

- **695** Participants received meals
- **18,094** meals delivered

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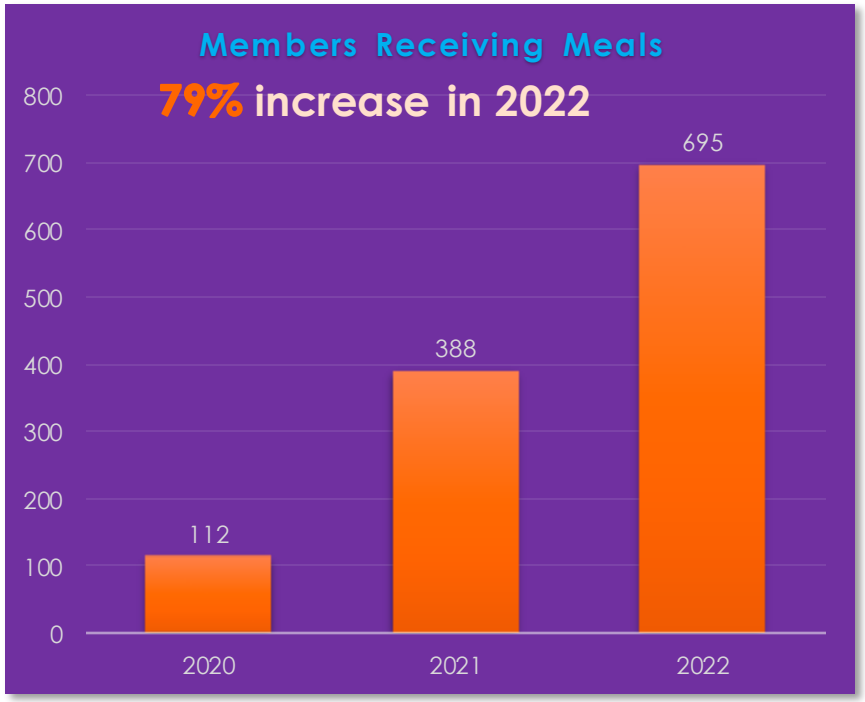
Post-Discharge Meals Program

- Up front payment to allow WNYICC cash flow to pay delivery partners prior to receiving payment from IH



Outcomes

73% **of meals recipients report via post-intervention survey that receiving the meals helped prevent a re-admission.**

Reduction in re-admission not yet proven by claims data due to number of factors associated with potential re-admissions. (ie variability in hospital data, member risk profile, diagnosis, etc.)

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Coaching Programs:

Individual Health Coach wrapped around evidence-based workshops

Participant is teamed with trained Health Coach

→

Health Coach conducts in-person / in-home Assessment

→

Health Coach & Client prioritize Areas of Concern - develop Person-Centered Care Plan

↓

Health Coach works with Client for 6-12 months to help address Areas of Concern

→

Health Coach reviews list of evidence-based workshops and enrolls client in workshop of their choice

→

Health Coach conducts Final Assessment

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Health Coaching Programs

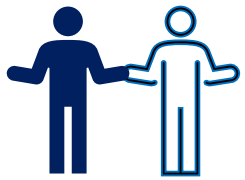
Billing codes Used:

- **0591T**: Individual Assessment & Care plan: flat fee, not time-based
- **0592T**: Monthly Coaching/Care Coordination – up to 6-12 months
  - 30 minute units; up to 3 units (90 min)/ month
- **S9451** Exercise workshops 2 Units:
  - Enrollment & attendance at 1 Session
  - Completes program (attendance at ~67% of Sessions)
- **98962** Health education workshops 2 units (units same as S9451)
- **Z-Codes** used to distinguish Programs.
  - Community Health Coaching: Dx codes varies - from referral (chronic condition)
  - Healthy IDEAS: Z73.89 - Other problems related to life management difficulty
  - Falls Prevention: Z91.81 – History of Falling (At risk of falling)
  - Caregiver Support: Z74.1 - Need assistance with personal care / 2ndary Dx: Y93.F9 – Activity, other caregiving

