Community Care Hub
National Learning Community

Network Expansion Track Meeting

June 8, 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
- ECHO Session: Transforming Billing and Coding – Value Based Contracting
- Michigan Region IV AAA / Corewell Health
  - Q&A
- Case Study Presentation
  - Group Discussion
- Closing

Community Care Hub Billing and Coding Mechanics Session #4

June 8, 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."

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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

Learning Objectives for Today's Session

- Increase participant knowledge of Value Based Contracting models
- Increase participant awareness of Value Based Contracting in their local markets
- Determine opportunities for CCHs/CBOs to support Value Based Contract models
- Increase understanding of the value that community-based organizations (CBOs) bring to providers participating in Value Based Contracting
- Identify ways that CCHs/CBOs can implement contract models with providers in Value Based Contracts

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Today's ECHO Session

Project ECHO

Time	Session Topics
5 minutes	Recap of topics covered in Session #3
10 minutes	Value Based Contracting Overview
10 minutes	Role of CBOs in Value Based Contracting Models
30 minutes	Michigan Region IV AAA /Corewell Health Presentation
10 minutes	Discussion/Questions for Presenter
20 minutes	Anonymized Case Study Introduction
5 minutes	Summary, Wrap-Up, Planning for Next Session

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ECHO Session #3 Summary

- Session #3 of our ECHO series on Billing and Coding.
  - Overview of hospital reimbursement policy.
  - Review of hospital quality measures that require hospitals to screen for HRSNs.
  - Role of CCHs/CBOs in addressing HRSNs in affected populations.
- CommonSpirit Health System Presentation
  - CommonSpirit Health is one of the nation's largest nonprofit health care systems with more than 1,000 care sites and 140 hospitals in 21 states.
  - CommonSpirit is making significant investments in solutions to address HRSNs in their hospitals and markets across the U.S.

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CMMI Definition

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- CMS Definition of Value Based Contracting
  - Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare or other payers.
  - These programs are part of our larger quality strategy to reform how health care is delivered and paid for.
  - Key Type of Value Based Contract
    - Alternative Payment Model (APM)
    - APMs move providers from Fee-For-Service to a different reimbursement approach.

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Diabetes Example

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Fee for Service

- Beneficiary with Poorly Managed Diabetes (HgbA1C 14.0)
  - Utilization: Admissions, Readmissions, Insulin, Amputations, ESRD….
  - Medicare Costs = $250,000+/year
  - Physicians are paid more when there are worse outcomes.
  - Financial Reward is tied to worse health outcomes

Pay for Value

- Beneficiary with Well Managed Diabetes (HgbA1C 6.0)
  - Medicare payments = Quarterly office visits
  - Annual Payments made by Medicare < $5,000/year
- VBC Model
  - Value-Based Payments changes the financial incentive to reward the doctor that achieves the best health outcome at the lowest cost (value)

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Risk Models

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- Risk Arrangement: Payment model where the organization is held financially responsible for the quality and total cost of care delivered to a set of beneficiaries
- Risk:
  - One-Sided Risk Model: A financial risk arrangement that provides financial gains when there is improvement but no risk of financial losses for cost increases.
  - Two-Sided Risk Model: A financial risk arrangement that provides financial risk for both upside gains and downside losses.

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Federal Initiatives to increase BIPOC Participation in VBPs

- Centers for Medicare & Medicaid Innovation (CMMI) Strategic Refresh (2022)
  - “The full diversity of beneficiaries in Medicare and Medicaid is not reflected in many models to date.
  - Medicare-focused models have limited reach to Medicaid beneficiaries and safety net providers.”
    - https://innovation.cms.gov/strategic-direction-whitepaper
- CMMI Goal: **100%** of Medicare & Medicaid beneficiaries will be receiving care in a value-based payment model **by 2030**.
- CMMI Recommendations
  - Safety Net Providers cannot accept downside risk without the proper tools a) care management b) protection against financial risk of loss c) technology tools for risk stratification and data analysis d) staff augmentation to address high need beneficiaries

