Community Care Hub
National Learning Community

Network Expansion Track Meeting

May 11, 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"
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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
- ECHO Session: Transforming Billing and Coding – Contracting with Hospitals
- Presentation by CommonSpirit: Addressing Health-Related Social Needs
  - Q&A
- Case Study Presentation
  - Group Discussion
- Closing

Community Care Hub Billing and Coding Mechanics Session #3

May 11, 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."

ECHO Learning Framework for Billing and Coding

- The Billing and Coding Series will use the ECHO Learning Framework for each session
- Overview of the ECHO Learning Framework can be found at:
  - https://hsc.unm.edu/echo/what-we-do/about-the-echo-model.html
- Hallmark tenet of the ECHO Learning Framework
  - **"All Teach, All Learn"**
- ECHO participants engage in a virtual community with their peers where they share support, guidance, and feedback
- Goal: Collective understanding of best practices to address complex issues derived from interactive discussions in a virtual group setting
- Remember that 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

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Community Care Hub Billing and Coding
An ECHO Initiative

Project ECHO

Learning Objectives for Today's Session

- Identify ways that CCHs/CBOs can address hospital Joint Commission Health Disparity accreditation standards
- Increase participant literacy in billing and coding as it relates to hospital reimbursement policies under the CMS IPPS Rule
- Increase understanding of the value that community-based organizations (CBOs) bring to health systems to meet financial and quality performance metrics
- Identify ways that CCHs/CBOs can implement contract models with hospitals to address performance metrics to include HRSN Screening, Length of Stay, and Readmissions

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Today's ECHO Session

Project ECHO

Time	Session Topics
5 minutes	Recap of topics covered in Session #2
5 minutes	Joint Commission Health Disparity/IPPS Rule Requirements
15 minutes	Medicare Benefits supporting transitions of care (TCM/CCM)
20 minutes	CommonSpirit Health System Community Partnership model
10 minutes	Discussion/Questions for Presenter
30 minutes	Anonymized Case Study/Group Discussion and Problem Solving
5 minutes	Summary, Wrap-Up, Planning for Next Session

ECHO Session #2 Summary

- Session #2 of our ECHO series on Billing and Coding
  - Overview of the Gravity Project
  - Z-Code Reporting and Adoption
  - Relevance of Z-Codes for CCHs/CBOs
- Application of Z-Codes in healthcare
- Use cases for CCHs/CBOs to have clearly defined roles in screening and reporting Z-codes for identified HRSNs
- Sustainability strategies for CCHs that support Z-Code adoption
- All information related the Session #2 ECHO session can be accessed at:

Joint Commission Health Care Disparities Requirements

- Joint Commission accredits 80% of U.S. Hospitals
  - 3,800 hospitals have current Joint Commission Accreditation.
- Health Disparities standards effective **January 1, 2023**
  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 IPPS Rule Background

- IPPS: Inpatient Prospective Payment System
- Background
  - CMS pays acute care hospitals for inpatient stays, under IPPS
  - MS-DRG (Medicare Severity Diagnosis-Related Groups
    - Medicare pays for inpatient hospital services on a **rate per discharge basis** that varies according to the DRG to which a beneficiary's stay is assigned.
      - Payment rate to the hospital is defined by the MS-DRG classification and is not a daily rate.
  - Length of Stays beyond the MS-DRG classification = Loss of revenue for the hospital.

FY2023 IPPS Final Rule

- Link: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page#FinalRule
- Date of Display: August 21, 2022

Key Rule Changes:

- Hospitals are required to begin screening patients for HRSNs
  - Housing Insecurity
  - Food Insecurity
  - Transportation Insecurity
- FY2023: Voluntary reporting of HRSN Screening
- FY2024: Mandatory Reporting of HRSN Screening
- FY2026: Payment Adjustment based on satisfactory reporting of HRSN Screening

FY2024 IPPS Proposed Rule

- Payment adjustment for hospital admissions that have a MS-DRG Complicating Condition that includes an ICD-10 Z-Code for Homelessness.
  - (*Connection to the Gravity Presentation)
- Formal recognition of the negative impact of homelessness on admission and potential for extended length of stay.
- Hospitals will receive additional reimbursement for DRG classification when there is a homelessness Z-Code complicating factor.

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Length of Stay vs Readmission Penalty

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- Hospitals are required to establish a safe discharge.
- If a safe discharge cannot be established, the person must remain at the hospital beyond the approved length of stay, per MS-DRG classification.
- Average length of hospitalization for Medicare = 5.3 days.
- Average cost per hospital inpatient day, per patient (Medicare) = $2,566.
  - Commonwealth Fund. ROI Calculator Cost Table:
  - https://www.commonwealthfund.org/sites/default/files/2019-06/ROI_Cost_Utilization_Table.pdf

Hospital Readmissions Reduction Program (HRRP)

- Medicare value-based purchasing program applies a payment penalty to hospitals based on the percentage of 30-day risk-standardized unplanned readmissions for the following conditions:
  - Acute Myocardial infarction (AMI)
  - COPD
  - Heart Failure
  - Pneumonia
  - Coronary Artery By-pass Grafting (CABG)
  - Total hip/Total knee
- Analysis is conducted in the following manner:
  - Number of discharges
  - Predicted readmissions
  - Number of readmissions
  - Excess readmissions