Health Coaching Programs

Health Coach Requirements

- **Experience with Care Coordination, Motivational Interviewing, Peer Navigation; Non-Clinical**
  - Ie. Case Manager, Social Worker, Community Health Worker, Care Coordinator, Peer Navigator
- **Initial Training:** WNYICC Developed
  - Workflow, Documentation, Timeframes, Assessment, Motivational Interviewing, Person-Centered Care Planning, Care Coordination, Program-Specific Elements
- **On-Going Training:**
  - Care Management Workgroup – led by WNYICC; TA Support from WNYICC

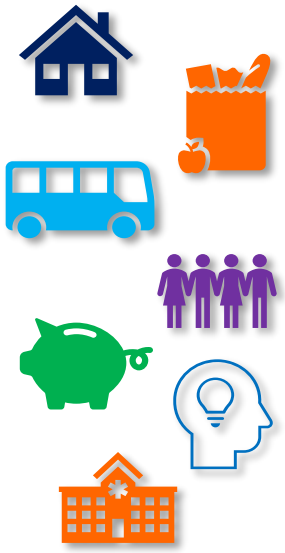


Community Health Coaching

Assessment: CMS ACH Tool + Enhanced with additional co-developed questions

Evidence-Based Workshops: Chronic Disease/Chronic Pain Self-management; Aging Mastery

Assessment Results:



46% had needs with **Physical Environment / Housing**

46% had needs with **Food/Nutrition**

40% had needs with **Transportation**

38% had needs with **Community / Social**

16% had needs with **Economic Stability**

70% had needs with **Health Education/Literacy**

31% had needs with **Health Care System**

COMMUNITY HEALTH COACHING

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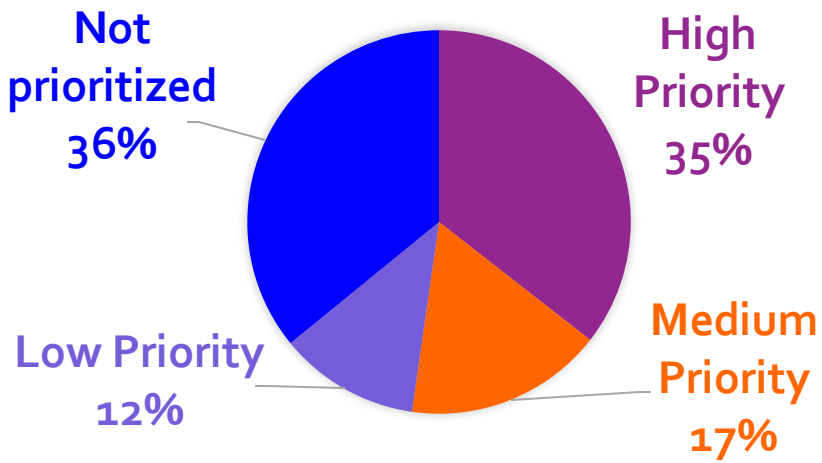
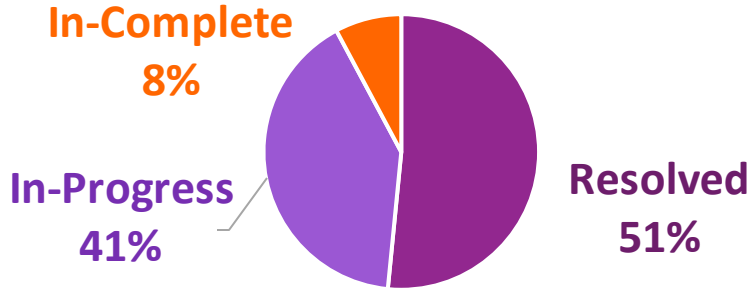
Community Health Coaching

Area of Concerns Resolved:

