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Community-Driven, Multi-Payer Health Equity Solutions: An ECHO® Collaborative

May 2, 2024 | 2:00-3:30 p.m. ET

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A Few Reminders

- ✓ Please introduce yourself and your organization in the chat
- ✓ Recording and slides will be shared following this session of the Health Equity Learning Collaborative
- ✓ Please keep yourself muted unless you have a question. We will have time for questions, but feel free to raise your hand at any time.
- ✓ 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.”

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Agenda

1. Welcome and Introductions
2. April Session Recap
   - Detroit Area Agency on Aging
   - Chinese American Service League
3. Identifying Priority Populations
4. Chronic Care Management: An Example
5. Open Discussion
6. Next Steps

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ECHO Session Recap

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Health Equity Community-Clinical Team Snapshots

THE SENIOR Solution

Detroit Area Agency on Aging — The Senior Solution

Serving Detroit, Hamtramck, Harper Woods, Highland Park & the 5 Grosse Pointes

1333 Brewery Park Blvd. Ste. 200 | Detroit MI 48207 | 313-446-4444

www.DetroitSeniorSolution.org

Detroit Area Agency on Aging

Chinese American Service League
華人諮詢服務處

Chinese American Service League

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Identifying Priority Populations

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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.

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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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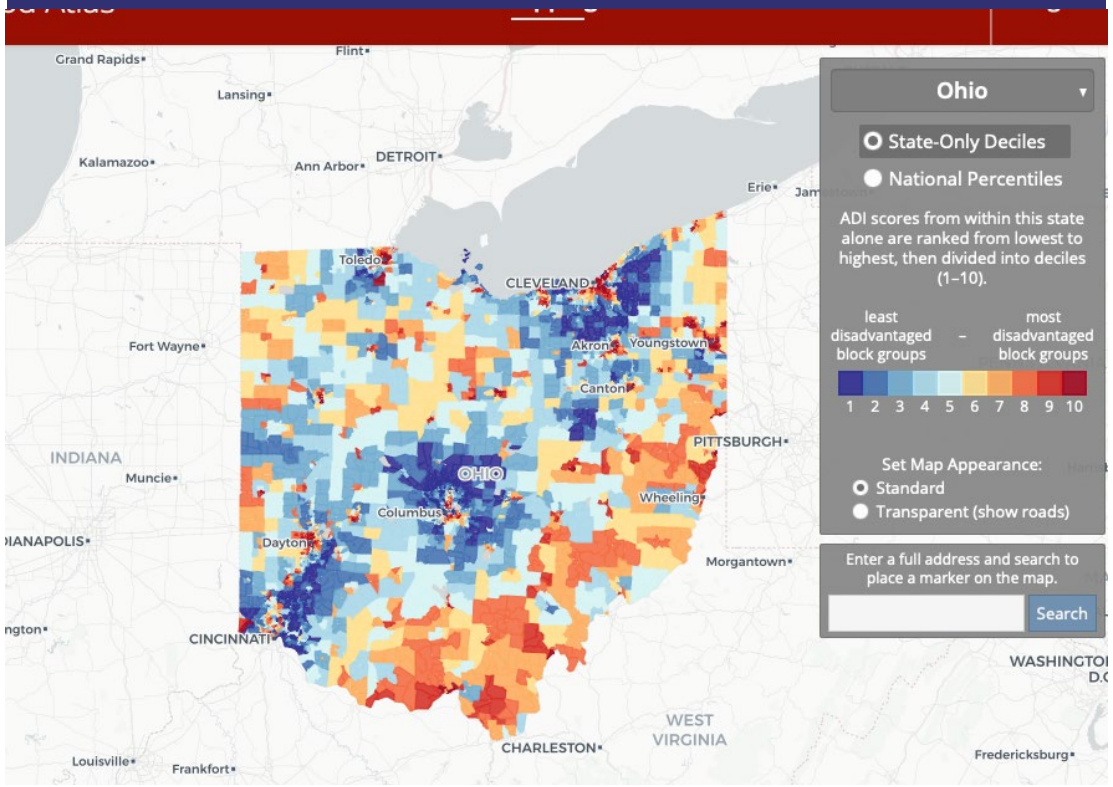
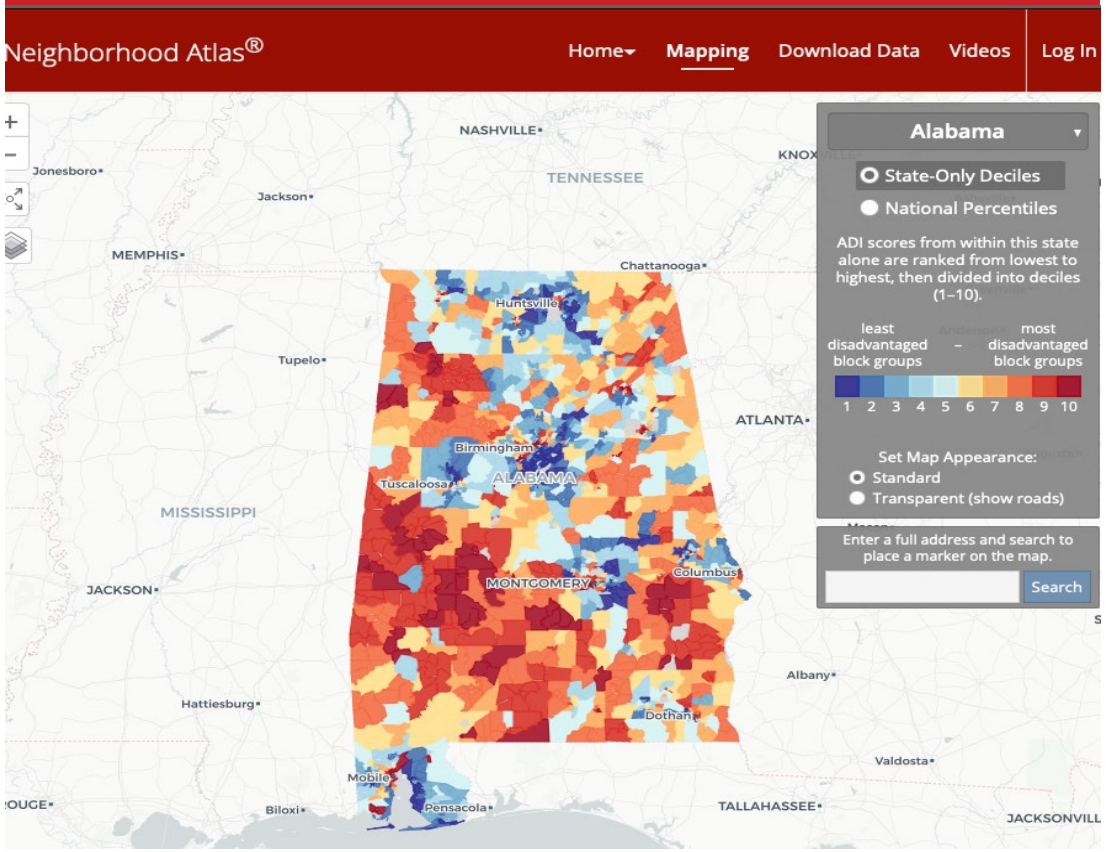
State Level ADI Mapping Examples

Ohio



Alabama



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HRSN Screening Regulatory Requirements

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2023 HEDIS® SDOH Measure (Required for Health Plans)

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

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Joint Commission Health Care Disparities Requirements

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

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

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CMS IPPS – Rule: HRSN Screening Requirement Goal

- "Specifically, in the inpatient setting, we [CMS] aim to **identify patient HRSNs as <u>part of discharge planning</u>** with the intention of promoting **linkages with relevant community-based services** that will address those needs and support improvements in health outcomes following hospitalization."
- **<u>Note: Discharge Planning begins on Admission</u>**

CMS. FY2023 IPPS Final Rule. Federal Register. Vol. 87, No. 153. August 10, 2022. Page 49215. Available Online [https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page]

Hospital IPPS Rule: SDOH Screening Numerator/Denominator

Screening for Social Drivers of Health

Number of patients admitted to an inpatient hospital stay who are 18+ and are **screened for HRSNs**