Readmission Payment Adjustment

- CMS applies a payment adjustment factor based on hospital performance on readmissions.
- Adjustment is capped at 3 percent (0.97 applied to all Medicare admissions during the next fiscal year).
- Hospitals continue to be paid for readmissions based on MS-DRG classification.
- Kaiser provides a website to lookup hospital performance:
  - https://kffhealthnews.org/news/hospital-penalties/

Hospital Comparison

Houston, TX

- Memorial Herman – Texas Medical Center
- 2023 Hospital Readmissions Reduction Program (HRRP) Penalty = 0.11
  - Heart Failure (HF): 424 Admissions
  - 104 Readmissions
- Application of HRRP to the average daily rate
  - 0.11 x $2,566 = $282.46
  - Daily loss for extended admissions, beyond DRG classification = $2,566

Dothan, AL

- Southeast Health Medical Center
- 2023 HRRP Penalty = 0.26
  - HF: 757 Admissions
  - 178 Readmissions
- Application of HRRP to the average daily rate
  - 0.26 x $2,566 = $667.16
  - Daily loss for extended admissions, beyond DRG classification = $2,566

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Medicare Benefit for Transitions

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CPT/HCPCS	Description	Comments
99496	Transitional Care Management **7-days**. Moderate complexity	Care Transitions Intervention including a face-to-face visit with a medical provider, medication review, and assessment of SDOH with a plan to address identified needs
99495	Transitional Care Management **14-days**. Moderate complexity	Care Transitions Intervention including a face-to-face visit with a medical provider, medication review, and assessment of SDOH with a plan to address identified needs
CCM	*Can bill concurrently	No comments
G0506	CCM-Initial Plan of Care	Person-centered planning for CCM
99490	**First 20 min** of CCM per calendar mo.	Non-complex chronic care management (CCM)
99439	CCM, **ea. Additional** 20 min	Non-complex care management during a calendar mo.

ASPE Analysis of CCM/TCM Utilization

- Assistant Secretary for Planning and Evaluation (ASPE) Report on the 2019 utilization of CCM and TCM by eligible Medicare beneficiaries:

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

CommonSpirit

Jurema Gobena (CommonSpirit Health)

Jurema Gobena is System Director of Social Care Integration for CommonSpirit Health—the nation's second largest nonprofit health system and a leading provider of Medicaid.

Jurema's work centers on orienting CommonSpirit towards addressing social needs as part of the standards of care and achieving a future state of sustainable social needs interventions with an accurate reflection of and investment in the voice of the community in its planning, design, and deployment while reducing disparities, advancing health equity, and promoting social justice.

Addressing Health-Related Social Needs

One Health System's Approach

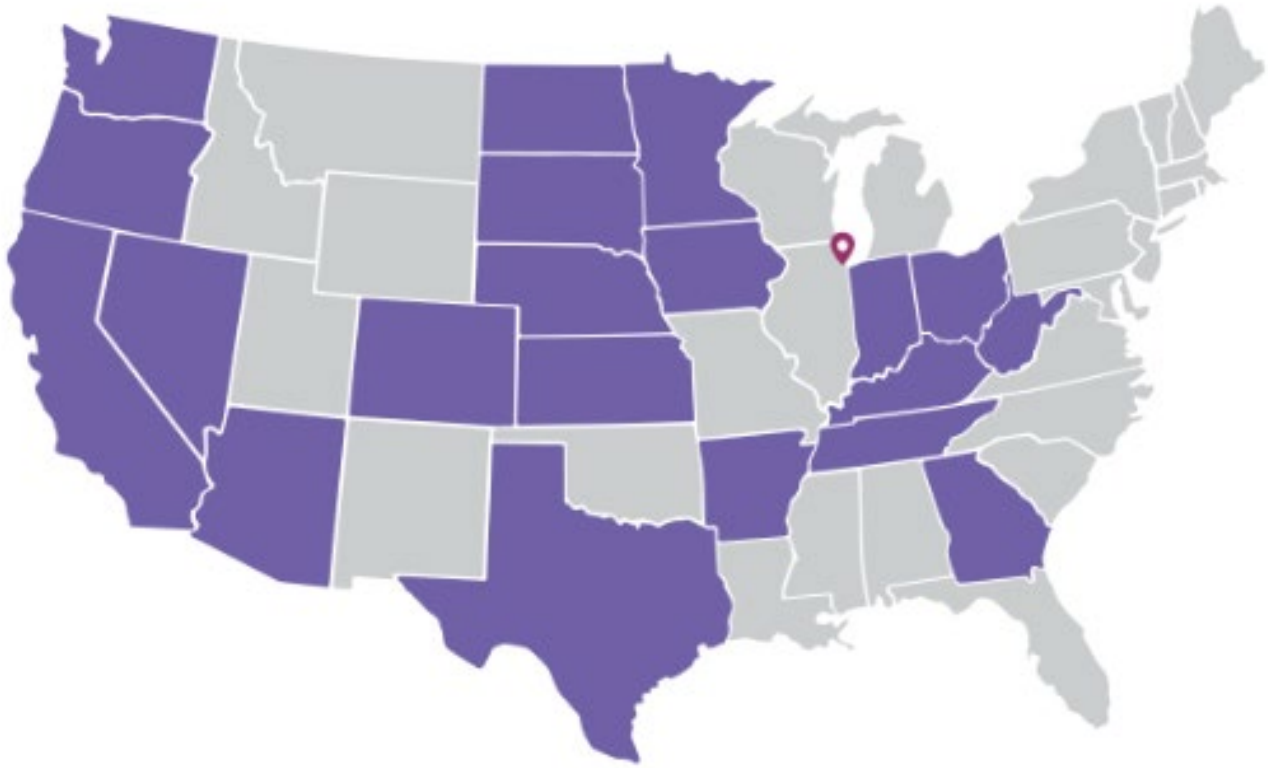
Jurema Gobena, System Director Social Care Integration