- **275** Areas of Concerns / Social Determinant of Health Barriers



- **128 High or Medium Priority Concerns** with Goals to resolve Areas of Concern
  - **15** participants Jan 2022-May 2023
  - Average **8** Goals per participant
  - **92%** Resolved or In-Progress
  - **8%** In-Complete



Healthy IDEAS Program

Healthy IDEAS

Assessment:

PHQ-9 + UCLA Loneliness

Additional Program Elements:

Education

Referrals and Linkages

Behavioral Activation

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Healthy IDEAS

Community Mental Wellness Program

- Members are teamed up with a certified **Healthy IDEAS Coach** for up to (12) months.
- Does NOT include enrollment in EBP
- Letters to identified IH Members + calls from Independent Health Behavioral Health CM

Healthy IDEAS

Healthy IDEAS Outcomes:

- **85%** of participants improved either PHQ9 or UCLA Loneliness score by 15%
- **76%** of participants increased their physical and/or social activity through the program.
- **57** referrals made to clinical providers: PCP, Mental Health providers or Registered Dietitians.

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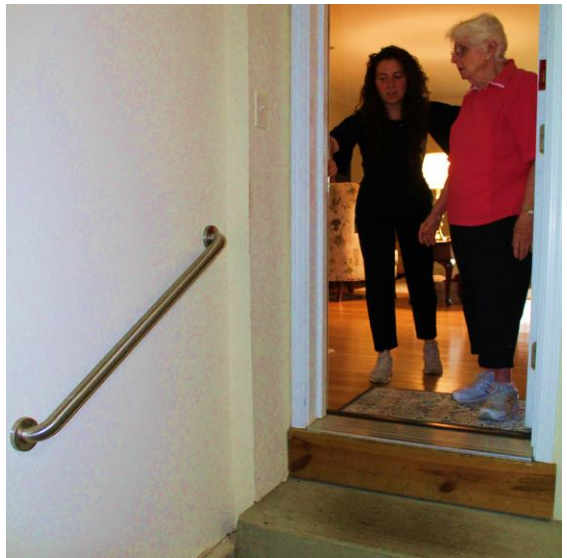
Falls Prevention Program

Assessment:

CMS ACH Tool + Falls efficacy, Falls Hazards, and Falls health history



Additional Program Elements:

Enroll Member for PERS Unit

Create MyMobility Plan with Member

Evidence-Based Program Workshops:

Matter of Balance

Tai Chi

Chronic Disease/Chronic Pain Self-Management

Enhance Fitness

Stepping on

Walk with Ease

Fall Prevention Program

Program Outcomes:

- **40** referrals all self-referrals through IH Servicing
- **32** participants assigned to Coach
- **27** Completed at least 1st appointment.
- **36%** have signed up for PERS unit
- **44%** completed MyMobility Plan
- **3** Enrolled into EBP Workshop
- **1** couple is enrolled and participating in the program together.

Members are **addressing falls hazards in their home**:

- ✓Higher toilet seat
- ✓Grab bars in bathroom
- ✓Handrails on stairs
- ✓Shower chair
- ✓Barrier on basement stairs
- ✓Set goal to reduce clutter

Members are **connecting with clinical providers**:

- ✓Physical Therapist
- ✓Primary Care Provider
- ✓Podiatrist

Members are **increasing their exercise**:

- ✓ Asking PCP re: pedal machine & safe exercises
- ✓ Set goal to increase by 5 min/day
- ✓ Getting balance DVD from library
- ✓ Attending strength class at Senior Center
- ✓ Tai Chi

Caregiver Support Program

Assessment:

CMS ACH Tool +

Caregiver Assessment

Additional Program Elements:

Health Plan member is care recipient.

Care Recipient must sign Authorization to Release information.