Number of patients who are admitted to a hospital inpatient stay

Screening Positive Rate for SDOH

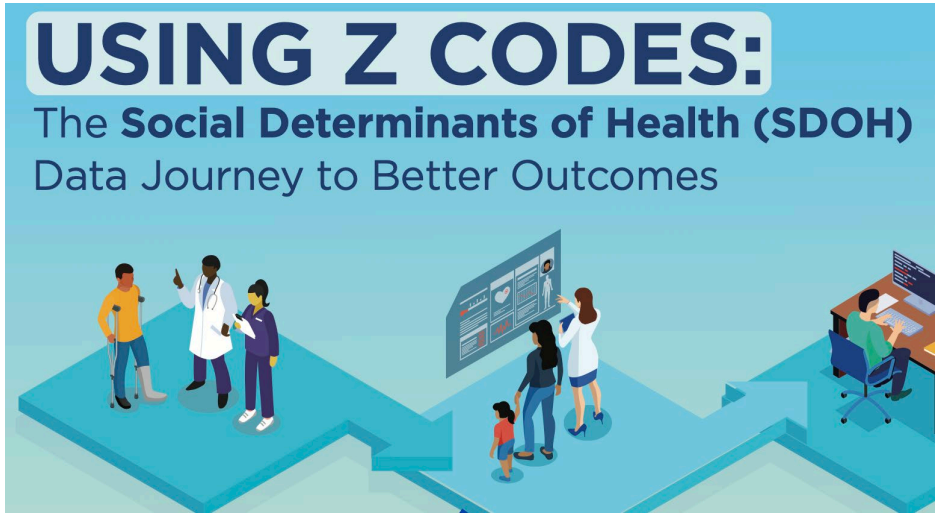
Number of patients admitted who had a positive HRSN screen

Number of patients admitted who were screened for HRSNs

* **Measures are reported for each of the following five (5) domains: Food, Housing, Transportation, Utilities, Interpersonal violence.**

Role of CCHs/CBOs in Reporting Z-Codes

- CMS Z-Code Implementation Infographic:
  - https://www.cms.gov/files/document/zcodes-infographic.pdf



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Implementation Key Steps

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HRSN Screening Process and Tool

- Evidence-Based HRSN Screening Tool
  - CMS AHC HRSN Tool
  - https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
- Domains Screened (10 Core Questions)
  - Housing Instability
  - Food Insecurity
  - Transportation problems
  - Utility help needs
  - Interpersonal safety

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Data Capture and Reporting – Housing Instability

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Inadequate, inadequacy	Instability	Lack of	Person without	Problem related to
1. Environmental temperature Z59.11 2. Heating Z59.11 3. Space Z59.19 4. Utilities Z59.12 5. NEC Z59.19 (NEC = Not Elsewhere Classifiable)	1. Unstable housed Z59.819 2. Housed but hx of homelessness in past 12 months Z59.812 3. Risk of homelessness Z59.811	1. Permanent housing Z59.10 2. Lack of adequate housing Z59.10 3. Living in shelter, motel, or scattered site housing Z59.01	1. w/o adequate housing Z59.10 2. w/o air conditioning Z59.11 3. w/o environmental temperature Z59.11 4. w/o heating Z59.11 5. w/o adequate space Z59.19 6. w/o permanent housing (temp.) Z59.00	1. Housing Z59.9 2. Inadequate housing 3. Isolated Z59.89 4. NEC Z59.89 5. Restriction of housing space Z59.19

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Data Capture and Reporting – Food Insecurity

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Description	Code(s)
Food Insecurity (Limited supply of food)	Z59.41
Inadequate food supply (Have food but not the supply does not meet my needs)	Z59.48
Lack of adequate food (Have access to the wrong types of food)	Z59.48

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Data Capture and Reporting - Transportation

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Description	Code(s)
Excessive Transportation Time (2 hour trip to dialysis)	Z59.82
Inaccessible Transportation	Z59.82
Inadequate Transportation	Z59.82
Insecure Transportation	Z59.82
Lack of Transportation	Z59.82
Unaffordable Transportation	Z59.82
Unreliable Transportation	Z59.82
Unsafe Transportation	Z59.82

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Data Capture and Reporting - Utilities

