Community Care Hub
National Learning Community

Network Expansion Track Meeting

August 10, 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 – Implementing HRSN Interventions with Health Plans and Hospitals
- Guest Presentation: UnitedHealthcare
  - Q&A
- Case Study Presentation
  - Group Discussion
- Closing

ACL Updates

- Please complete the NLC Feedback Survey!
  - The survey will be distributed today, input is requested by 8/23
- 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 #6

August 10, 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

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Community Care Hub Billing and Coding
An ECHO Initiative

Project ECHO

Learning Objectives for Today's Session

- Increase participant knowledge of incorporating multiple concepts to operationalize a delivery model to address HRSNs.
- Increase participant awareness of proposed changes in the Physician Fee Schedule to address HRSNs.
- Determine opportunities for CCHs/CBOs to contract with hospitals and providers to screen and address HRSNs.
- Increase understanding of the business case CBOs bring to health plans and hospitals to impact HRSNs for their population.

Today's ECHO Session

Time	Session Topics
5 minutes	Recap of topics covered in Session #5
5 minutes	Population Health and Health Related Social Needs
15 minutes	Implementing HRSN Interventions with Health Plans and Hospitals
20 minutes	UnitedHealthcare on the Business Case for Addressing HRSNs
10 minutes	Discussion/Questions for Presenter
30 minutes	Anonymized Case Study/Group Discussion and Problem Solving
5 minutes	Summary and Wrap-Up

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ECHO Session #5 Summary

Project ECHO

- Session #5 of our ECHO series on Billing and Coding
  - Overview of Medicare Advantage flexibilities to address HRSNs
  - Explanation of the Special Supplemental Benefits for the Chronically Ill (SSBCI)
  - Value-Based Insurance Design
- Independent Health / Western NY Integrated Care Collaborative (WNYICC)
  - Regional Medicare Advantage plan and CCH serving the Western NY market
  - Unique partnership and ongoing collaboration between a regional health plan and community partners organized by a CCH

Business Case for Addressing HRSNs

- Health plans and health systems are implementing programs to address health-related social needs (HRSNs) because there is evidence that there is a **business case to address HRSNs** in a population.
- "Evidence demonstrates that non-medical health-related social needs (HRSNs), such as housing instability, food insecurity, and exposure to interpersonal violence, **drive health care utilization** and **impact health outcomes**."
  - Billioux, A., K. Verlander, S. Anthony, and D. Alley. 2017. Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201705b

Research Validation of the Business Case

- *Social Determinants of Health and High-Cost Utilization Among Commercially Insured Population*.
  - **The American Journal of Managed Care**. **July 2023**. Volume 29 Issue 7.
- "Disadvantaged neighborhood residence was still associated with being a **high-cost utilizer**. Adults 65 years and older in disadvantaged neighborhoods had increased likelihood of high-cost utilization."
- "Our study demonstrates that SDOH are in fact **significantly associated** with the likelihood of becoming a **high-cost utilizer among commercially insured and Medicare Advantage** individuals."

Area Deprivation Index

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Area Deprivation Index (ADI) Data

- Available: https://www.neighborhoodatlas.medicine.wisc.edu
- The ADIs are provided in national percentile rankings at the block group level from 1 to 100.
- Group 1 is the lowest ADI and group 100 is the highest ADI.
- A block group with a ranking of 1 indicates the lowest level of "disadvantage" within the nation and an ADI with a ranking of 100 indicates the highest level of "disadvantage."
- Data is validated to the Census Block Group neighborhood level, but the data can be organized to the Zip Code+5 level for analysis.

Data Analytics to Identify Rising Risk in a Population

- Limitation: The ADI is limited insofar as it uses American Community Survey (ACS) 5-year data for its construction.
- Can be used as one of multiple variables to identify risk within a population in order to target interventions to reduce risk.
  - Risk = Increased cost/utilization and/or worsening clinical outcome measures
- Combining ADI and clinical factors can be a predictive measure to determine rising risk.