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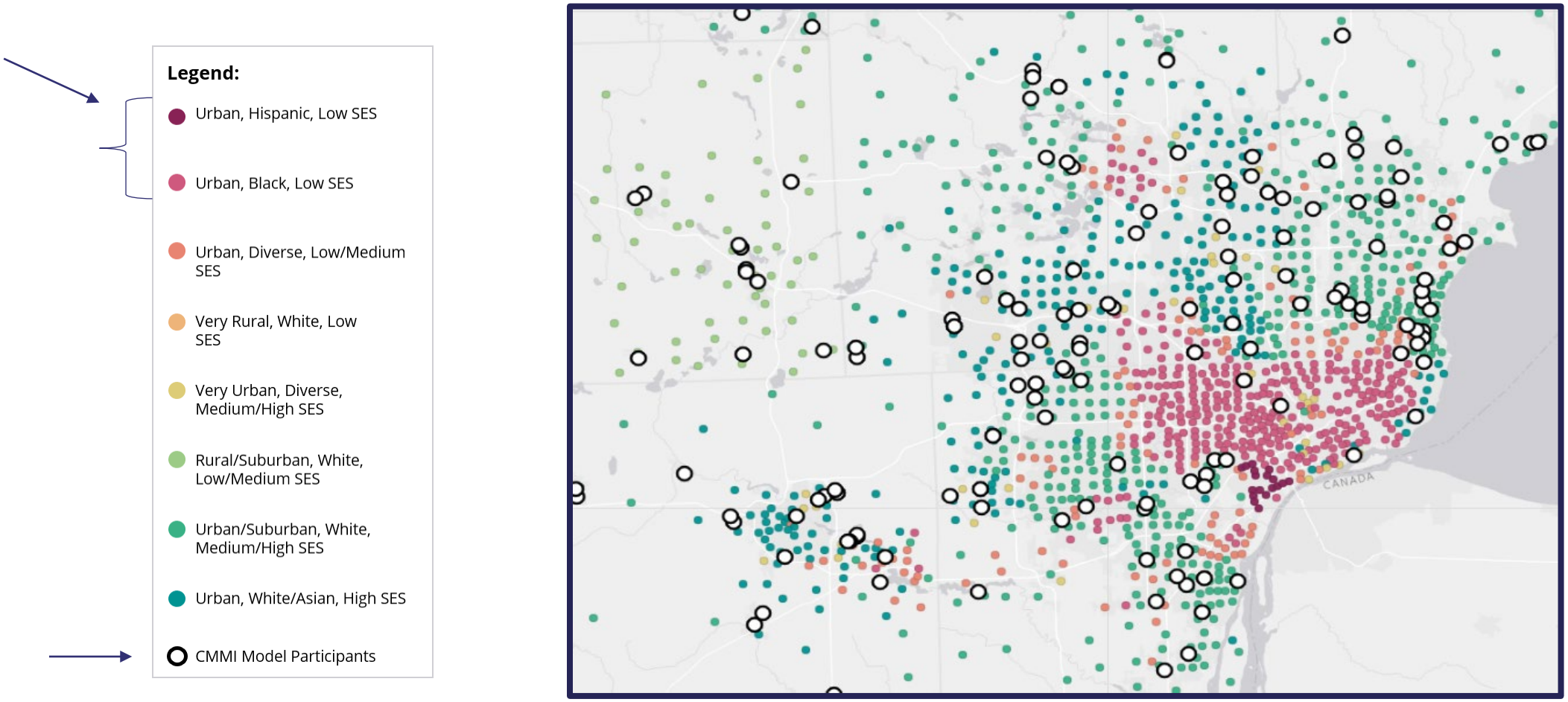
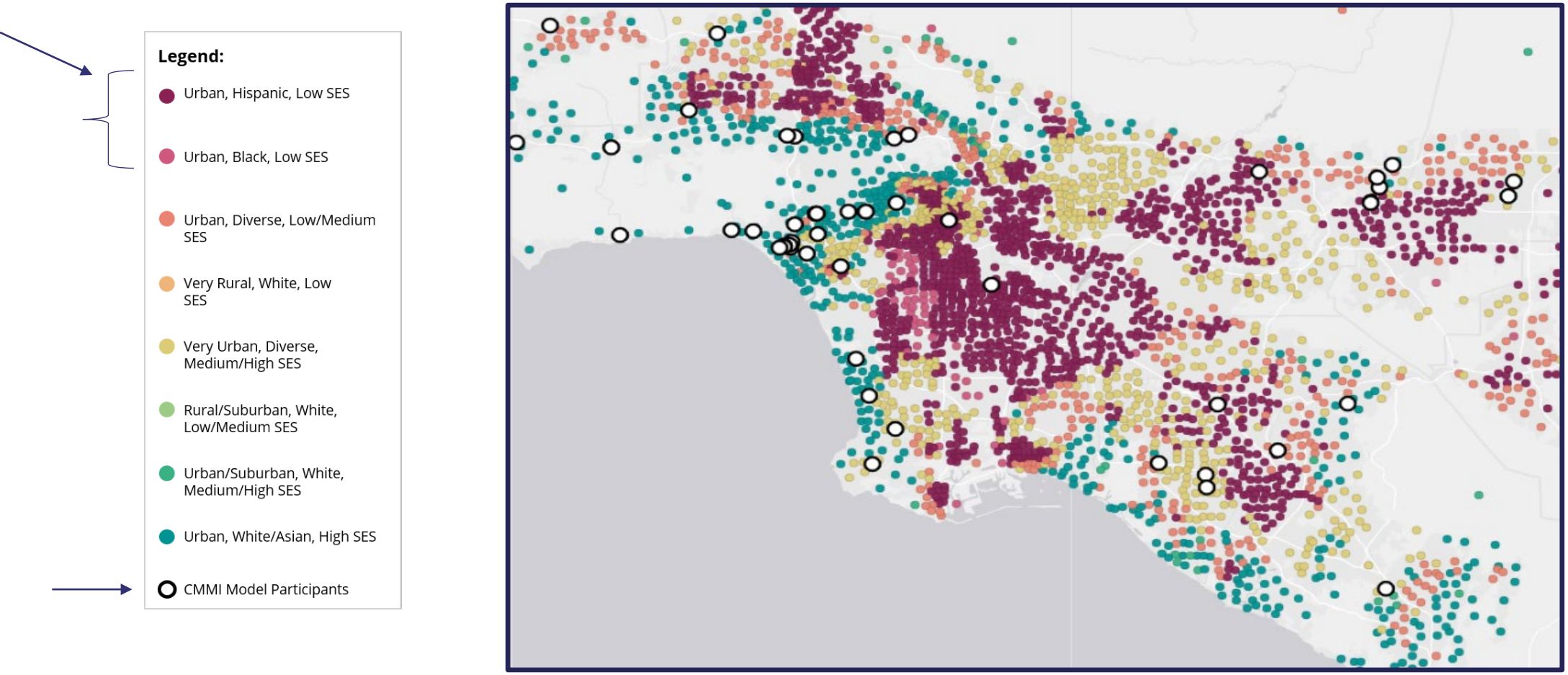
CMMI Primary Care First Model Participation in Detroit

Participants seem to be concentrated in the more affluent areas, **with fewer beneficiaries in low SES, predominantly Black census tracts.**



CMMI Primary Care First Model Participation in Los Angeles

Participants seem to be concentrated in the more affluent areas, **with fewer beneficiaries in low SES, predominantly Hispanic census tracts.**



CMMI Proposed Solution for Advancing Health Equity

Develop new models and modify existing models to address health equity and social determinants of health

Increase the number of beneficiaries from underserved communities who receive care through value-based payment models by increasing the participation of Medicare and Medicaid providers who serve them

Evaluate models specifically for their impact on health equity and share data and "lessons learned" to inform future work

Strengthen data collection and intersectional analyses for populations defined by demographic factors such as race, ethnicity, language, geography, disability, and sexual orientation/gender identity to identify gaps in care and develop interventions to address them

CMS Advanced Investment ACO Model Track

- **New CY2024 ACO Model** (Applications will open May/June 2023).
  - ***Goal: Increase participation, in the ACO VBP, by providers serving underserved communities.**
- Announced in the CY2023 Medicare Physician Fee Schedule Final Rule.
  - https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program
- Key Aspects of the Advanced Investment ACO Track.
  - Participants in this track can defer downside risk for seven (7) years
  - **Upside risk only for first seven (7) years.**
  - CMS will provide upfront funding to invest in the infrastructure required to participate in the ACO model.
  - Eligible applicants will be low-revenue providers (Groups that do not have hospital participation)
  - **Preference is for ACOs with safety net providers and providers serving BIPOC Communities**
  - Must have the minimum number of Medicare Fee-For-Service Beneficiaries (5,000 Medicare/Dual Eligible FFS)
  - Must be a new ACO

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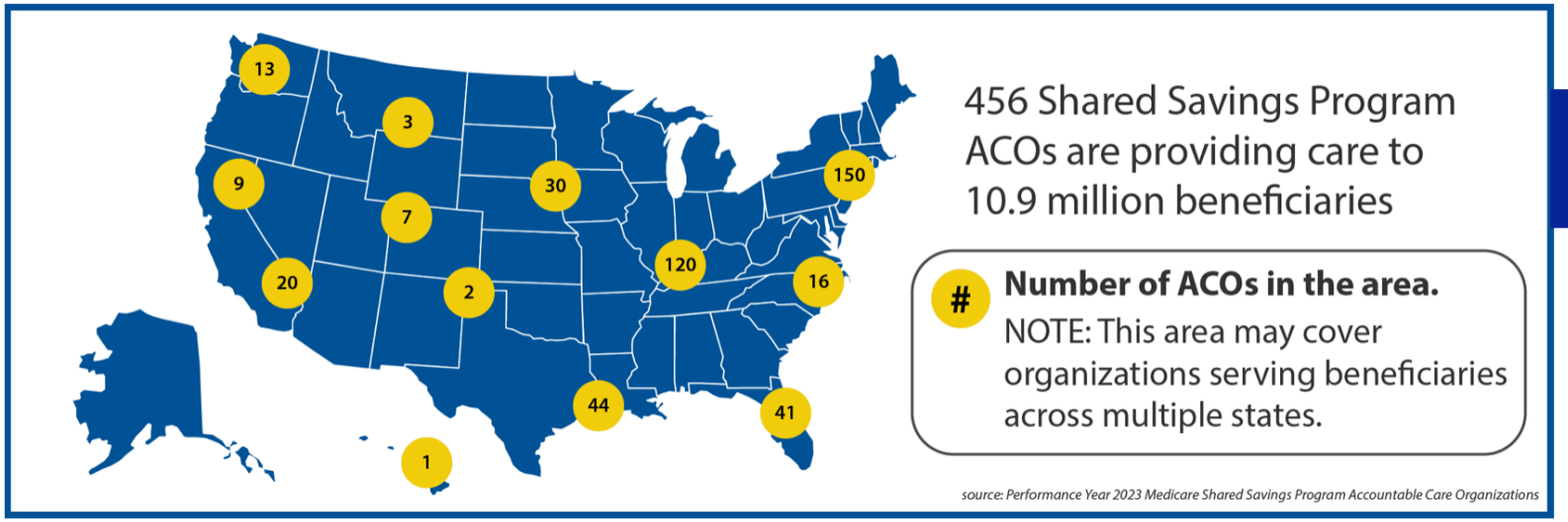
Accountable Care Organizations

- Groups of providers and suppliers participating in one-sided or two-sided risk models with CMMI for total cost of care for Medicare Fee for Service beneficiaries.