- ICD-10-CM Lookup Tool: https://icd10cmtool.cdc.gov/?fy=FY2024

Inadequate, inadequacy	Person without
1. Environmental temperature Z59.11 2. Heating Z59.11 3. Space Z59.19 4. Utilities Z59.12 5. NEC Z59.19	1. w/o adequate housing Z59.10 2. w/o air conditioning Z59.11 3. w/o environmental temperature Z59.11 4. w/o heating Z59.11

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Example Screening Process - Housing

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

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Additional Relevant Z-Codes

Description	Code
Problems related to education and literacy	Z55
Problems related to employment and unemployment	Z56
Occupational exposure to risk factors	Z57
Problems related to physical environment	Z58
Problems related to housing and economic circumstances	Z59
Problems related to social environment	Z60
Problems related to upbringing	Z62
Other problems related to primary support group, including family circumstances	Z63
Problems related to psychosocial circumstances	Z64

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Chronic Care Management and Concurrent Billing Business Model Analysis

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Medicare Benefit for Transitions / CCM

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	
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.

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CHI Financial Analysis

- One Community Health Worker supporting a caseload of 50 patients
- CHW spends an **average of 60% of their time** providing billable services
  - 1.0 FTE CHW works 160 hours per month (40 hours per week)
  - **96 hours per month billable (60%) with 64 hours/mo. non-billable admin time**
- Reimbursement
  - G0019 = $80.56 / 60 min. (average reimbursement per hour of CWH labor).
  - 96 hours CHI/mo. X $80.56 (avg rate) = $7,733.76

Salary (1.0 FTE CHW)	Fringe (35%)	Labor Expense	Gross Revenue	Net to CBO/CHW	Net for 10 CHW Team
$25/hr. X 160 hrs./mo. = $4,000.00/month	$1,400/mo.	$5,400/month	$7,733.76	$2,333.76	$23,337.60/mo. $280,051.20/yr.

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LET'S CHAT

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SWOT Update

NCQA Health Equity Partner Certification

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NCQA Request for Public Comment

- On January 15, 2024, NCQA closed public comments for a new certification program – Health Equity Partner.
- The program is intended to provide a pathway to support health plan delegation for services in support of the NCQA Health Plan Health Equity and Health Equity Plus Accreditation.
- *Very likely to become approved effective July 2024.

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Public Comment

November 28, 2023 to January 15, 2024

NCQA
Measuring quality. Improving health care.

For Public Comment
November 28, 2023–
January 15, 2024
Comments due 11:59 p.m. ET

Health Equity Partner Certification Program:

Overview Memo

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NCQA Stated Purpose

- "NCQA proposes a new program, Health Equity Partner Certification, that focuses on the role of delegates, vendors, and other business partners, such as payers and care providers, in performing health equity requirements in NCQA Accreditations in Health Equity and Health Equity Plus."

- This will build on the foundation of Health Equity **by providing a framework for health care organizations to partner with community-based organizations** and cross-sector partners **to address both social risk factors and social needs experienced** by patients or members they serve.
  - NCQA. Health Equity Partner Certification Program: Overview Memo. January 14, 2024.

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NCQA Delegation Prohibition

- NCQA generally discourages health plan delegation of core accreditation activities unless they are delegated to an organization that has a NCQA Accreditation or Certification.
- Improper delegation can put a health plan's accreditation in jeopardy.
- The Health Equity Partner Certification will allow for Health Plan delegation to CBOs that have the current certification.

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NCQA has proposed Automatic Credit for Health Plan Health Equity Accreditation

NCQA
Measuring quality. Improving health care.

Health Equity Partner Certification

Proposed Elements for Automatic Credit

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Program Provides Auto Credit to Health Plan Health Equity Accreditation: Part 1

2 Health Equity Partner Certification—Proposed Elements for Automatic Credit

Table 1: Elements Eligible for Conferring Automatic Credit to Health Equity Accreditation

Health Equity Certification Standards/Elements		SURVEY TYPE		
		Interim	Initial	Renewal
HEC 4: Race/Ethnicity and Language Data				
C	Collection of Data on Race/Ethnicity	NA	Y	Y
D	Collection of Data on Language	NA	Y	Y
E	Collection of Data on Gender Identity	NA	Y	Y
F	Collection of Data on Sexual Orientation	NA	Y	Y

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Program Provides Auto Credit to Health Plan Health Equity Accreditation: Part 2