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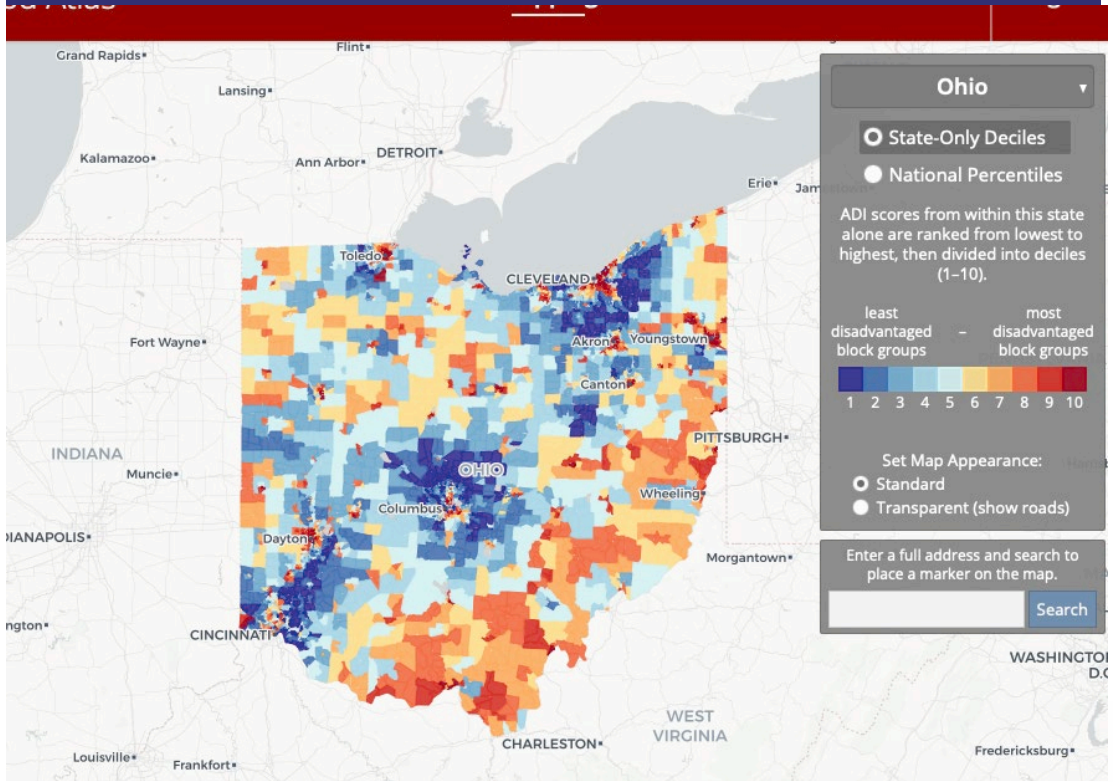
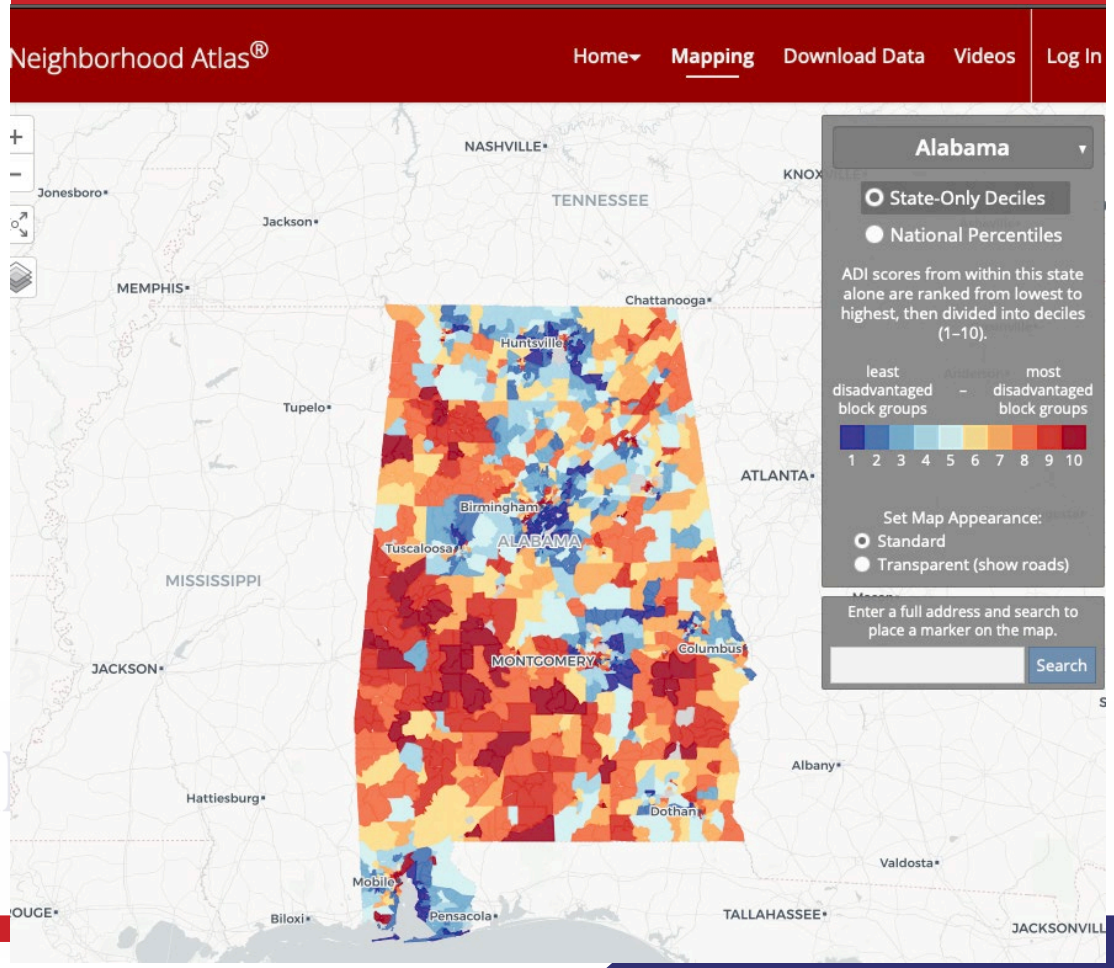
State Level ADI Mapping Examples

Project ECHO

Ohio



Alabama



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Business Case Validation using ADI Data

Project ECHO

- "Area Deprivation Index and Cardiac Readmissions: Evaluating Risk-Prediction in an Electronic Health Record.
  - Journal of the American Heart Association. 2021;10:e020466. DOI: 10.1161/JAHA.120.020466
- "Our results support the prior study's determination that ADI carries as much risk for readmission as would the addition of another chronic medical illness…
- Our work adds to this body of literature by showing that ADI, in combination with EHR data, can predict adverse risk for individual patients."

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Identifying Priority Populations - Hospitals

- Identifying persons with rising risk for extended length of stay (LOS) where the LOS is contributed to by complicating HRSNs.
- Opportunity: Housing insecurity causes a delay in establishing a safe discharge. Outcome LOS beyond the DRG allowable payment, which causes the hospital to lose money for each additional admission day.
- Financial Impact of Extended LOS (per day):
  - Medicare: $2,071/day
  - Medicaid: $1,701/day
  - The Commonwealth Fund ROI Calculator Data Tables: https://www.commonwealthfund.org/sites/default/files/2020-08/meps_average_cost_utilization_table.pdf

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Identifying Priority Populations – Health Plans

- Identifying health plan members with rising risk for increased healthcare utilization and poor clinical outcomes.
- Opportunity: Roster referral of members screened for HRSNs, with the potential to reduce total cost of care and improve HEDIS measures for priority populations.
- Example: Members with a) two or more chronic conditions, b) a positive HRSN screen, and c) residing in a high ADI neighborhood.
  - Would benefit from targeted interventions to address HRSNs.
  - Measure: total cost of care, improvement in HEDIS measures, reduced gaps in care.

CY2024 Physician Fee Schedule Proposed Rule Changes

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Medicare Physician Fee Schedule Changes

- CMS proposed rule changes to the Physician Fee Schedule creates a new set of codes to address HRSNs in the Medicare population.
  - New Part B benefits for screening and addressing HRSNs
  - Payment to cover the labor associated to addressing HRSNs (Community Health Integration [CHI])
  - Clear references to clinicians partnering with CBOs and using CHWs to provide the services
- Medicare providers can contract with CBOs to implement the services, under the current proposed rules.