National Participation



Feedback

To learn more about the number and geographic location of Shared Savings Program ACOs, reference Program Data.

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Analyzing ACO Data

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- Link to finding ACOs in your State and ACO Quality Data:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data
- DC Example – GW Health Network

	A	B	C	D	E	F
106	A4986	Privia Quality Network Maryland	DC, MD	1	1/1/22	1/1
107	A4873	Accountable Care Coalition of Northeast Partners, LLC	DC, MD, VA	2	1/1/20	1/1
108	A3667	GW Health Network	DC, MD, VA	3	1/1/18	1/1
109	A3319	Mid-Atlantic Collaborative Care, LLC	DC, MD, VA	2	1/1/17	1/1
110	A3272	Netrin Primary Care ACO, LLC	DC, MD, VA	2	1/1/17	1/1
111	A2057	Privia Quality Network, LLC	DC, MD, VA	3	1/1/14	1/1
112	A5253	Privia Quality Network Delaware, LLC	DE	2	1/1/23	1/1
113	A5003	Chesapeake MSSP	DE, DC, MD	2	1/1/22	1/1
114	A4856	MD MSSP Enhanced	DE, DC, MD	2	1/1/20	1/1
115	A3454	Trinity Health Integrated Care	DE, FL, ID, IL	2	1/1/17	1/1

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Reading ACO Data

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- **GW Health: ACO ID A3667**
  - Total Population: 7,161
  - ESRD: 75
  - Disabled Duals: 658
  - Aged Duals: 953
  - Aged Non-Duals: 5,475
  - Persons Aged 75 – 84: 2,113
  - Persons Aged 85+: 769

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HCP-LAN: Expanding APMs Across All Payers

- Public-Private Efforts to Expand adoption of Value-Based Contracting
- The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, **reduce the barriers to APM participation**, and promote shared accountability.
- Website: https://hcp-lan.org/about-us/
- HEAT: Health Equity Action Team
  - Focus: Defining the role of CBOs in Value-Based Contracting

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Texas Example

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- In 2018, at least 25% of MCO total medical spend must be in any type of VBC payment model and 10% in risk-based model.
- In 2021, at least 50% of MCO total medical spend must be in VBC payment model with 25% in risk-based model.
- State has just undergone a Medicaid rebid which will build upon the prior VBC requirement.

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Michigan Region IV AAA/Corewell Health

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HEALTH CARE CONTRACTING

Addressing health related social needs (HRSN) through the integration of social care and medical care in a Primary Care First practice.

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Laura Wohler, RN
(Caring Circle, Corewell Health South)

Director of Clinical Services
Caring Circle
laura.wohler@corewellhealth.org

Laura Wohler has been the Director of Clinical Services and Organizational Excellence with Caring Circle of Corewell Health South for the past six years, with oversight of operations for their post-acute services which include home-based primary care, a facility provider service serving six local nursing facilities, hospital and clinic based palliative care and a CHAP accredited hospice including a hospice residence. With her leadership, Caring Circle won the prestigious AHA Circle of Life award in 2020. Laura has four decades of experience as a registered nurse, having experience in acute care as well as in the post-acute care arena. She received her bachelor's degree in nursing from Ferris State University. Her guiding principles include improvement of health equity, enhancement of the consumer experience, improvement of quality, value and outcomes and making health care more affordable for the communities we serve.

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Christine Vanlandingham, CEO
(Region IV Area Agency on Aging)

CEO, Region IV Area Agency on Agingcvanlandingham@areaagencyonaging.org

Christine Vanlandingham is the Chief Executive Officer for Region IV Area Agency on Aging. With more than 20 years of experience in the field of aging and a background in gerontology, journalism, and public policy, Vanlandingham is a nationally recognized speaker on innovations in aging and health care contracting. Through strategic partnerships, structural linkages, and contractual relationships, Vanlandingham leads the integration of health and social care on a regional level and state level and works with public health, academia, state and federal policy makers, community planners, and coalitions to shape public policy and service systems to meet the needs of older adults, persons with disabilities and caregivers. Vanlandingham has 15 years of health system governance experience and currently serves as Corewell Health South Board Chair, Watervliet Community Hospital Board Chair, PACE of Southwest Michigan Board Vice Chair, President of three HUD housing corporations and is the Strategic Initiatives Committee Chair for Michigan's aging network. Vanlandingham is also a newspaper columnist.

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Theresa Uhrich, COO
(Region IV Area Agency on Aging)

Chief Operating Officer
Region IV Area Agency on Aging
theresauhrich@areaagencyonaging.org

Theresa Uhrich, a Licensed Master Clinical Social Worker, brings over 15 years of experience in the Aging Network to her role as Region IV Area Agency on Aging's Chief Operating Officer. Uhrich spearheads the development and implementation of health care partnerships, product development, and contract execution and implementation. Uhrich is passionate about leading data-driven, human-centered strategies for process improvement and utilization of technology to solve service delivery challenges and enhance engagement and outcomes for both her team and the individuals and communities they serve. In addition to her COO responsibilities, Uhrich actively contributes to various health and human service councils and committees. Currently, she serves on the governing boards for both the Michigan Medicare/Medicaid Assistance Program and PACE of Southwest Michigan. She is also a member of the Advisory Board for Senior Outreach of Van Buren County, the Care Coordination Committee of Bronson Healthcare, and the Board Population Health Committee of Corewell Health South.

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WHO WE ARE:

Corewell Health™

At our core, we are here to help people be well so they can live their healthiest life possible.

What guides us.

Mission: Improve health, instill humanity and inspire hope.
Vision: A future where health is simple, affordable, equitable and exceptional.
Values: Compassion. Collaboration. Clarity. Curiosity. Courage.

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WHO WE ARE:

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At our core, we are here to ensure that older adults and people with disabilities can live life as independently as possible in the setting of their choice.

What guides us.

Mission: Offering Choices for Independent Lives

Vision: Through choice and range of service, every aging adult lives a quality life.

Core Values:

- *Empowerment*
- *Independence*
- *Dignity*
- *Person-centeredness*
- *Interdependence*
- *Equity*
- *Wisdom of age*

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SHARED VISION:

Integrate social care into the delivery of health care and unify the efforts of both medical and home & community-based organizations to improve health & reduce health care cost for older adults with complex care needs. {add collaboration; coordination

ALIGNED OBJECTIVES:

Better health (reduced ED/inpatient utilization)	**Driving care to the right setting** (increased primary care utilization)	**Improved patient experience**
Connectivity to community-based services/resources	**Maintenance of independence**	**Support for caregivers**

Pilot Project leading to executed contracts

Beyond Coordination:

Interagency Care Team (ICT)

Medical and Social Partnership for better health outcomes and lower costs.