May 11, 2023

CommonSpirit

CommonSpirit Health

- 140 hospitals, >1000 care sites in 23 states
- Strive to build more resilient communities, advocate for those who are poor and vulnerable, and innovate how and where healing can happen—both inside the hospital and out in the community
- Committed to a mission of serving all people, especially those who are vulnerable.
- Nation's leading provider of Medicaid services working to ensure those in need have access to quality care.



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Dignity Health.

CHI Health

Community Health

Address the social, economic, and environmental conditions that influence health and health equity in communities by engaging in collaborative health improvement programs, strategic grant-making, investing, and innovative partnerships.

Guiding Principles

- Emphasize prevention and wellness
- Build community capacity and resiliency
- Foster multi-disciplinary and cross-sector collaboration
- Contribute to a person-centered, integrated continuum of care
- Address disparities and challenge systemic inequities inclusive of and guided by community voice
- Commit to learning, innovating, and demonstrating impact

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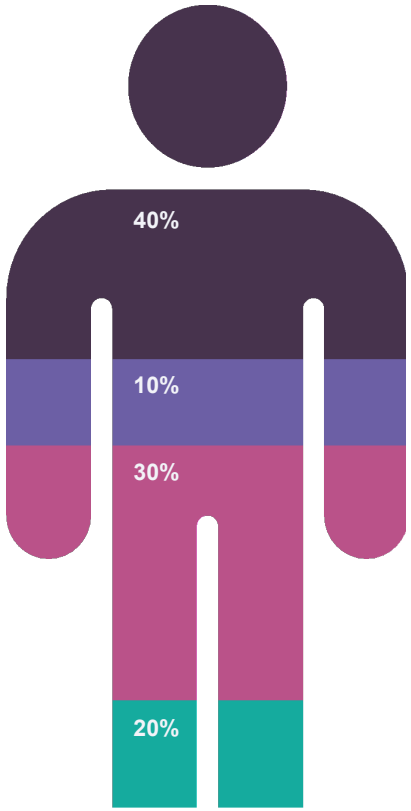
Why: Value of Robust Social Care

Addressing social needs by expanding our hospital walls to include community partners as part of the “care team”