Comment Period

Available:

- https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched
- Comments due no later than 5pm on September 11, 2023
- Comment submission methods
  - In commenting, please refer to file code CMS-1784-P.
  - Comments, including mass comment submissions, must be submitted
  - 1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov
  - Follow the "Submit a comment" instructions.

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.

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).

United Healthcare

Dr. Alexander Billioux, MD, DPhil, FACP
(United Healthcare)

Chief Medical Officer, Community & State
Sr. Vice President, Population Health & Social Care
UnitedHealthcare

Dr. Alex Billioux is the chief medical officer (CMO), Community & State, and senior vice president for population health and social care at UnitedHealthcare (UHC). As CMO, he is responsible for the individual care, population health, and provider partnership strategies for UHC's Medicaid plans. He also leads UHC's enterprise-wide strategy and capabilities to address individual health-related social needs and community social drivers of health. He is an internal medicine doctor focused on supporting whole-person health by delivering coordinated physical, behavioral, and social care and advancing cross-sector population health strategies and sharing data to foster coordinated, learning health systems. Dr. Billioux was formerly the Assistant Secretary for the Office of Public Health and a senior advisor and division director at the Center for Medicare and Medicaid Innovation

Advancing Health Equity through Social Care

UnitedHealthcare's coordinated program to address individual social needs and support community capacity

Alex Billioux, MD DPhil
CMO, Community & State (Medicaid)
SVP, Population Health and Social Care
August 9, 2023

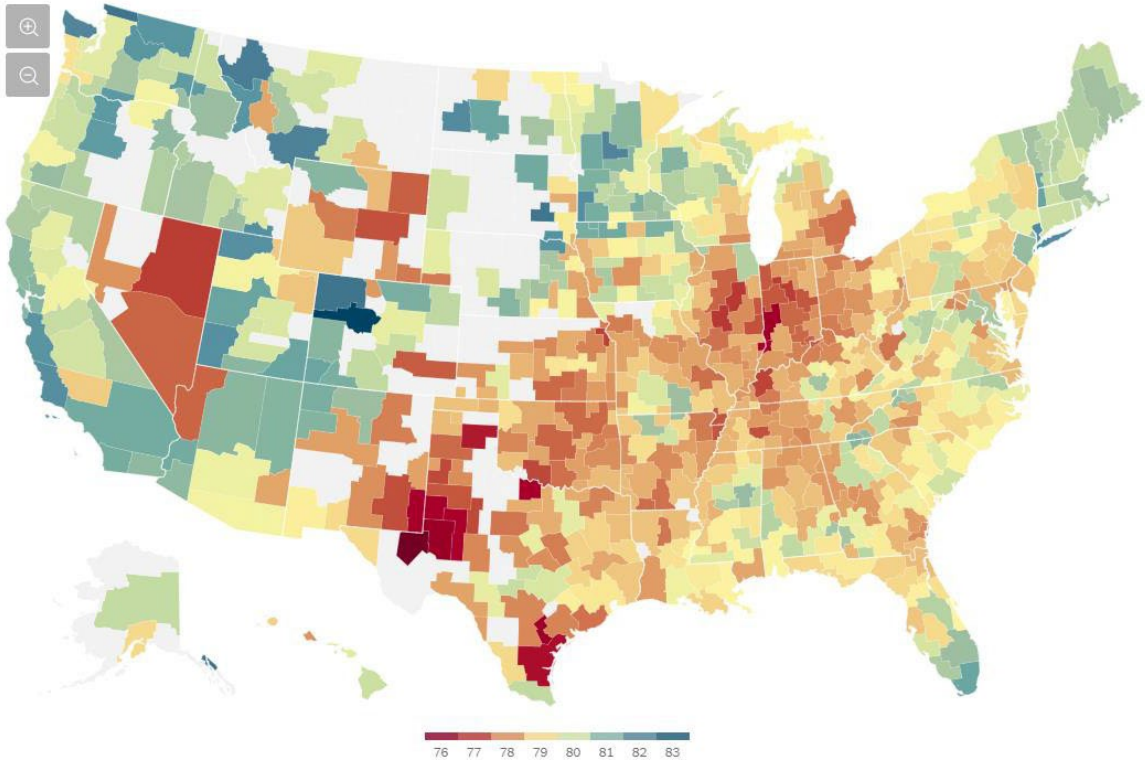
UnitedHealthcare

3 Big Things:

1. **You have to *center* equity to *advance* equity**
2. ***Leading with help* enables care coordination**
3. **We want to *foster healthier communities* for all**

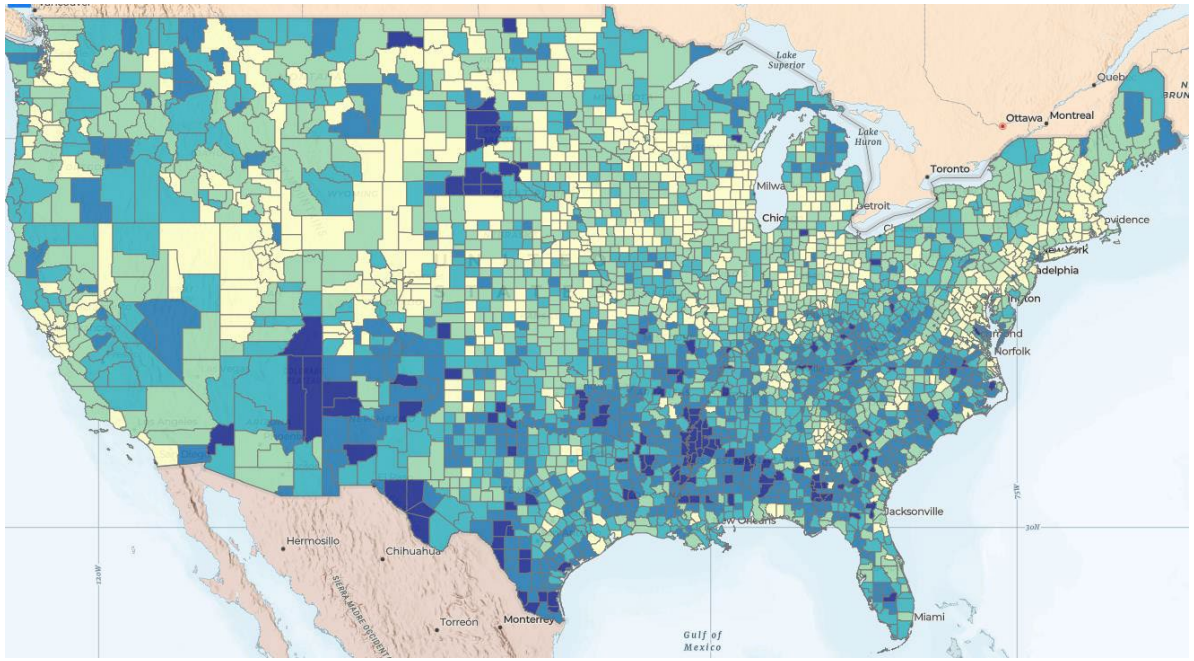
Where you live impacts how long you live