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Common purpose:

Identified Issue

Seniors who have multiple chronic conditions experience some of the worst health outcomes in the region often resulting in increased disability and avoidable death. (HBC, Aging Subcommittee 2012)

HBC Healthy Consortium Berrien

Value Expectations…

Stabilized Health for Seniors with Multiple Chronic Diseases

Right Care, Right Setting, Right Time

Reduced cost of care overall: Reduced Hospitalization & ED visits Increased Primary Care

Increased Caregiver and Social Support

Sustainability through Establishment of Payment Model

ICT Project Key Elements

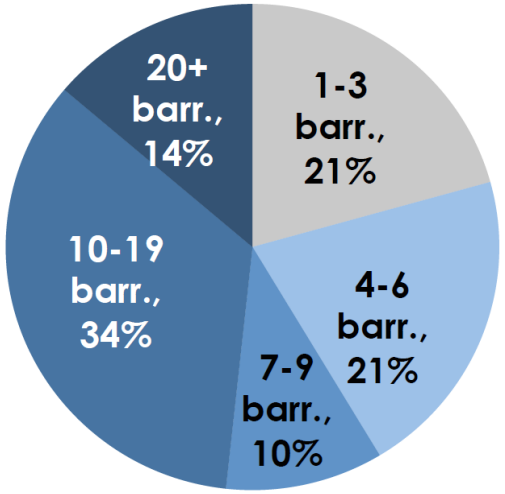
Patients & Caregivers	Providers (Health and Social Services)	Resources	Technology	Process
In-Home Assessment, Health Benefits Counseling & Health Coach visits/access to HCBS	Aligned objectives	Interagency Care Team including CM functions across health and social service sectors	Web-based Care Management communication tool	Improved Cross-organizational Care Coordination
↓	↓	↓		↓
Chronic Disease Self-Management Training	Access to timely data/information sharing across health and social services sectors	Community Roadmap of full array of health and social services and supports		Chronic Disease Management
↓				↓
Caregiver education and support				Barrier identification/home stabilization
↓				↓
Improved population health	←	←	←	Coordinated care management/increased monitoring to reduce unnecessary care and utilization of appropriate setting of care
				↓
				Reduced cost

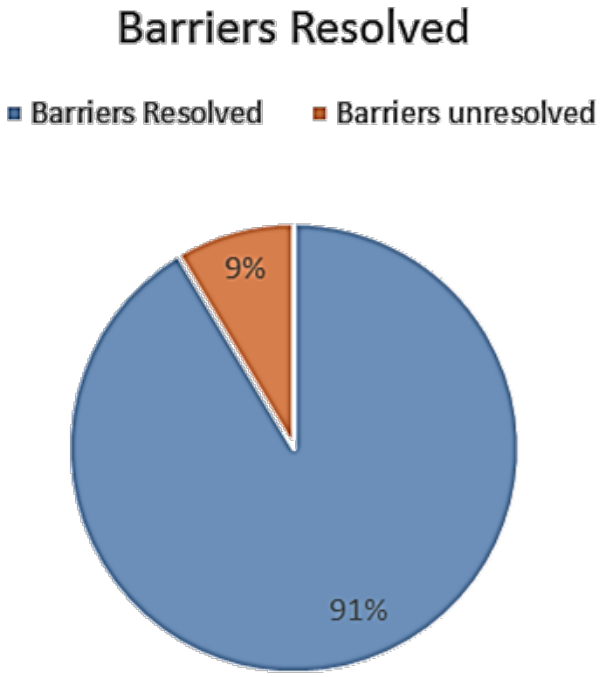
Resolving SDoH barriers through social care integration

iEval report:

91% of barriers were resolved through coordination of care and connection to community resources, services and supports.

Average Number of SDoH Barriers per patient





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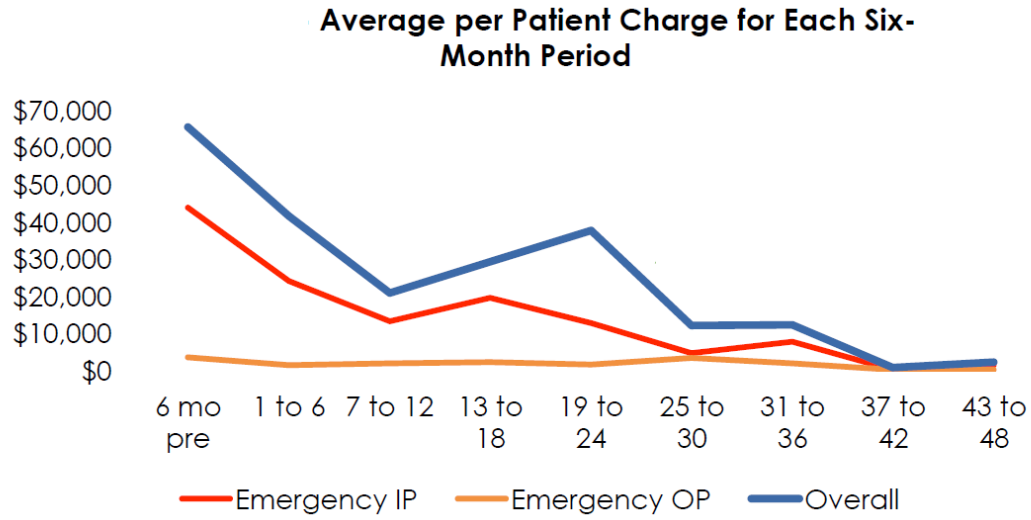
Improve health outcomes and reduce costs - iEval report



Patient engagement up

6-months post ICT intervention Patient survey results:

- Pts indicate "*I know who to call if I am getting worse or feeling bad*" (100%)
- Pts indicate that rather than immediately presenting to the ER, he/she would telephone a known contact for advice first. (86%)
- Only one patient thought they would definitely be going to the ER or hospital in the next 30 days

Cost of care down

6-month post ICT intervention Cost Evaluation report:

- After the first six months of enrollment, the **average overall costs** for patients served **decreased by 55%.** (iEval Cost Report, January 2019)

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Driving Care to the Right Setting

Patient encounter data for six months before enrollment and six months after was available for twenty-five InterCare patients. The average number of encounters at InterCare increased after enrollment. Before enrollment in ICT, the average ICT patient had 4.3 encounters at Intercare; the six months after enrollment, the average number of encounters per patient increased to 5.1.