Socioeconomic Factors

Education | Job Status | Family/ Social Support | Income | Community Safety

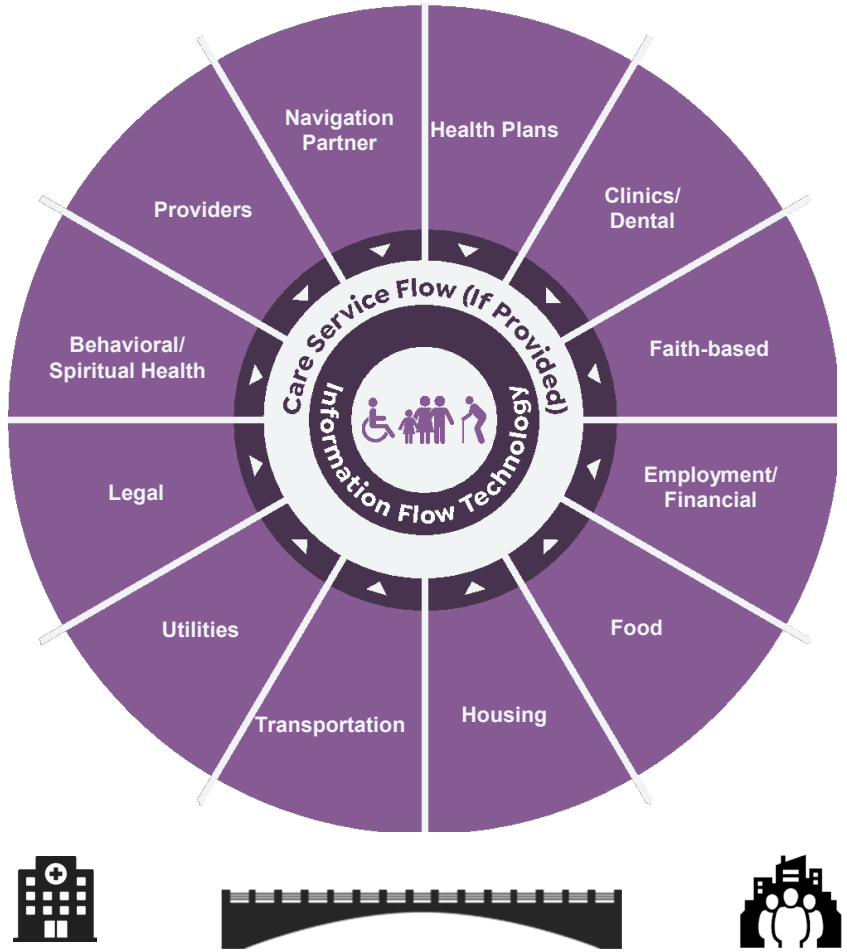
Physical Environment

Health Behaviors

Tobacco Use | Diet & Exercise | Alcohol Use | Sexual Activity

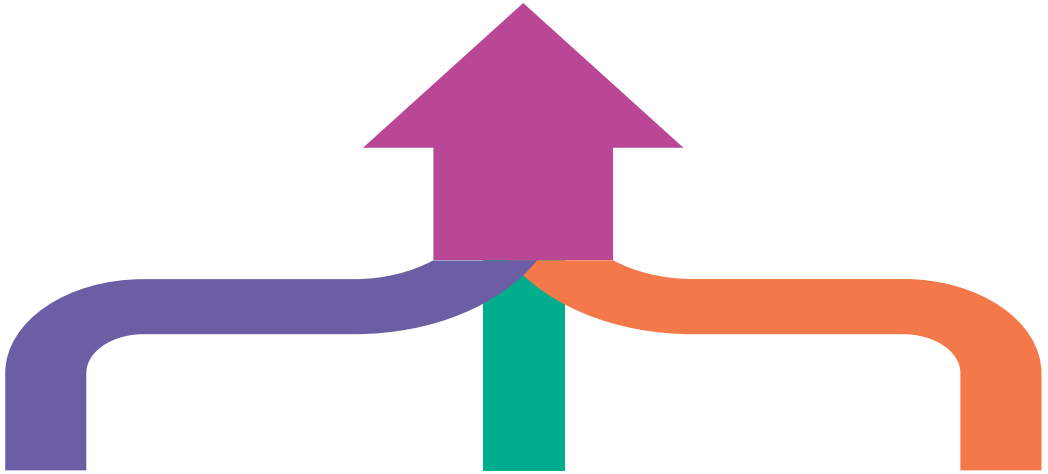
Clinical Care

Access to Care
Quality of Care



Social Care Integration Strategy

Robust Social Health Response



Screening

- Health-Related Social Needs Screening

Access & Connectivity

- Resource directory
- Closed-loop referrals
- 211 call centers

Sustainability

- Social payment models
- Workforce development
- Capacity building
- Documentation (z-codes)
- Evaluation
- Policy/Advocacy

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Social Care Ecosystem: A Build in Two Parts

Internal (Social Care Integration)

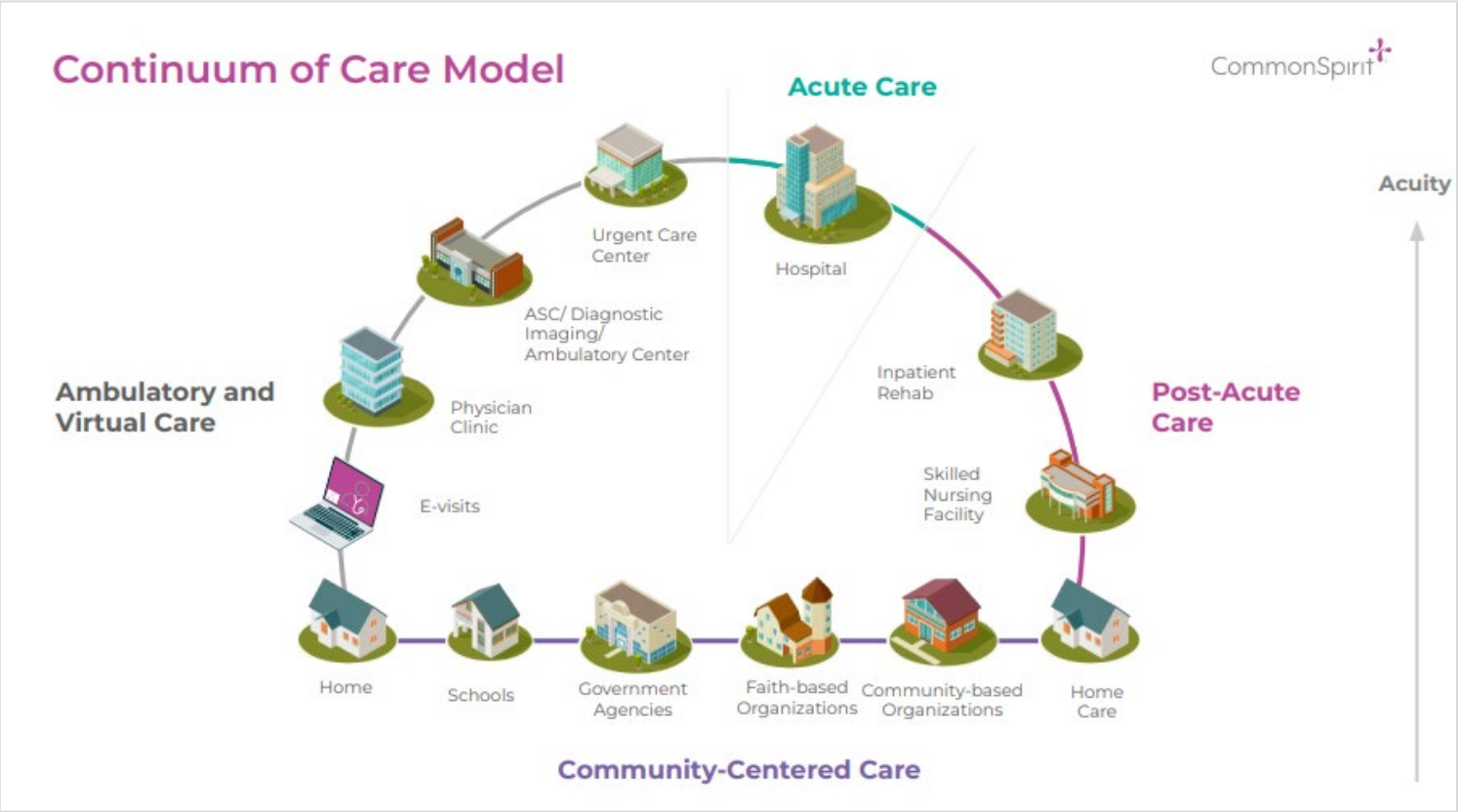
- Leadership Buy-In
- User Identification
- Contract Determination
- Standardize HRSN Screening
- Workflow Design
- IT Integration
- Staff Training
- Legal
- Communications