Life expectancy at 40 for household incomes below $28,000



New York Times adaptation of R. Chetty et al. JAMA 2016

Community Resilience Estimates



HRSA Health Equity Mapping Tool

Social Drivers of Health and Health Equity

- Systems of discrimination create barriers to social resources and disrupt family and community structures
- Social drivers are major pathways driving health disparities

Our opportunity – counteract effects by addressing:

- individual social needs
- community social drivers through an approach centering health equity

UnitedHealthcare's Social Care Approach

Close gaps so everyone has an opportunity to be as healthy as possible

Understand
individual's barriers to better health through screening

Connect
people to resources in the community

Expand
community capacity to foster health and promote health equity

Member Social Care Journey

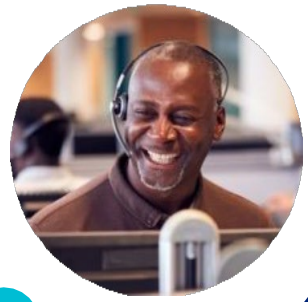
- UnitedHealthcare
- Social Agency
- Member
- Provider/Data Source

Member communicates they are in need of assistance through various channels

UnitedHealthcare dives deeper to assist the member in identifying resources/services

UnitedHealthcare refers the member to community resources and programs

Member seeks assistance



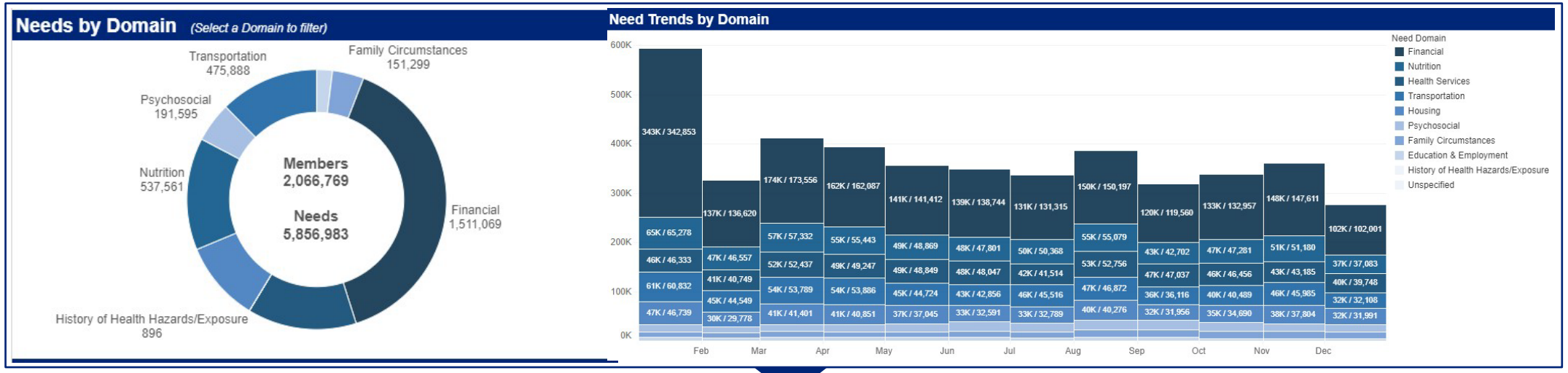
UnitedHealthcare follows up with members to confirm they received the service and their satisfaction with resource