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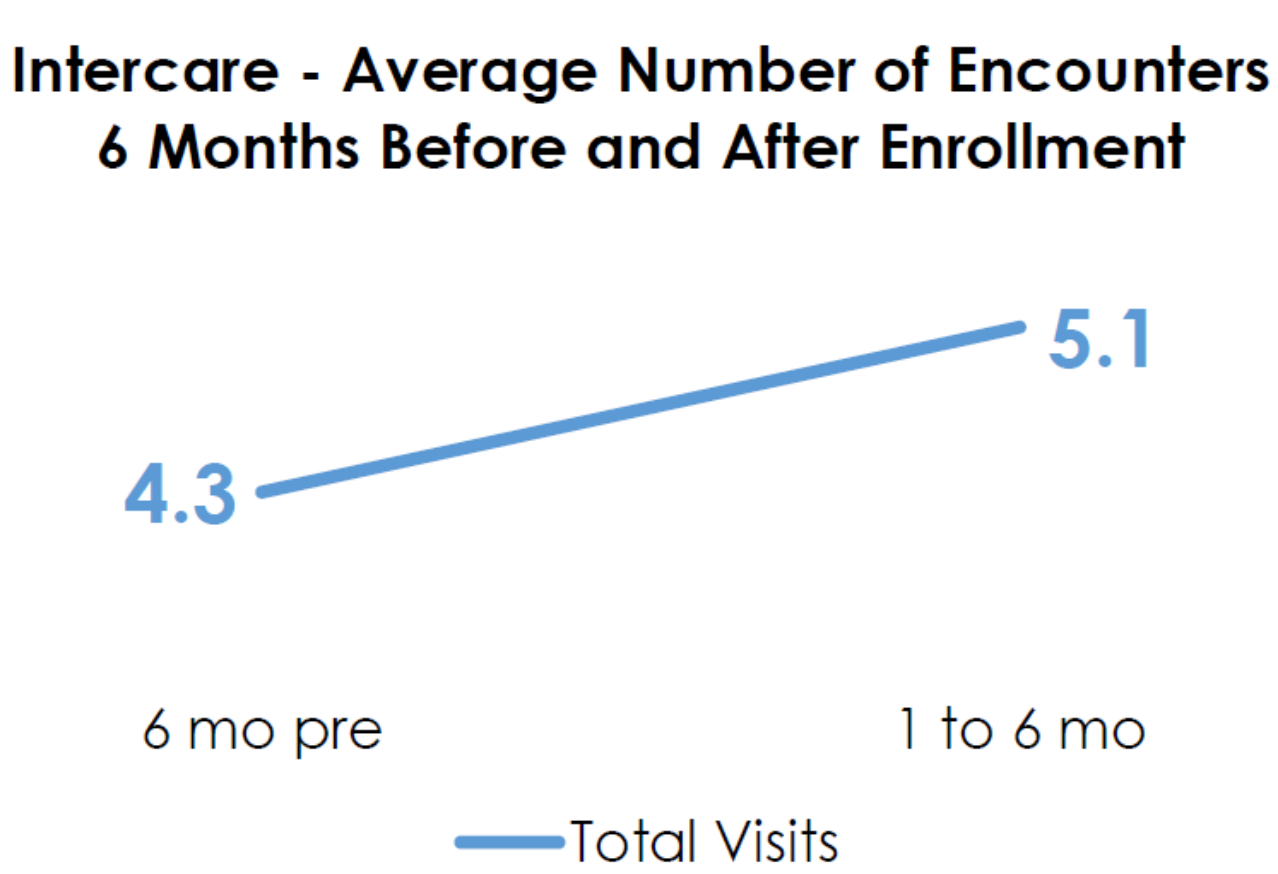
Primary Care Visits up (19%)



Payment Evolution Journey:

Initial: Self-funded

Bi-weekly cross-organizational meetings – 2012-2014

Interim: Foundation funded – 2015-2018

4 local and 1 state foundation funding services, evaluation, and payment model development for scalability

Executed contracts: 2019 -present

FFS for distinct Medicare billable codes

- contracts executed/MA codes dropped/payment received
  - Rural Health Clinic
  - Home-based Primary Care – Primary Care First practice

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Current State

Fee For Service Billable Codes

Billing Code	Code Description	Summary Requirements
HCPCS G0506	Comprehensive Assessment & Care Planning	▪ Patient enrolled in person ▪ Systematic assessment & care planning personally performed by the billing provider ▪ Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit
CPT 99490	Standard CCM	▪ 20+ minutes of care management outside of office visits performed by clinical staff ▪ Care plan established and regularly reviewed
CPT 99439 (New in 2021)	Non-complex Add-on	▪ Additional 20 minutes of "non-complex" CCM ▪ Reportable up to 2x per month (after 99490)
CPT 99487	Complex CCM	▪ 60+ minutes of care management outside office visits ▪ Care plan created and/or significantly revised
CPT 99489	Complex Add-on	▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case

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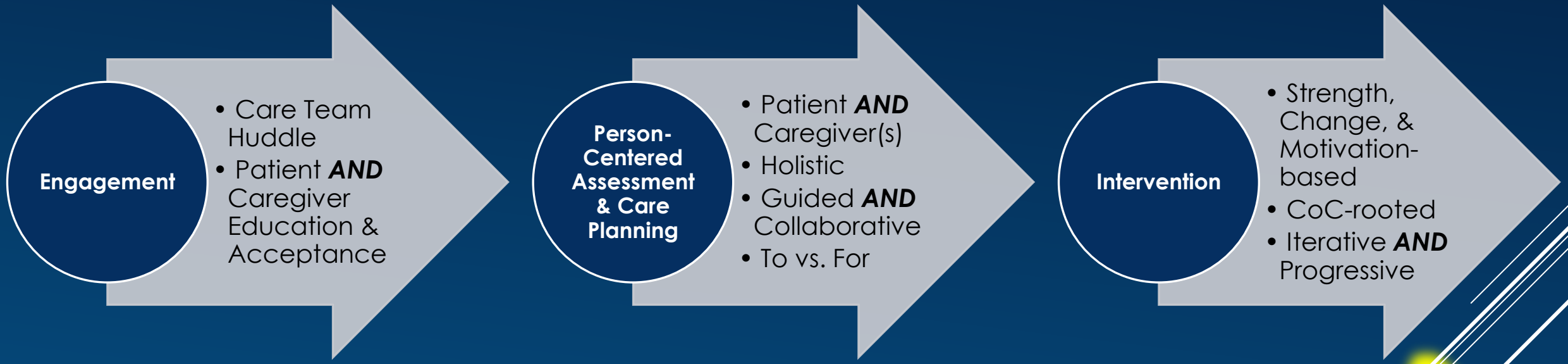
INTEGRATED SOCIAL & MEDICAL CARE WORKFLOW



