

Data, Billing and Coding: What CBOs Need to Know

Part One: New CMS Rules on Health-Related Social Needs

November 13, 2023

Webinar Instructions

Audio Options

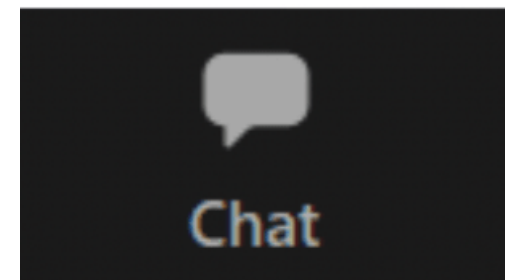
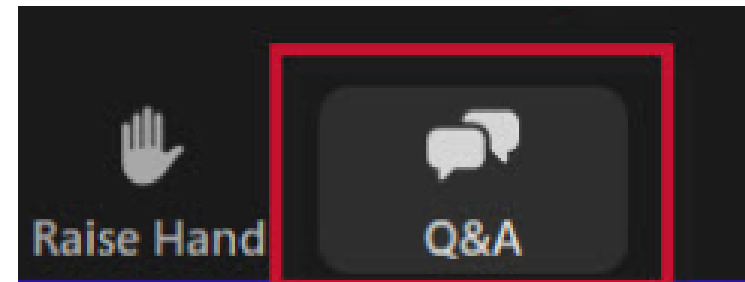
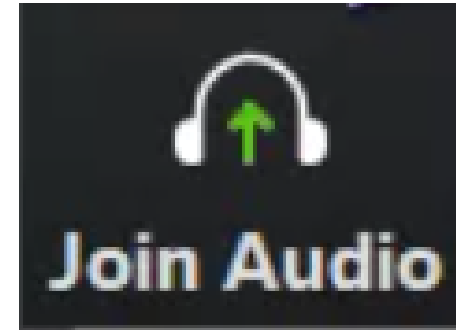
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Speakers

- Courtney Baldrige, Business Strategy & Health Systems Integration, USAging
- Sara Singleton, Principal at Leavitt Partners and an advisor to the National Alliance to impact the Social Determinants of Health (NASDOH)
- Olivia Umoren, Director, Public Policy and Advocacy, USAging
- Nancy Myers, Vice President, Leadership and System Innovation, American Hospital Association Center for Health Innovation

NASDOH

US AGING WEBINAR

NEW CMS RULES ON HRSN SCREENING

November 13, 2023



NASDOH

NATIONAL ALLIANCE TO IMPACT THE
SOCIAL DETERMINANTS OF HEALTH



NASDOH

NATIONAL ALLIANCE TO IMPACT THE
SOCIAL DETERMINANTS OF HEALTH



Governor Michael O. Leavitt

Former US Secretary of Health and Human Services
Administrator of US Environmental Protection
Agency
Founder of Leavitt Partners



Karen DeSalvo, MD, MPH

Former Health Commissioner, City of New Orleans
Former Acting Assistant Secretary for Health
US Department of Health and Human Services

A group of stakeholders working to systematically and pragmatically build a common understanding of the importance of addressing social needs as part of an overall approach to health improvement.