UnitedHealthcare analysis reveal social disparities and community resource gaps

Meeting members' needs at scale delivers impact

4.95M
members screened in 2022

>85%
member-level follow-up



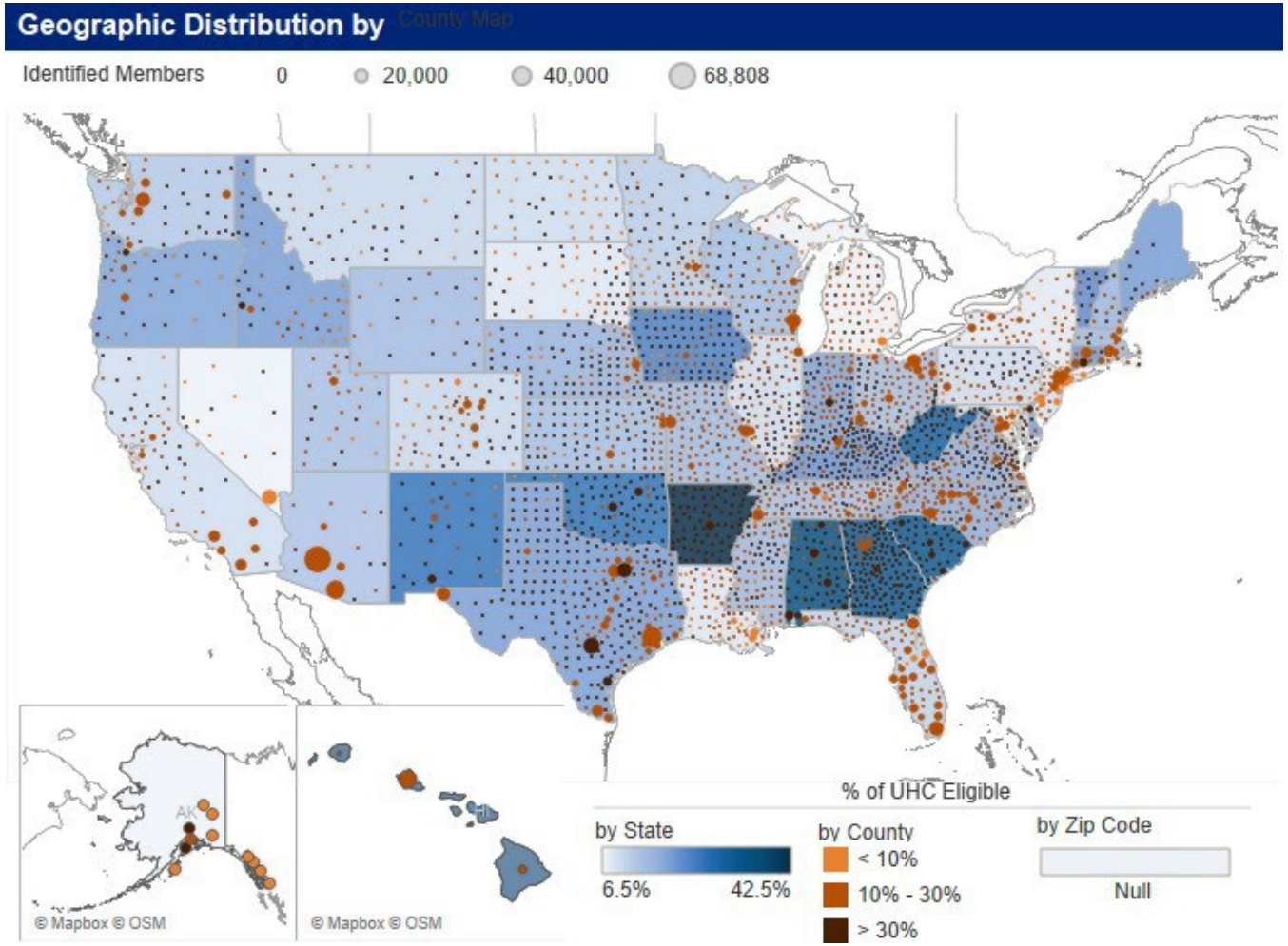
80+
average NPS

$1,500
average in goods/services per member

862,480
members with at least one need met

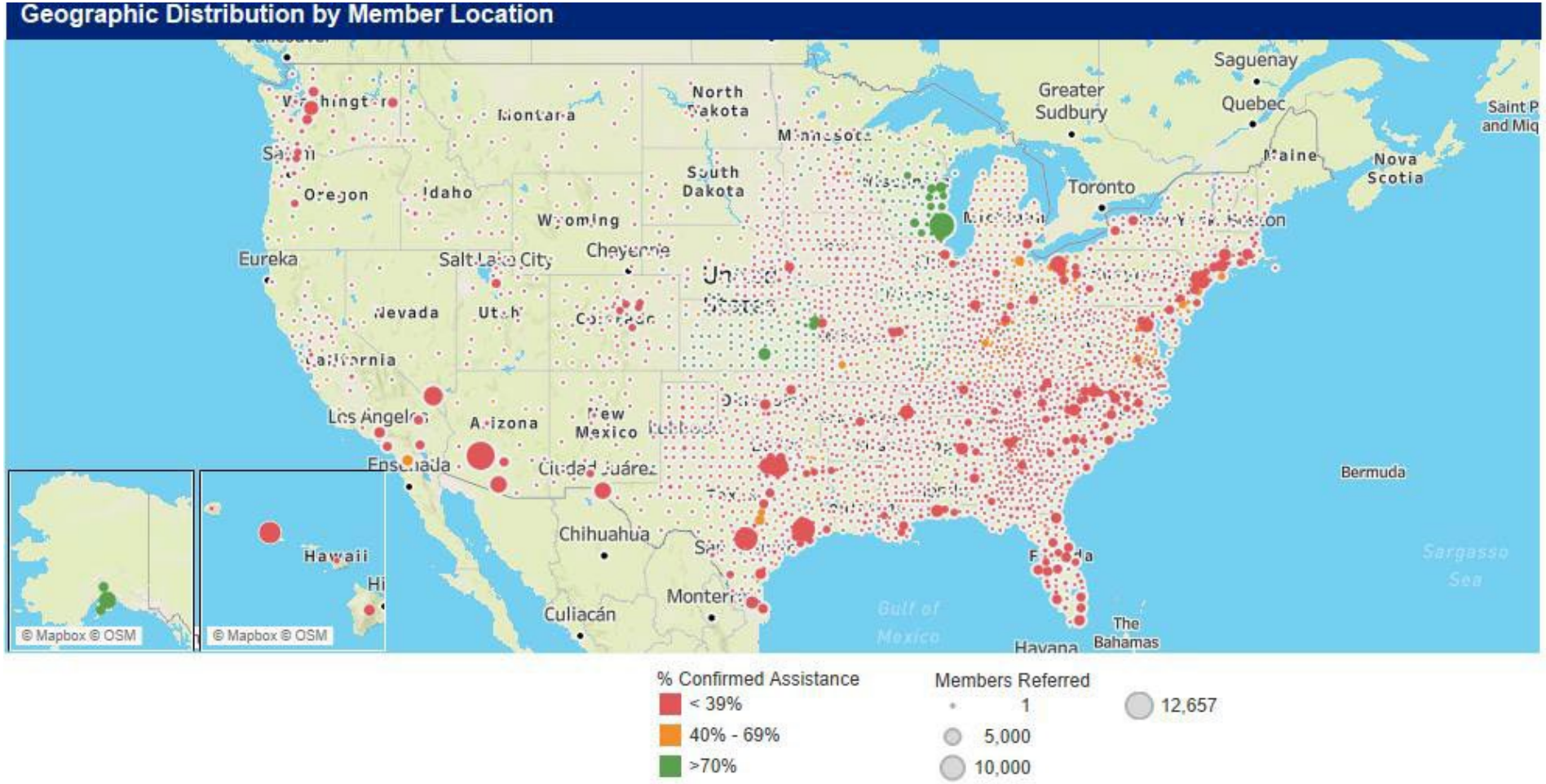
Our approach helps us understand where our members have needs