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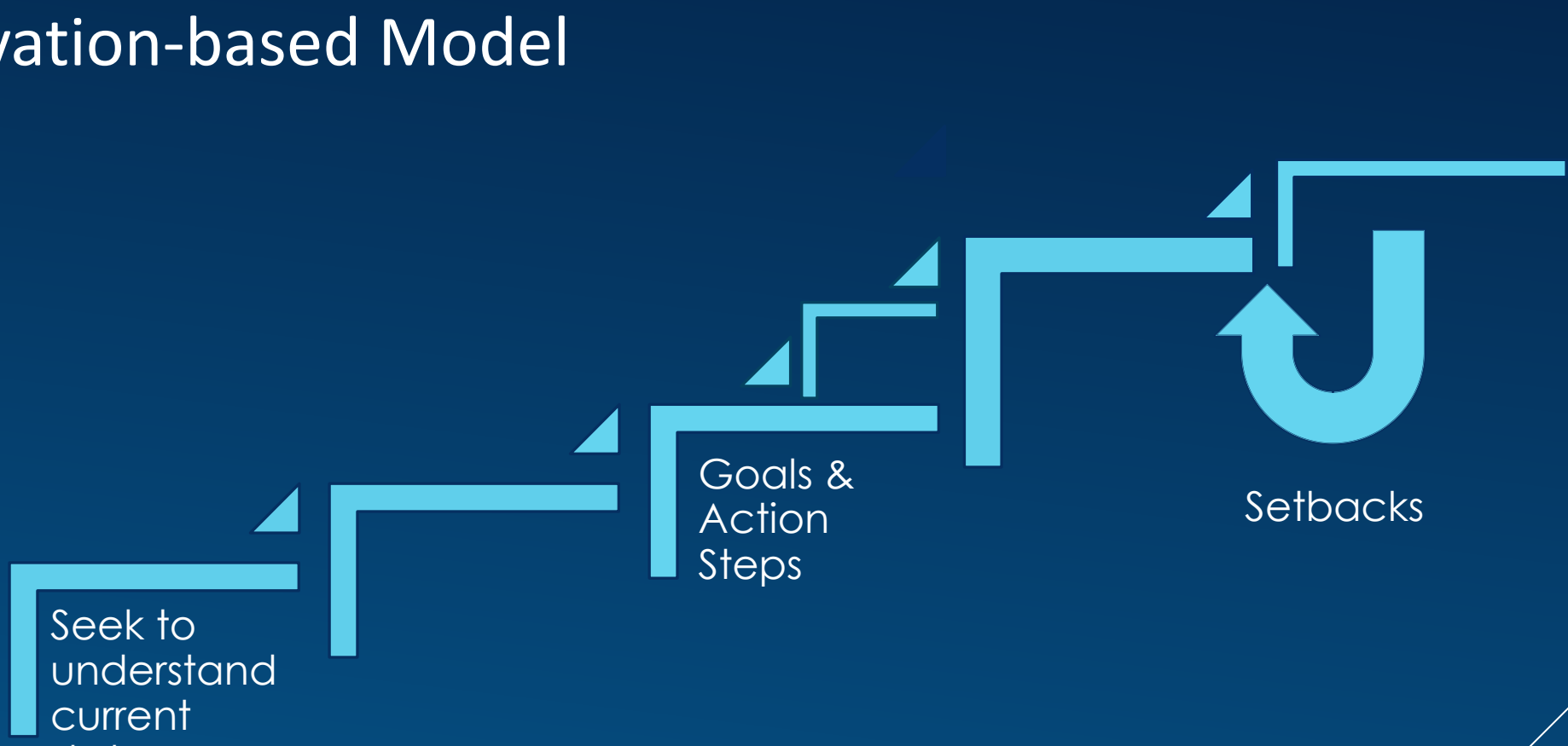
Strength, Change, & Motivation-based Model



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Outcomes

Barrier Identification & Resolution

- Subset of 59 Clients
- 227 Barriers identified
- 408 Interventions recommended

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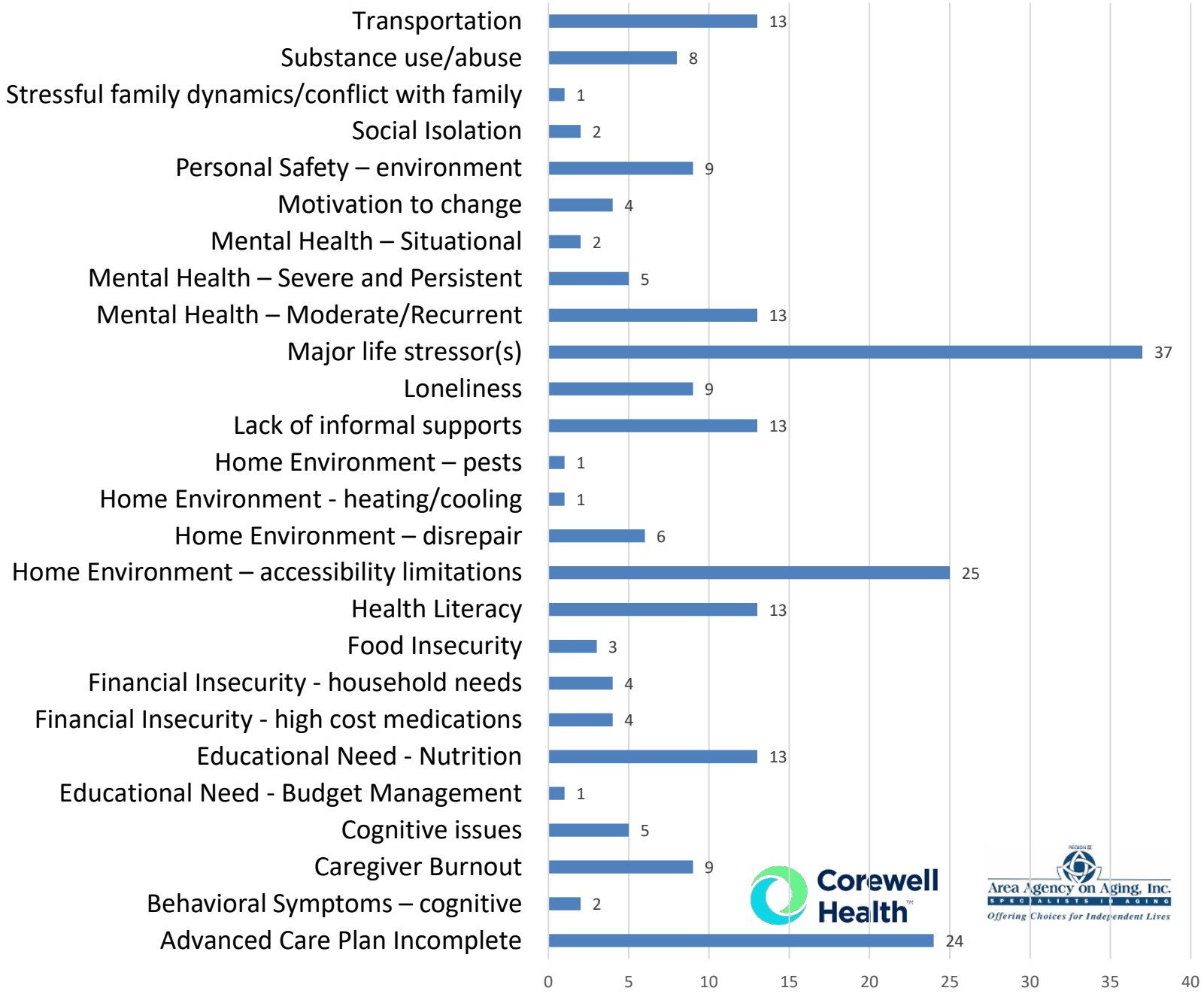
Barrier Types

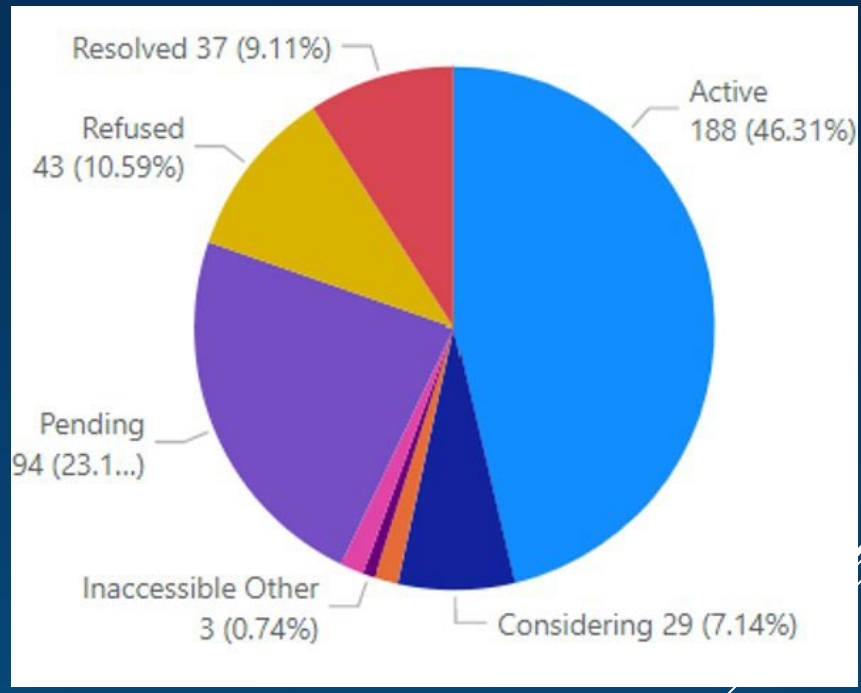
Top Three Categories:

Mental Health = 57
Home Environment = 33
Food/Nutrition Education = 16

[ACP incomplete = 24]



Tapping a network of Community-Based Organizations to resolve barriers



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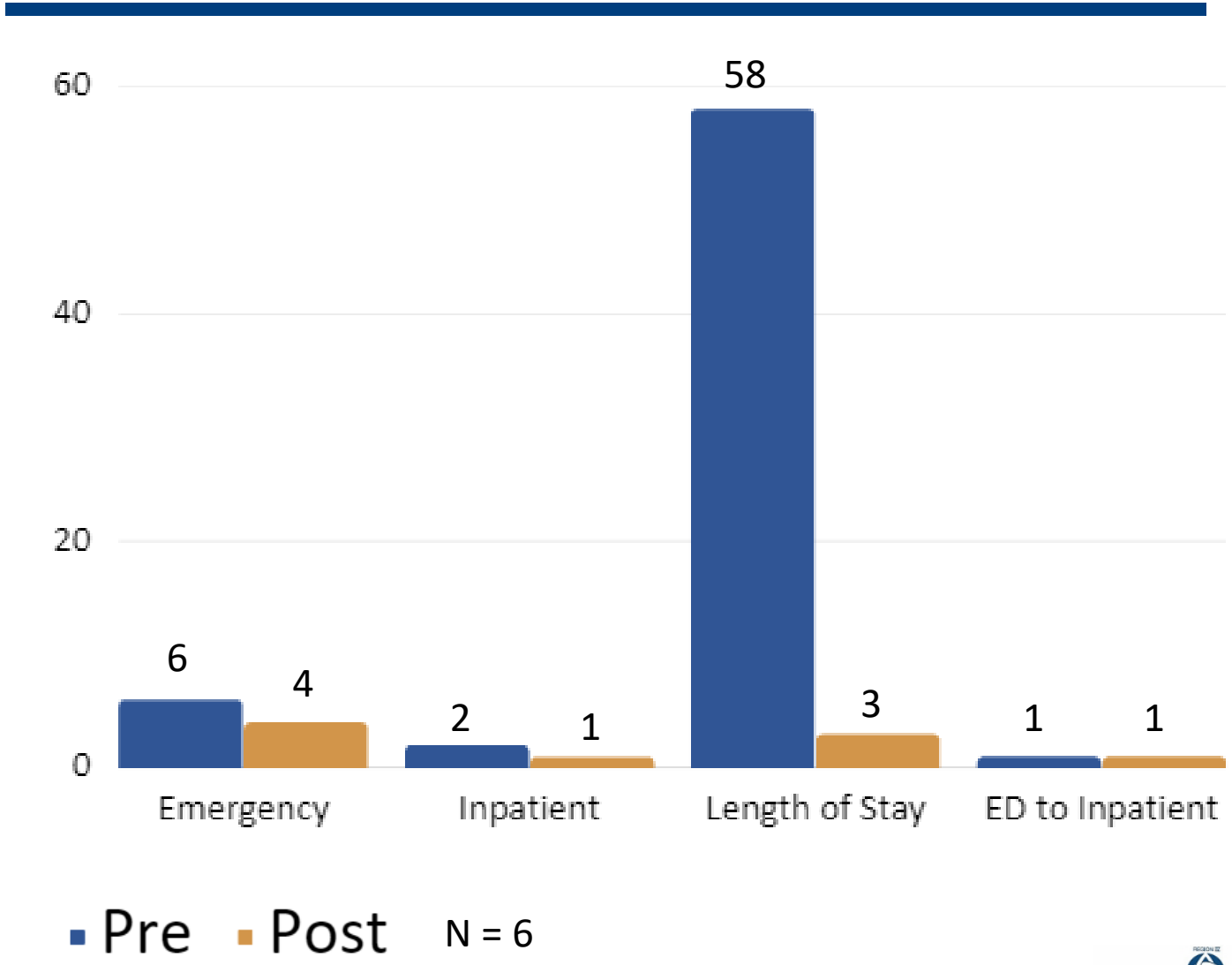
Utilization
12 months pre-post

- 33% reduction in ED
- 50% reduction in Inpatient
- 95% reduction in Length of Stay
- 0% reduction in ED to Inpatient



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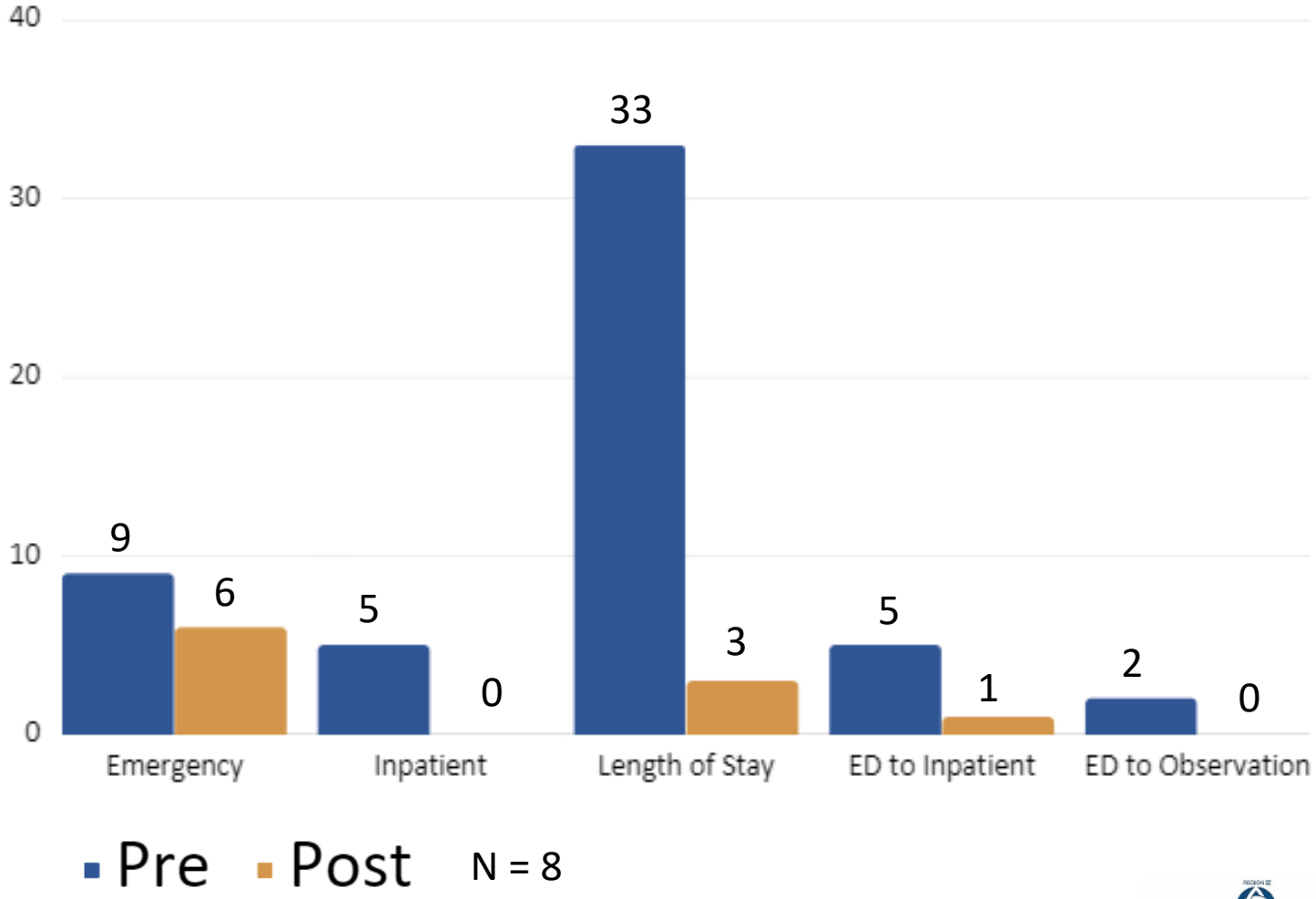
Utilization
6 months pre-post