Evidence-Based Program Workshops:

Chronic Disease/Chronic Pain Self-Management

Aging Mastery

Powerful Tools for Caregivers

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Medical Nutrition Therapy

- **Part B Benefit - MNT covered for individuals who:**
  - Are diabetic
  - Have kidney disease
  - Had a kidney transplant during the past 36 months

Medical Nutrition Therapy

- **Supplemental Benefit**
  - IH added Supplemental Benefit for **any** Medicare Advantage Member
  - Waived diagnosis requirement
  - Waived Physician Referral Requirement

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Medical Nutrition Therapy

- Individual Nutrition Assessment and Counseling with a Registered Dietitian
- No diagnosis or physician referral required
- Meals Program automatic referral
- In-person, virtual, telephonic

Medical Nutrition Therapy

Outcomes:

- **25** Active participants: April 2023
- **100%** of completers increased vegetable intake.
- **92%** made changes in eating habits
- **62%** increased amount of physical activity
- **67%** of those at risk for malnutrition improved to Normal nutrition status.

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Additional Programs - Part B Benefits

- Diabetes Prevention Program
- Diabetes Self-Management Training

A True Partnership:

Joint Operating Committee/ Workgroup

- Meets Weekly
- Discusses the following for each program:
  - Referrals / referral process
  - Marketing/ Communication
  - WNYICC/CBO Capacity
  - Escalation of incidents
  - Provider outreach
  - Billing
  - Outcomes/ Reporting

Co-Branded Handouts/Materials

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Value of Partnering with a Community Care Hub like WNYICC

- 50+ local, trusted Community-Based Organizations
  - Independent Health values local partnership
  - Local CBOs know our community and community needs
  - Community knows and trusts the local CBOs
- One-stop contracting/ billing/ referrals
- One contact for program development, escalation
- Regional – able to reach all IH members/ beneficiaries
- In-Person Safety Check with Meals program
- In-Home intervention with trusted, recognized CBOs
- Flexibility to co-develop programs

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Project ECHO

Case Study Discussion

New Case Study Process

- Participants will be organized into small groups.
- Each group must designate at least one group spokesperson.
- The group will problem solve to identify solutions to the anonymized case study questions.
- Each small group will present their solutions to each case study question before the entire group.

Anonymized Case Study

- A CCH organized a network of CBOs to pursue contracts.
- The CCH engaged a local MA plan to pursue a contract.
- Several barriers had to be overcome in order to secure and implement the contract.
- Each Team will present your solutions to the following issues that the CCH faced in the MA contracting process.

Case Study Exercise

Pre-Contract Questions

- The CCH did research on the MA plan prior to the initial meeting. What are some key factors that the CCH should know about the plan prior to the initial meeting?
- The CCH was concerned that the MA plan would do all of the services in house. The CCH researched the Medical Loss Ratio to adjust their pitch. How does the MLR impact health plans doing services in house?
- The health plan required claims and would not accept an invoice process. How can a CCH address requirements for claims?

Post Contract Questions

- The MA plan had concerns about the outcomes for their Low-Income Subsidy population. Why would the low-income subsidy population cause a greater concern for the health plan?
- The CCH did not have coverage for the entire MA plan coverage area. What should the CCH do to address gaps in coverage?
- The MA plan wants a social care navigation program to target their Duals and Low-Income Subsidy population. One of the CBOs in the CCH expressed concerns about double-dipping if they receive payment for social care navigation services. How can this concern be addressed?
- The CCH launched the contract and the volume is well below expectations. What actions can the CCH do to increase volume independent of the health plan?

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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	Spectrum Health, Michigan (CCM/TCM/APMs)	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

Tim McNeill, RN, MPH

811 L Street, SE;
Washington, DC 20003

202-344-5465

202-344-1234

tmcneill@freedmenshealth.com

Upcoming Meetings & Events

- All Member IT Peer Group Dialogue Meeting – July 27, 2023, 2-3pm ET

Please complete pre-session survey by July 19th:
https://www.surveymonkey.com/r/ITPGD

- Network Expansion Track Curriculum Meeting – August 10, 2023, 2-3:30pm ET

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

Administration for Community Living