External (Community Linkages & Sustainability)

- Identify & Onboard Convener
- Build Community Partners
- Engage 211s (If Capable)
- Stakeholder/Funding Partner Buy-In
- Funding Round
- CBO Training
- Establish Governance
- Ongoing Convenings/Process Improvement
- Integrate Social Payment Model

Community Centered Care (External Build Approaches)

A community-centered approach to care expands prevention and treatment models outside the confines of hospitals and hospital systems and incorporates models centered in communities.



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Role of Community Centered Care Within CommonSpirit

Engage internal and external partners across the care continuum to increase investments in community

Test new care models that are important to future success in healthcare

Demonstrate that mission/margin can be symbiotic rather than competing forces

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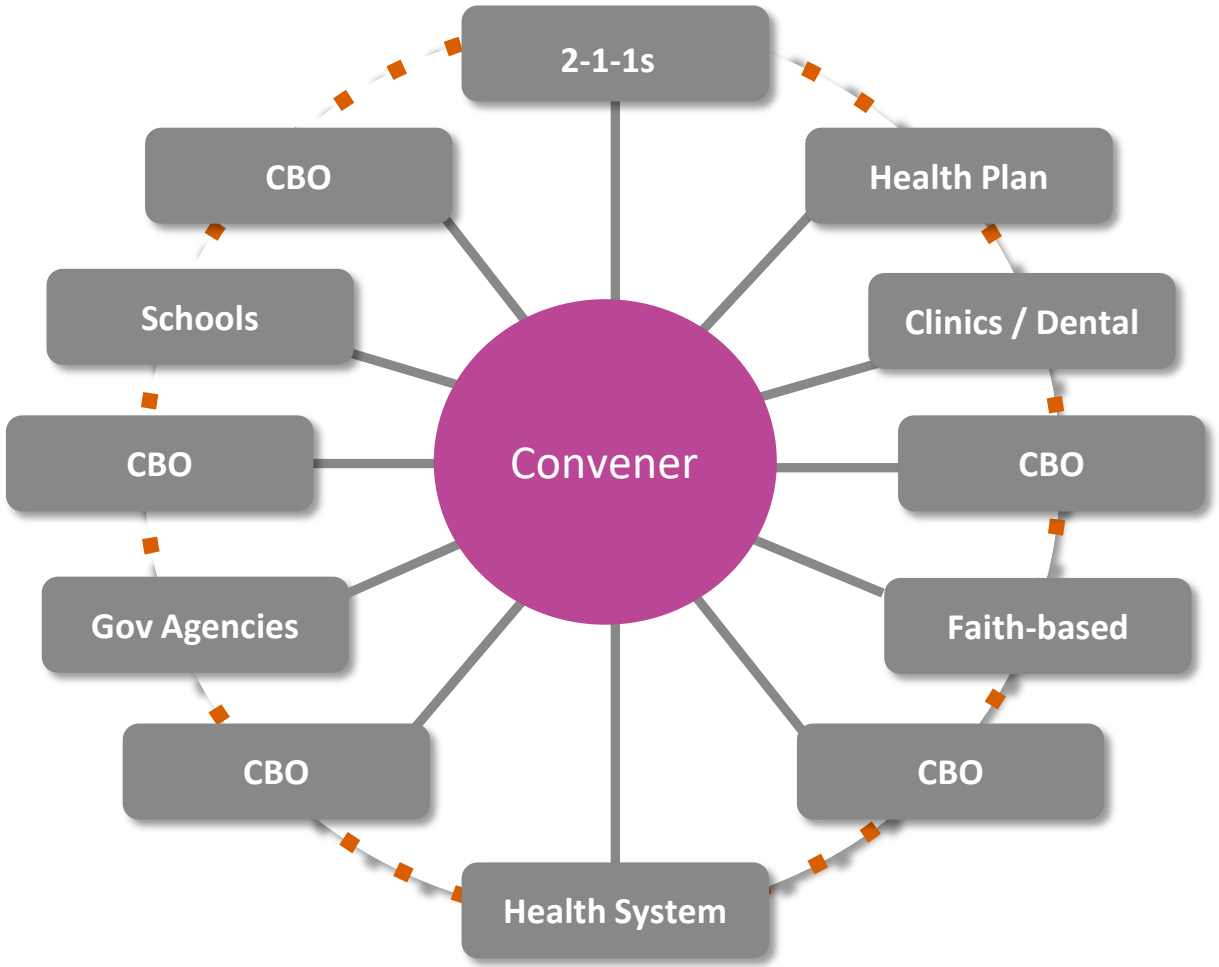
CSH Community Centered Care Models