- 33% reduction in ED
- 100% reduction in Inpatient
- 80% reduction in Length of Stay
- 100% reduction in ED to Inpatient



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Offering Choices for Independent Lives

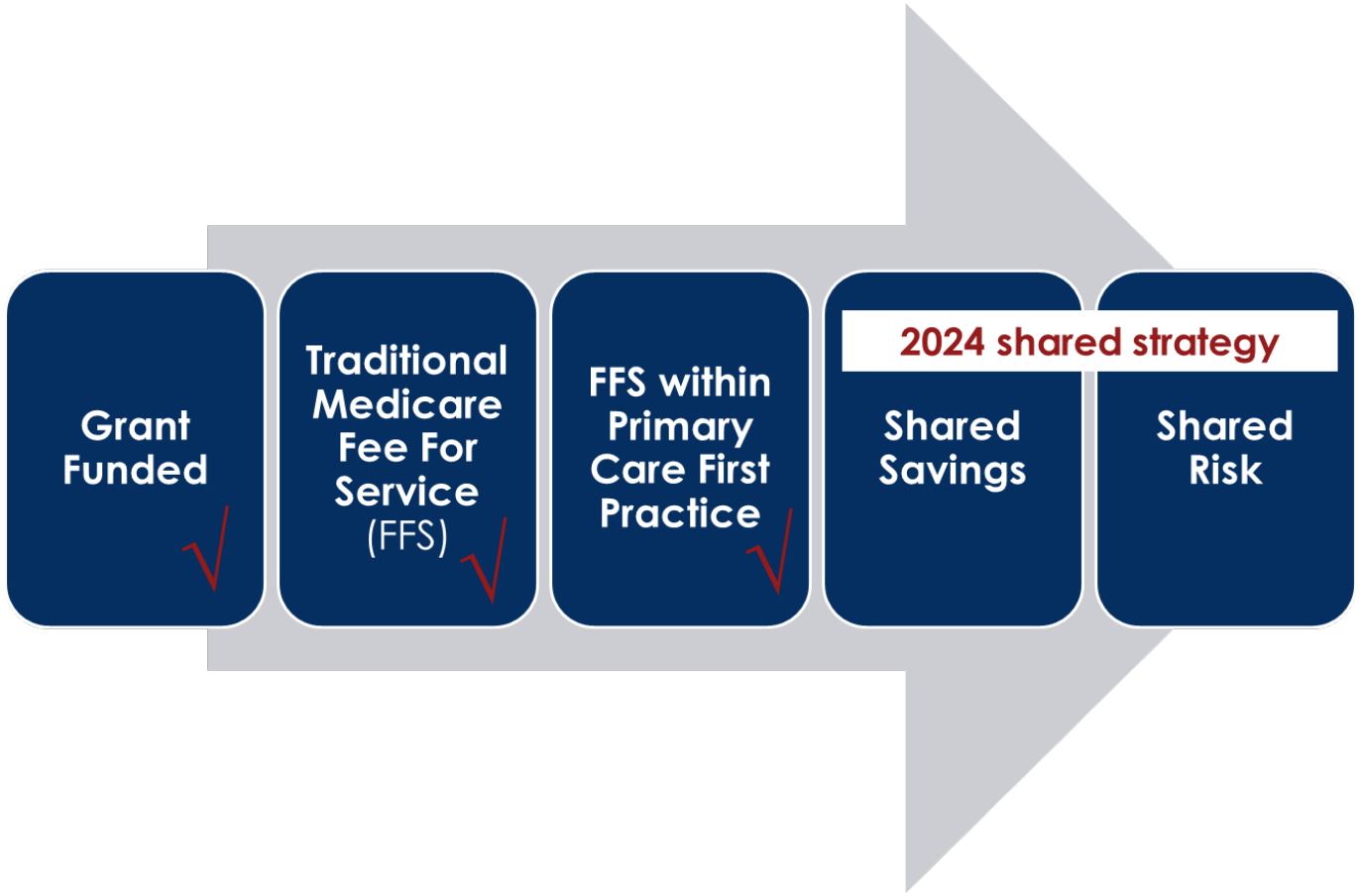
Area Agency on Aging / HouseCalls Partnership –

Why it works

- Allows providers and patients to prioritize care goals and create a plan around chronic diseases that require more attention
- Utilizes subject matter experts on Health-Related Social Needs in order to achieve disease related goals – Longitudinal care plan
- Provides for a more pro-active and tailored (personalized) approach to complex needs
- Improves patient / care giver satisfaction
- Reduces TPCC by efficient use of community-based services, and reducing inpatient and emergency department utilization, SNF admission and outpatient services
- Increases touch points with patients
- Expands the team for team-based care
- Reimburses team for non-face to face work
- Improves quality outcomes

Where we're going:

From Fee-For-Service to Value-Based Payment



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Questions?

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Project ECHO

Case Study Discussion

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Anonymized Case Study

- A regional ACO has value-based contracts with Medicaid MCOs and Medicare Advantage plans in your region. The ACO has been sending referrals to the CCH using a Unite Us platform. The CCH would like to transition from a free resource for HRSNs to a contracted partner of the ACO.
- The CCH engages with the ACO and enters into a negotiation for services that align with the ACOs value-based contracts model by payer type.
  - **Medicare FFS**
  - **Medicare Advantage**
  - **Medicaid MCO**

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Medicare/Medicaid MCO Population

Medicare/MA Population

Questions

- What CCH interventions could have the largest impact on the total cost of care for the Medicare population?
- Are there targeted CCH interventions that could have more of an impact on duals in the ACO?
- How can HCBS be leveraged to have an impact on hospital transitions and total cost of care for the Medicare population?
- Persons with multiple HRSNs have complex needs, what are the possible payment models to sustain care coordination for persons with multiple HRSNs in the Medicare ACO model?

Medicaid MCO Population

Questions

- The ACO would like the MCO to pay the CCH for interventions to address HRSNs. How could the ACO assist the CCH to obtain payment from the MCOs to address needs of ACO patients?
- The MCO offers a value-based contract to the ACO for screening and addressing HRSNs. How could the CCH benefit from the value-based contract extended to the ACO?
- ACO wants the CCH to participate in the value-based payment model. How could the CCH approach the risk requirement with minimal risk?

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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	Corewell 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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