NASDOH Members

STEERING COMMITTEE



GENERAL MEMBERS

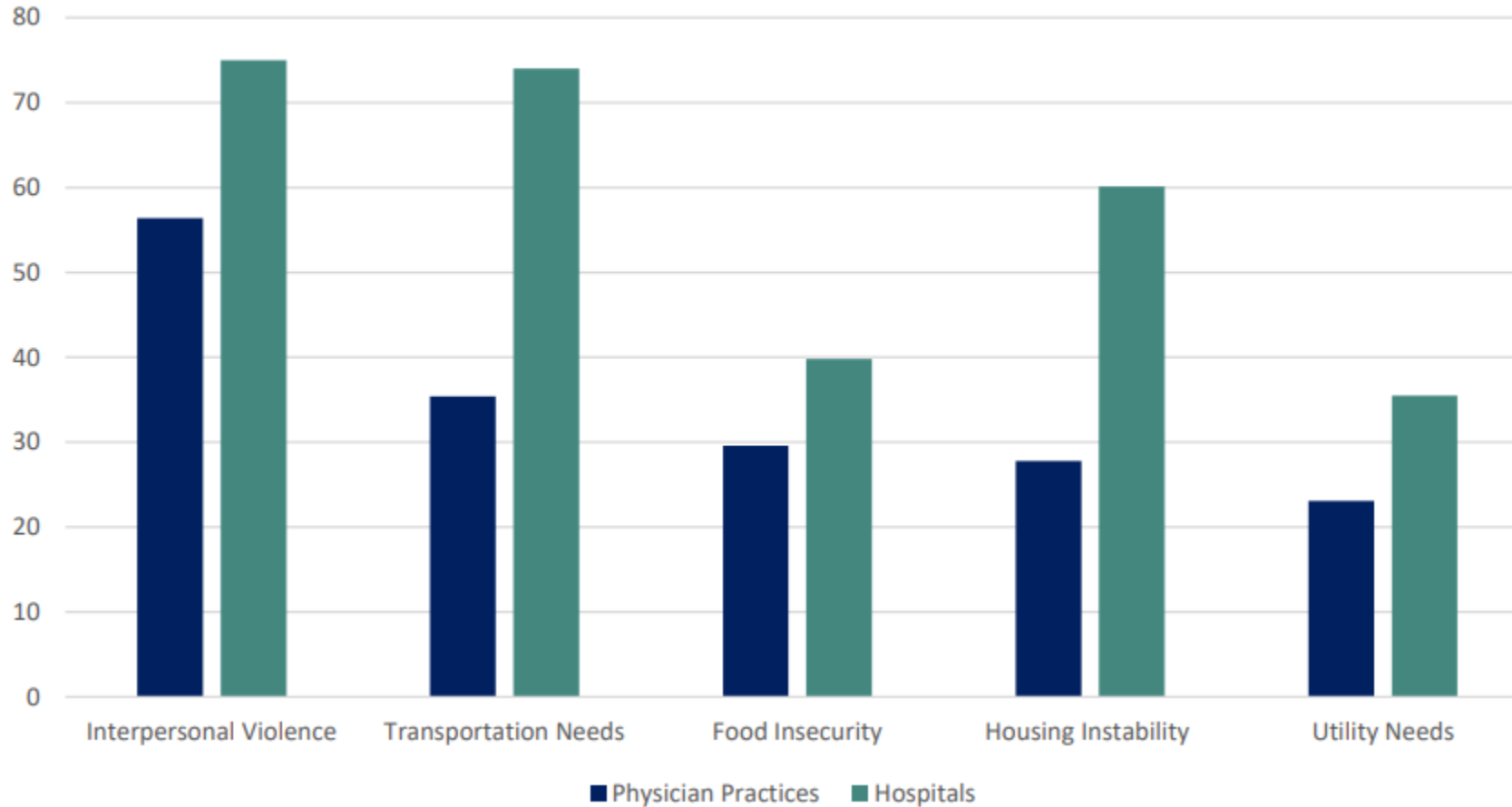


STRATEGIC PARTNERS

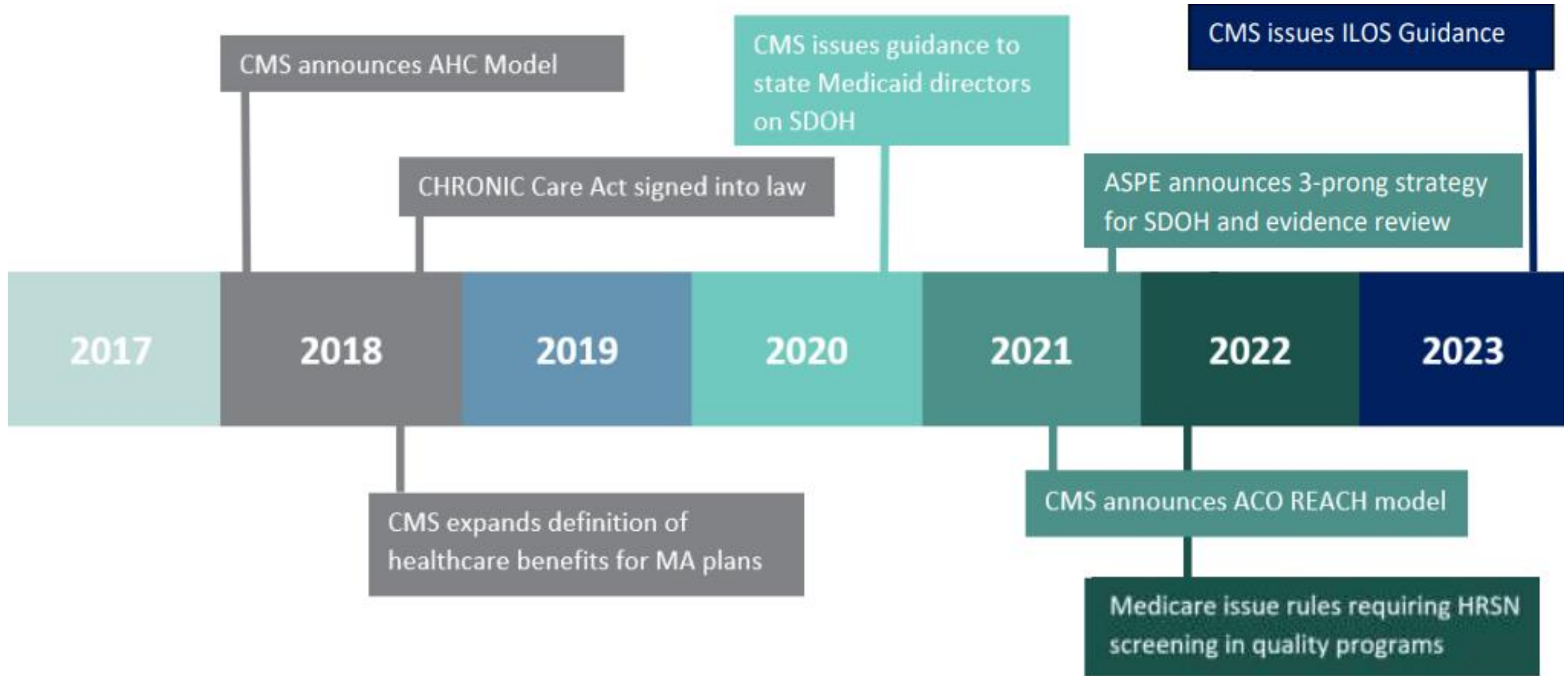


A Snapshot of the Data Six Years Ago

Percent of Physician Practices and Hospitals that Screen for Each Social Need, 2017

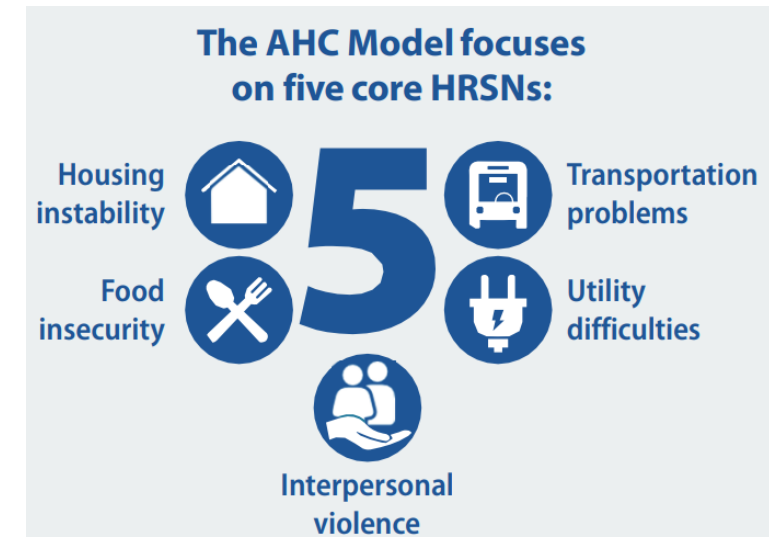


Major Federal Policy Developments

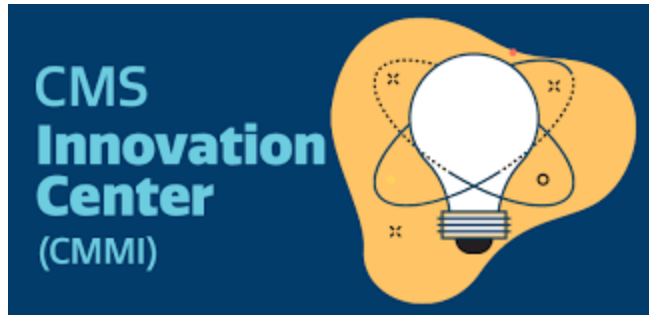


Trump Administration Activities

- Accountable Communities for Health CMMI Model (2017)
 - Multisector, community-based partnerships that bring together health care, public health, social services, other local partners, and residents to address the unmet health and social needs of the individuals and communities they serve.
 - Tested whether connecting Medicare and Medicaid beneficiaries to community services that may address their HRSN can improve health outcomes and reduce costs
 - \$157 million allocated over 5 years (ending in April 2022)



Trump Administration Activities



Medicare Advantage (MA)