1. **Connected Community Network:** organized network of social service providers, health systems, and other stakeholders collaborating in an accountable way to meet the social needs of individuals. CSH mechanism for catalyzing social care integration internally.
2. **Community Care Hubs**
    a. Pathways Community Hub: contracting for CHW case management services
    b. Medicare CCH: focus on older adults

CCN: Community Integrated Networks of Care



Aim: allow communities to get organized and begin to anchor health in community through an all-comer network.

Components (*not all required*): convener, community partners, governance structure, technology, and community bank

Network Costs: $100-$200k/year

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Information Flow (Technology)

CCN Evolution

2016

CCN 1.0

Nevada
Unidirectional referrals to internal CH programs

- No FPs
- No Convener
- No Standard Screening
- No 211
- No CBO Network
- Technology= Not Robust

2017

CCN 2.0

Santa Cruz, CA
Unidirectional referrals to internal & external community programs

- No FPs
- No Convener
- No Standard Screening
- No 211
- Technology= Not Robust
- 13 CBOS in-network.

2020

CCN 3.0

San Joaquin, CA
Bidirectional referrals to internal & external community programs

- 11 FPs, >$200k raised
- Convener
- Standardized Screening in ED
- 211 engaged
- Technology= Robust
- 105 orgs in-network

2023+

CCN 4.0

Convener > Care Hubs
One-stop hub for contracting entities (health systems, payers, gov, etc.)

Contract, billing, data support for CBOs

Value-based payments for social services

Standardized screening in all clinical settings

TAKEAWAY

Conveners & 211s are necessary backbone organizations in this work to meaningfully engage partners and impact the greater community. Conveners/Hubs offer a scalable pathway for community integrated networks.

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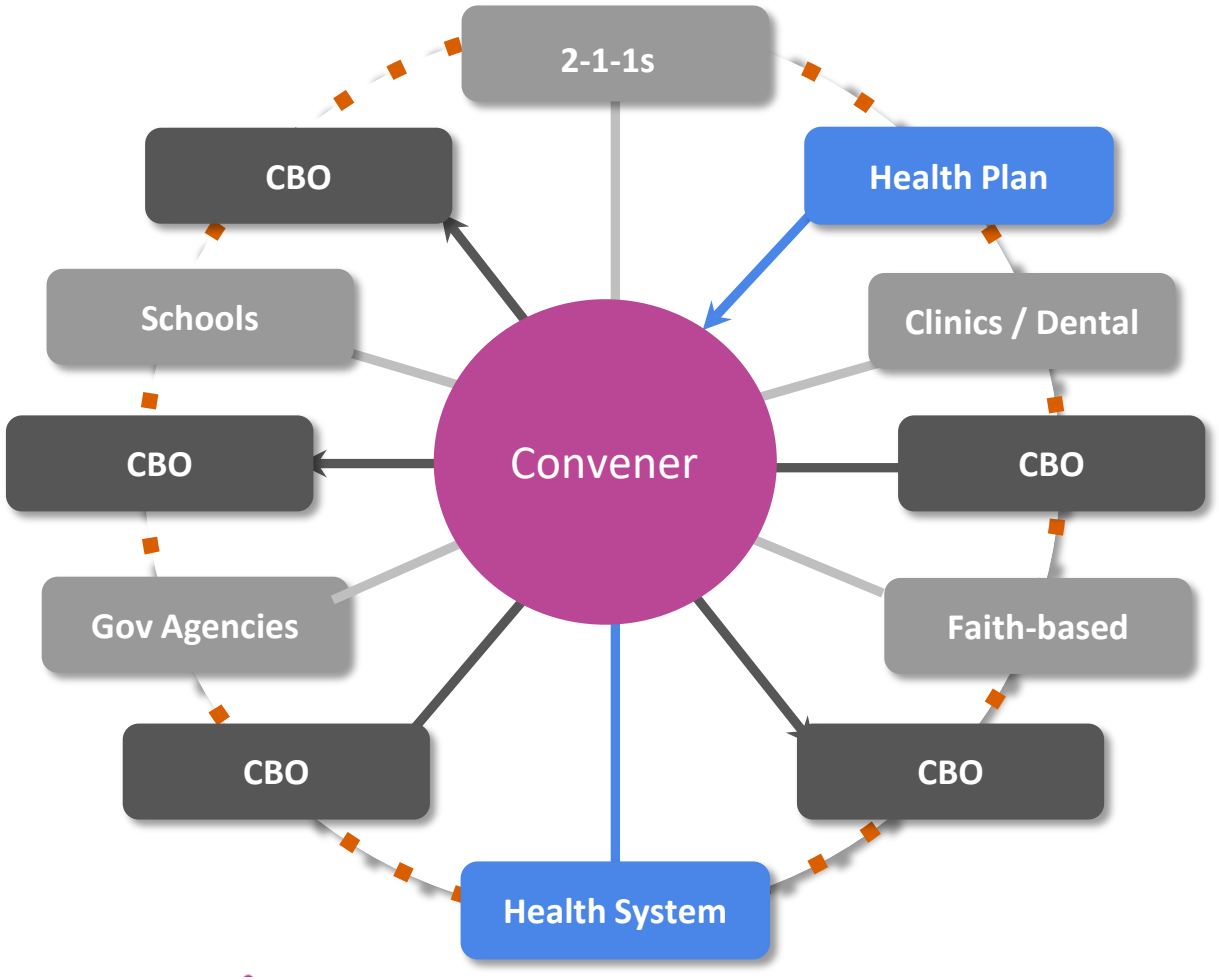
Community Care Hubs (General)