Geographic Distribution of Members with Social Needs



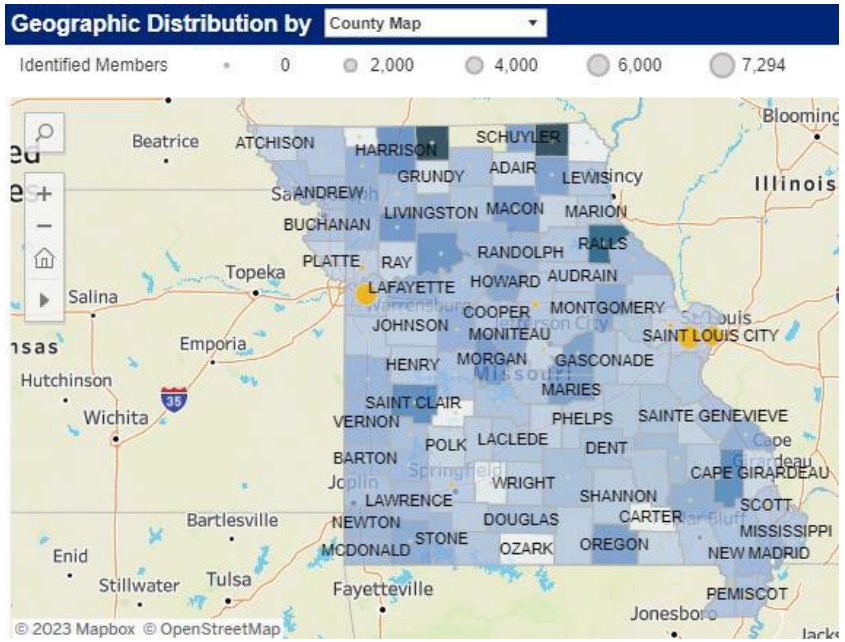
Where community social care gaps exist

Geographic Distribution of Community Social Care Capacity



And Where Social Gaps are Greatest

Missouri — BIPOC* Members



*Members identifying as African American, Asian, Hispanic, Native American, Pacific Islander, Multiracial

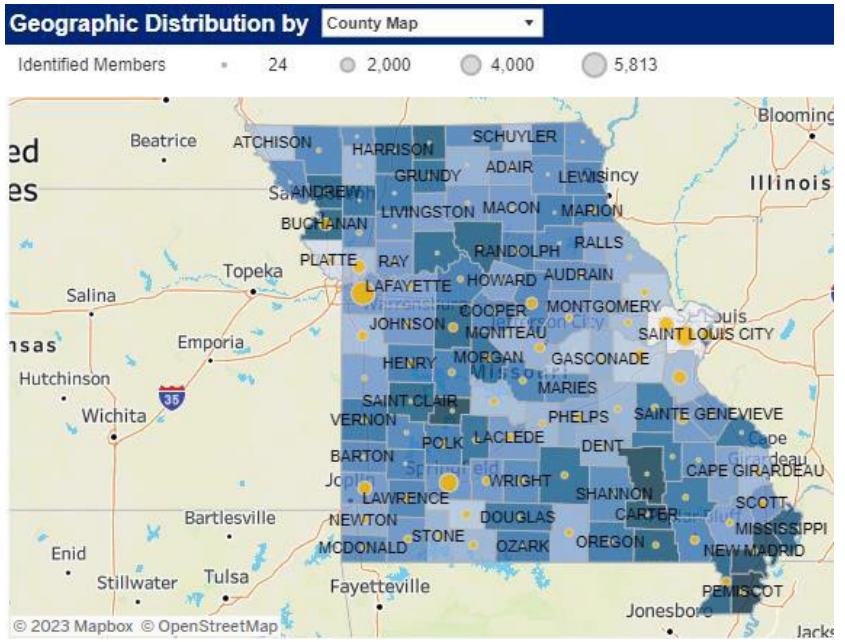
Needs by Subdomain

Need Domain	Need Subdomain	
Financial	Low Income	7,387
Nutrition	Nutrition	6,665
Transportation	Transportation	6,489
Financial	Utilities Cost	5,619
Housing	Housing	4,721
Financial	Clothing Cost	3,573
Financial	Medical Cost	3,390
Health Services	Personal Care	2,989
Financial	Phone Cost	2,945
Financial	MSP	2,265
Family Circumstan	Family Support	1,703

Age Group

0 - 20	16%
21 - 54	24%
55 - 64	19%
65 - 74	28%
75 - 84	9%
85+	3%

Missouri — White Members



Needs by Subdomain

Need Domain	Need Subdomain	
Nutrition	Nutrition	14,977
Transportation	Transportation	13,777
Financial	Low Income	12,350
Financial	Utilities Cost	10,612
Housing	Housing	9,422
Financial	Medical Cost	8,334
Financial	MSP	8,171
Financial	Clothing Cost	7,864
Health Services	Personal Care	6,371
Financial	Phone Cost	6,360
Family Circumstan	Family Support	5,281