HEC 5: Access and Availability of Language Services				
A	Access to Written Documents	NA	Y	Y
B	Access to Spoken Language Services	NA	Y	Y
C	Access to Support for Language Services	NA	Y	Y
D	Notification of Language Services	NA	Y	Y

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Program Provides Auto Credit to Health Plan Health Equity Accreditation: Part 3

HEC 6: Practitioner Network Cultural and Linguistic Responsiveness				
A	Collection of Data on Practitioners	NA	Y	Y
B	Enhancing Network Cultural and Linguistic Responsiveness	NA	Y	Y

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Program Provides Auto Credit to Health Plan Health Equity Accreditation: Part 4

HEC 7: Reducing Health Care Disparities				
A	Use of HEDIS Measures to Assess Disparities	NA	Y	Y
B	Use of Data to Assess Disparities	NA	Y	Y
C	Use of Data to Monitor and Assess Language Services	NA	Y	Y
D	Use of Data to Improve CLAS	NA	Y	Y
E	Use of Data to Address Health Care Inequities	NA	Y	Y

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States Mandating NCQA Health Equity Accreditation for Health Plans

- ***States/Entities mandating HEA as of December 2022***
  1. California Medicaid (by January 2026)
  2. Covered California (Marketplace) (by 2023)
  3. Delaware Medicaid (by January 2025)
  4. DC (Marketplace); (deadline under development)
  5. Massachusetts Medicaid ACOs (2 years from start of contract)
  6. Mississippi Medicaid (date TBD)
  7. Rhode Island Medicaid (by July 2025)
  8. Pennsylvania Medicaid (by 2022)
  9. South Carolina Medicaid (by 2022)
  10. Tennessee Medicaid (by 2022)
  11. Wisconsin Medicaid (by 2023)
  12. New Mexico Medicaid (by 2025)

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Open Discussion

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CCM Contract Negotiation

- An ACO multi-specialty practice notifies the CBO 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 CBO.

<u>Questions:</u>

- How can the CBO 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 CBO instead of building the program themselves?

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TCM/CCM/CHI Rate Negotiation

- 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
CHI	G0019	$80.56

Questions:

- How should the CBO approach the contract rate discussion with the ACO practice?
- What rate would you recommend the CBO request for 1 hour of CHI?

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Next Steps

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Reminder: Change in Direction

- <u>May Sessions</u>
  - May 16 – Business Planning
- <u>Starting in June</u>
  - Emerging Community-Clinical Teams – 1st Thursday
  - Advanced Community Clinical Teams - 3rd Thursday

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Selecting Your Group

Point of Contact
<Name>
<E-Mail>

<Applicant Organization Name>

Geographic Coverage:
<insert here>

Community-Clinical Team

Community-Based Organization or Community Care Hub	<insert contact name and organization – if more than one, insert in this space>	<insert e-mail addresses>
Healthcare Provider		
Health System or Hospital		
Health Plan		
Person with Lived Experience		

Primary Goals
Insert primary goals from application

Target Population(s)
- Insert bullets

What We Know About the Market
- Insert Data Points

Current Strengths
Insert strengths

Target Service(s)
- Insert bullets

Technical Assistance Needs
Insert technical assistance needs

Infrastructure Needs
Insert infrastructure needs

- Complete Community-Clinical Profile by **May 15th**
- The Health Equity Planning Team will work with you to self-select a group based on your profile

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Community-Driven, Multi-Payer Health Equity Solutions: *An ECHO Collaborative*

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Project ECHO®

Learning Collaborative Resources

- HELC ECHO Sessions Recordings & Resources: https://www.partnership2asc.org/healthequity/helc-resources/
- Partnership CHI/PIN Implementation Resources and Events: https://www.partnership2asc.org/implementation-resources/
- Freedmen's Health Consulting Implementation Resources: https://communityintegration.info

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FREEDMEN'S HEALTH I
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Learning Collaborative Resources

- Overview: www.partnership2asc.org/heathequity/
- FAQ: www.partnership2asc.org/FAQ
- Example: https://www.partnership2asc.org/healthequity/example-participating-market/
- Health Plan Outcomes: https://www.partnership2asc.org/healthequity/healthplanoutcomes/
- CHI Implementation: https://www.partnership2asc.org/healthequity/chiimplementation/

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Thank you!

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