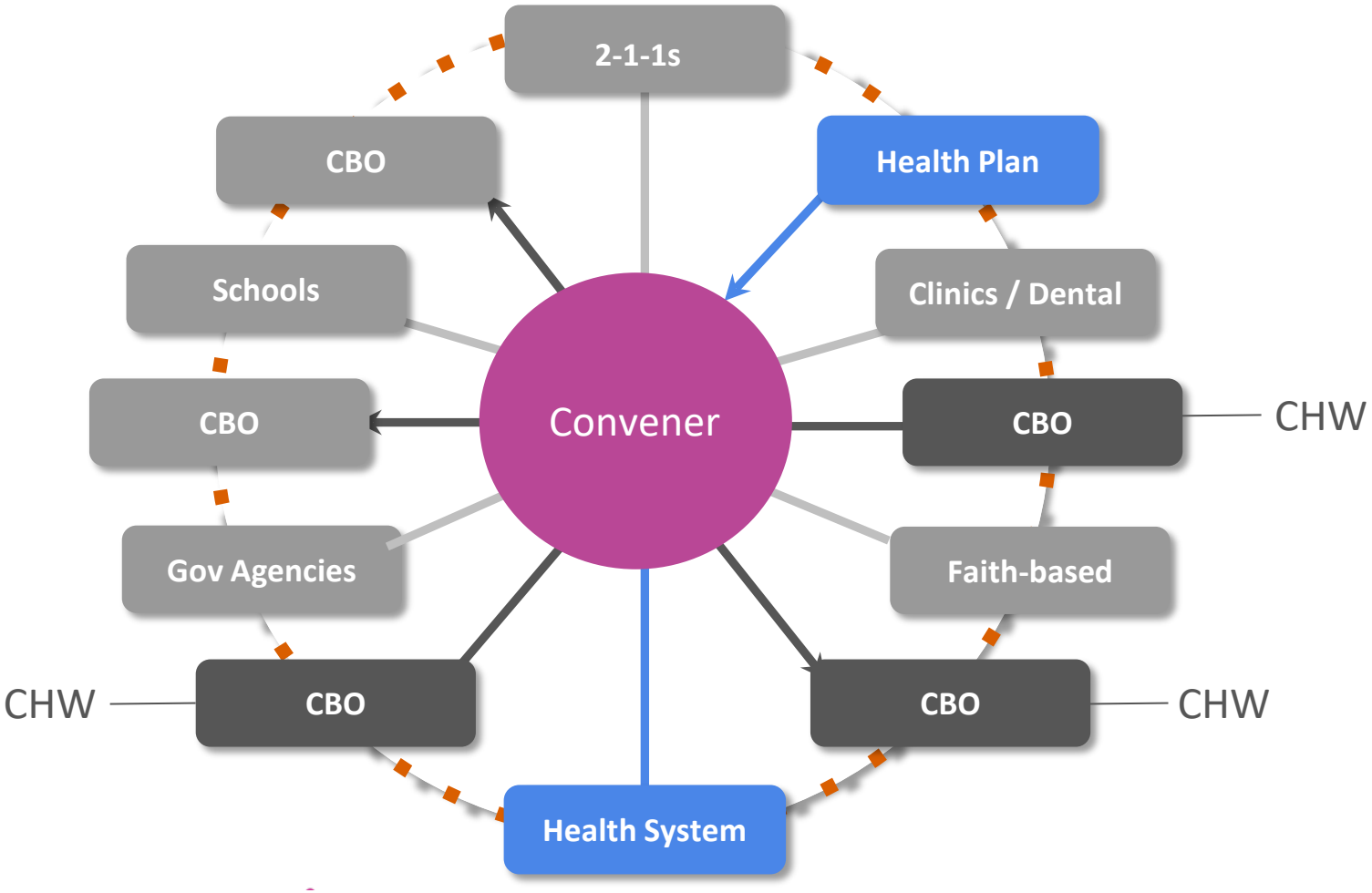


Aim: centralize administrative and infrastructure functions to support social service contracts for community agencies