Age Group

0 - 20	10%
21 - 54	25%
55 - 64	20%
65 - 74	27%
75 - 84	13%
85+	5%

Where social and health disparities co-exist

UHC Member SDoH & Demographic Summary for MO & Behavioral Health

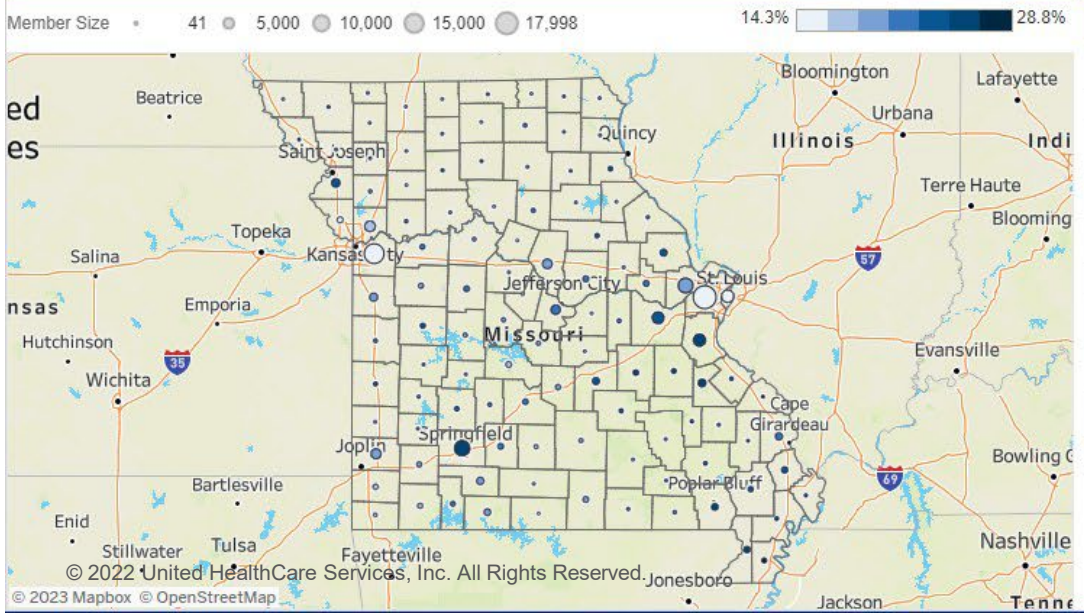
137,830
Members w/ Behavioral Health & No SDoH Need Selected

19.5%
% of Members w/ Behavioral Health & No SDoH Need Selected

Top 10 MO Counties for Behavioral Health (Select a County below to filter dashboard)

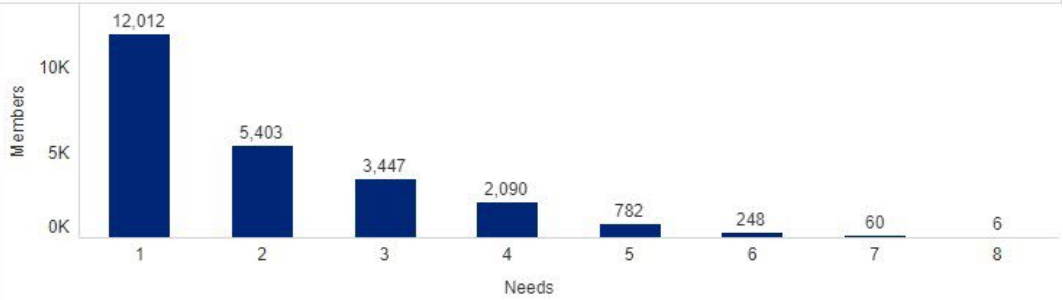
State + County	Members	% of Total State Membership	Members w Selected Condition	% w/ Selected Condition
MO - SAINT LOUIS	111,724	15.8%	17,998	16.1%
MO - JACKSON	83,267	11.8%	13,342	16.0%
MO - SAINT CHARLES	36,963	5.2%	7,468	20.2%
MO - SAINT LOUIS CITY	36,459	5.2%	5,265	14.4%
MO - GREENE	31,393	4.5%	7,765	24.7%
MO - CLAY	21,966	3.1%	3,797	17.3%
MO - JEFFERSON	20,162	2.9%	4,989	24.7%
MO - FRANKLIN	19,122	2.7%	4,628	24.2%
MO - BOONE	16,884	2.4%	3,232	19.1%
MO - COLE	14,422	2.0%	3,017	20.9%

% of MO Members with Behavioral Health by County



UHC Member SDoH Needs Distribution for MO & Behavioral Health

2.0
Average SDoH Needs per Member



MO SDoH Needs for Behavioral Health by Race

Race

Need Domain	Asian	Black	Hispanic	Multiracial	Native American	Other	Unknown	White
Financial	10.3%	15.2%	15.1%		23.8%	13.7%	11.8%	8.1%
Nutrition	6.3%	11.0%	8.0%		16.4%	7.1%	8.3%	5.4%
Transportation	4.0%	7.8%	5.4%		9.8%	6.6%	6.7%	3.5%
Housing	2.9%	7.8%	5.5%		9.0%	6.6%	7.1%	3.5%
Family Circumstances	5.2%	4.1%	4.2%	100.0%	4.1%	2.8%	4.6%	2.6%
Psychosocial	2.0%	3.6%	2.5%		0.8%	0.9%	6.0%	2.0%
Health Services	3.2%	4.3%	3.3%		4.1%	3.3%	4.9%	1.8%
Education & Employment	1.7%	2.6%	1.9%		0.8%	0.9%	3.5%	1.2%
Unspecified		0.0%					0.0%	0.0%
History of Health Hazards/Exposure		0.0%					0.0%	0.0%

UnitedHealthcare Catalyst™ Model

UnitedHealthcare Catalyst™ creates community-based collaborations that leverage the capabilities and capacities of community partners to address community health challenges.

The model establishes and powers cross-sector collaboratives in communities across the country.

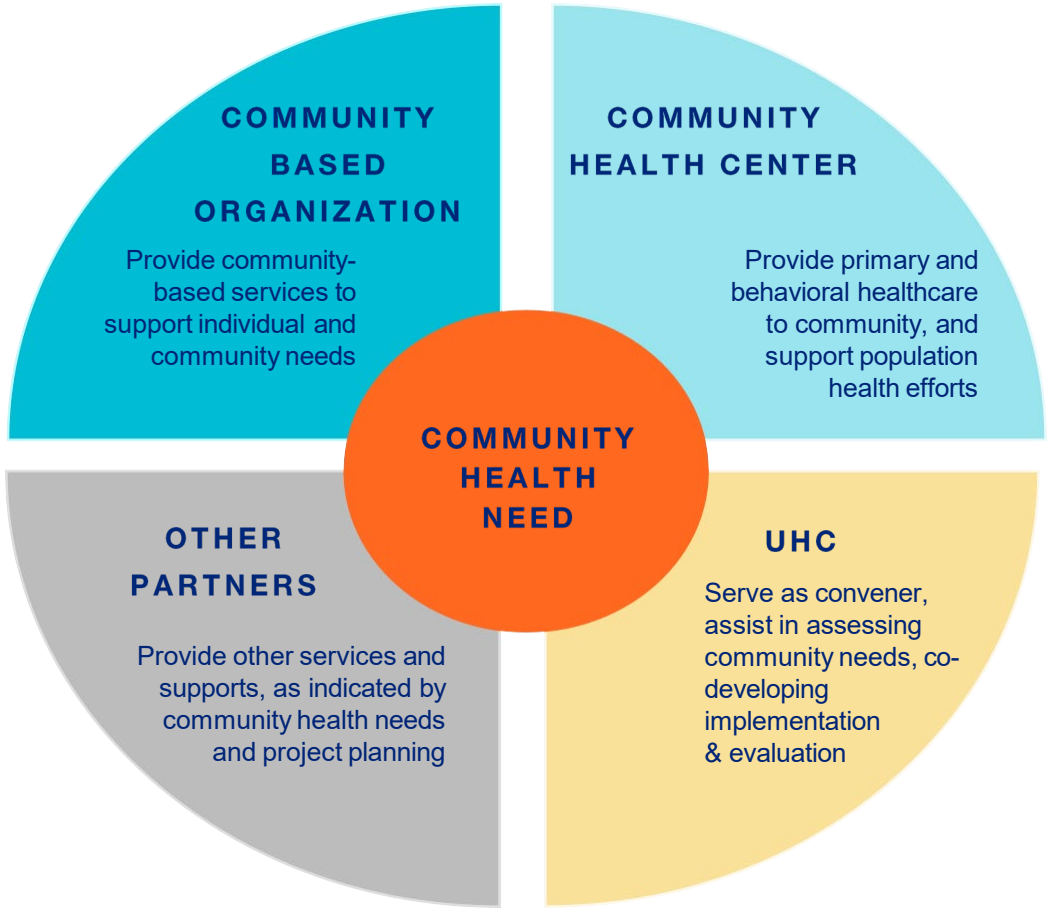
The approach uses data to identify a community health issue to focus its efforts with measurable goals and clear responsibilities.

The collaborative is built from the ground up to create lasting local relationships and enduring change at a community level.

The goal is to help achieve health equity — one community at a time

A new approach to transforming community health

Partnerships are foundational to the success and there are critical roles to play.



Catalyst in Action:
Addressing Maternal Health Disparities

SAMUEL U. RODGERS HEALTH CENTER

NORTHLAND HEALTH CARE ACCESS

Catalyst in Action: Addressing Maternal Health Disparities

Key Strategies:

- Education
- Case Manager Support
- Behavioral Health and Dental Care
- SDoH Screenings
- Post-Natal Care Follow-Up
- Cultural Expertise

▲ 30%

increase in the number of completed behavioral health screenings and dental care provided as part of pre-natal care plans

▲ 3.6%

increase in number of individuals delivering at full-term (at least 38 weeks)

▲ 90%

increase in individuals attending all of their post-partum care appointments

Thank you!

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Case Study Discussion

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New Case Study Process

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- 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.

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Anonymized Case Study – Community Member

Project ECHO

- Jane lives in public housing and only receives social security for her monthly income. She has failed 2 inspections of her public housing unit because she requires assistance with ADLs and unable to keep her apartment clean. She has been notified that multiple failed inspections could lead to eviction.
- She has difficulty going out to shop for groceries, obtaining her medication, and has no caregiver support in the community.
- Jane was admitted to the hospital for complications related to diabetes and comorbid depression.

Anonymized Case Study – Health Plan

- The health plan has identified that their Medicare Advantage members, that are dually eligible or enrolled in a low-income subsidy (LIS), have a greater likelihood of being impacted by HRSNs.
  - The Part D Low Income Subsidy (LIS/Extra Help) program helps pay for a portion of Part D prescription drug plan costs, including Part D premiums, deductibles, and copayments.
    - NCOA. Understanding Medicare's Part D Low Income Subsidy. 2023. Available online: https://ncoa.org/article/understanding-medicare-part-d-low-income-subsidy-extra-help#:~:text=Medicare's%20Part%20D%20Low%20Income%20Subsidy%20(also%20called%20LIS/Extra,premiums,%20deductibles,%20and%20copayments.
- The health plan would like to engage with a CCH, to assist members with a positive HRSN screen, to apply for a range of social service programs that they may be eligible for.

Case Study Questions - Community Member

- Identify each of the HRSNs that are impacting Jane's hospitalization.
- How do the HRSNs impact hospital Length of Stay?
- How do the identified HRSNs impact health plan clinical outcomes (HEDIS) for Jane?
- What are the interventions that a CCH could deploy to address each of the identified HRSNs in this case study?
- What are the funding sources associated with each of the identified HRSN interventions?
- How could the hospital use data to identify persons that have similar hospitalization risk as Jane?
- How could the hospital and physician groups leverage the Physician Fee Schedule proposed rules to address the needs of persons like Jane, in a sustainable manner?

Case Study Questions – Health Plan

- The health plan agrees to pay for navigation services but not social services. Can the CCH have an impact on the social needs with just navigation services, if the plan will not pay for things such as food and housing?
- The health plan has utilization data for their members. The utilization data could guide the CCH to target outreach. How could the CCH use the health plan hospital utilization data to increase engagement of vulnerable members?
- The CCH would like to engage in a care transitions contract with the health plan, but the health plan is more interested in addressing HRSNs in their high-risk population. How could the CCH present their "care transition intervention" in a manner that it focuses on screening, addressing, and reporting outcomes for HRSNs?
- How can the CCH leverage their hospital relationships to make the business case to the health plan for a contract to address HRSNs for the health plan members?
- The health plan requires the CCH to report data on HRSN screening, interventions, and outcomes. How could the CCH address this requirement if they do not have a fully operational IT system?

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Billing ECHO Sessions Completed

	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

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Upcoming Meetings & Events

- Network Expansion Peer Group Dialogue Meeting – August 24, 2023, 2-3pm ET
- NLC All-Member Capstone Meeting – August 30, 2023, 2-3:30pm ET

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

Administration for Community Living