Components (*not all required*): convener, community partners, governance structure, technology, and community bank

Hub Costs: TBD

CCH Example: Pathways Community Hub



Aim: centralize administrative and infrastructure functions to support contracts for CHW case management services in the community

Components (*not all required*): Convener/Hub, Pathways Agencies, governance structure, technology, and community bank

PCH Costs: $300k/year for first 2 years. Pay for outcomes thereafter.

Lessons Learned

- Even for healthcare agencies, internal education is needed regarding importance of addressing health-related social needs and the amount of effort required to intentionally do so.
- Models & Governance must flex to needs of community
- Continuous community and funder engagement is critical
- Funding agencies (e.g. health plans) supportive of community centered care models and willing to participate
- Mind shift towards community ownership can be difficult.
- **This is change management for everyone.**

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Thank You!
Questions?

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Case Study Discussion

Anonymized Case Study

- A CCH has a current project with the largest local hospital. A grant paid for the CCH labor. **When the grant expired**, both organizations wanted to continue the project; but the **hospital cited financial losses** that prevent the hospital from paying for the CCH labor.
- The hospital requests that the **CCH look for their own funding** to support the project.

<u>CCH Sustainability Plan</u>

- CCH seeks to sustain the program by blending and braiding funding from **resources outside of the hospital.**

MA Plan

- The CCH reviewed the Medicare Advantage enrollment data, for their catchment area, and determined that a BCBS plan has the highest enrollment in their region.

Question:

- How could the CCH leverage the relationship with the hospital in a contract negotiation with the BCBS plan?
- What are the value-added benefits that the CCH can bring to address the needs of the payer, as it relates to hospital utilization?
- The BCBS requires the CCH to accept a value-based contract. How can the CCH minimize risk in a value-based contract model?

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MA Plan High Utilizers

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- The BCBS plan contracts with the CCH to target high utilizers.
- The target population does not traditionally obtain services from the CCH.
- Many of the high utilizers have frequent ED visits and hospital admissions at the local hospital.

Question:

- What steps can the CCH take to conduct outreach and engagement with the target population?
- How can the CCH target BCBS patients at the hospital?

HCBS Impact on Length of Stay/Readmissions

- The State has approval for Medicaid Administrative Claiming to expedite enrollment in Medicaid Waiver and Medicaid State Plan benefits.
- The CCH secured the contract with BCBS and has a transition worker embedded at the hospital.
- CCH will leverage their access to the hospital to engage Medicaid beneficiaries to enroll in HCBS (State Plan, Medicaid Waiver, or Money Follows the Person (MFP))

Questions:

- What is the payer source for using HCBS to support Transitions?
- How can expediting access to HCBS support hospital length of stay and readmission quality measure goals?
- How can the CCH target persons eligible for HCBS at the hospital?

Large Physician Group

- The CCH noted that the largest provider group is a hospital-owned multi-specialty practice in an ACO.
- The CCH pitched a care transition program to the multi-specialty practice that leverages TCM and CCM for reimbursement.

Questions:

- How can the CCH target ACO patients aligned with the multi-specialty practice that are admitted?
- The ACO cites high utilization for CHF patients. What can the CCH do to impact utilization of CHF patients admitted to the hospital?

CCM Contract Negotiation

- The ACO multi-specialty practice notifies the CCH that their ACO now has a relationship with Signify (CVS Health).
- Signify identifies 400 patients that require enhanced chronic care management, that will be contracted to the CCH.

Questions:

- How can the CCH provide a rapid deployment CCM model to address the care management needs of the patients identified by Signify?
- Signify is now acquired by CVS Health, what would be the advantage to the ACO to contract with the CCH instead of building the program themselves?

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TCM/CCM Rate Negotiation

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- The National rate for TCM/CCM services is the following:

Services Description	Code	National Rate
TCM 7-days	99496	$278.21
TCM 14 day	99495	$205.36
Non-Complex CCM 20 Min	99490	$62.69
CCM +20 Min	99439	$47.44

Questions:

- How should the CCH approach the contract rate discussion with the ACO practice?
- What rate would you recommend the CCH request for 1 hour of CCM
  - National Rate for 1 hour of CCM: $62.69+$47.44+$47.44 = $157.57 per patient

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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 – Jurema Gobena	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

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Upcoming Meetings & Events

- Network Expansion Peer Group Dialogue Meeting – May 25, 2023, 2-3pm ET
- Network Expansion Track Curriculum Meeting – June 8, 2023, 2-3:30pm ET

NLC In-Person Gathering at the
USAging Conference in Salt Lake City
on July 15, 2023

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

Administration for Community Living