- VBID: Beginning in 2017, CMS allowed MA plans participating in CMMI's Value-Based Insurance Design (VBID) model to target benefits for enrollees, such as grocery assistance and transportation services, based on chronic conditions or socioeconomic characteristics. Model recently extended through 2030 with updates to more fully address HRSN.
- In 2019 CMS changed the definition of "primarily health-related" benefits for MA plans to include benefits such as adult day health services, home-based palliative care, therapeutic massage, support for caregivers of enrollees, and in-home support services to help enrollees with activities such as dressing, eating, and housework

Capitol Hill

- The CHRONIC Act of 2018 allowed MA plans beginning in 2020 to offer non-primarily health-related **Special Supplemental Benefits for the Chronically Ill (SSBCI)**.
- These supplemental benefits include services such as non-medical transportation, home modifications, general support for care at home, and pest control.
- GAO found that slightly over one-fifth of MA plans they reviewed offered at least one SSCBI in 2022.
 - The most commonly offered SSCBI benefit in 2022 was food and produce, which was offered by almost 15 percent of plans.
 - Under 6% of plans were offering each of the other supplemental benefits like transportation for non-medical needs, general supports for living (e.g., for rent or utilities) or pest control



2021 State Medicaid Director Letter

- Letter described opportunities under Medicaid and CHIP to better address SDOH
- Cataloged existing authorities, but did not create new ones

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



SHO# 21-001
RE: Opportunities in Medicaid and CHIP
to Address Social Determinants of Health
(SDOH)

January 7, 2021

Dear State Health Official:

The purpose of this State Health Official (SHO) letter is to describe opportunities under Medicaid and CHIP to better address social determinants of health (SDOH)¹ and to support states with designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing SDOH. This letter describes: (1) several overarching principles that CMS expects states to adhere to within their Medicaid and CHIP programs when offering services and supports that address SDOH; (2) services and supports that are commonly covered in Medicaid and CHIP programs to address SDOH; and (3) federal authorities and other opportunities under Medicaid and CHIP that states can use to address SDOH. A table that summarizes the information on key federal authorities for addressing SDOH is also included in

Biden Administration Equity Priorities

- Day 1 Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government
- COVID-19 Equity Task Force



CMMI Strategy Refresh (2021)



DRIVE ACCOUNTABLE CARE

ADVANCE HEALTH EQUITY

SUPPORT INNOVATION

ADDRESS AFFORDABILITY

PARTNER TO ACHIEVE SYSTEM TRANSFORMATION

HHS Action Plan to Address SDOH (2021)

Goals

The HHS strategic approach to address SDOH will drive progress through coordinated strategies and activities to better integrate health and human services and to advance public health initiatives involving cross-sector partnerships and community engagement to address specific SDOH drivers.



Goal 1

Build a robust and interconnected data infrastructure to support care coordination and evidence-based policymaking



Goal 2

Improve access to and affordability of equitably delivered health care services, and support partnerships between health care and human services providers, as well as build connections with community partners to address social needs



Goal 3

Adopt whole-of-government approaches, support public-private partnerships, and leverage community engagement to address SDOH and enhance population health and well-being

CMS Framework for Health Equity



- **Priorities for 2022-23**
 - Expand collection, reporting analysis of **standardized data**
 - Assess causes of disparities within CMS program and address **inequities in policies and operations** to close gaps
 - **Build capacity** of health care organizations and the workforce to reduce health and health care disparities
 - Advance **language access, health literacy**, and the provision of **culturally tailored services**
 - Increase all forms of **accessibility to health care services** and coverage

Community Care Hubs (2022/23)

- ACL and CDC selected 58 organizations in 2022 to participate in the Community Care Hub National Learning Community
- In 2023, Center of Excellence awarded to US Aging
- Goal is to strengthen preparedness to address HRSN and public health needs through contracts with health care entities
- Hubs centralize administrative functions and operational infrastructure



CMS Requirements for Hospitals in 2023 Rules

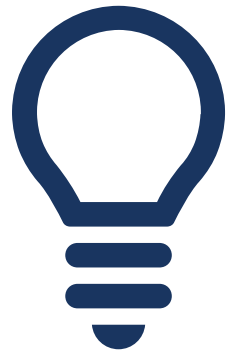
Screening for Social Drivers of Health
(5 domains)

Screening for SDOH
(screen positive rate)

Additional diagnostic codes (Z codes)

Inpatient Quality Reporting
(% of dual eligibles)

Hospital Commitment to Health Equity Measure



Improving Health by
Advancing Value

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CMS CY 2024 Physician Fee Schedule

Olivia Umoren, Director of Public Policy and Advocacy

11.13.23

CMS CY 2024 Medicare Physician Fee Schedule Final Rule

- The annual schedule that sets Medicare Part B reimbursement/payment rates for physicians, other professionals—and can include policy changes
- USAging submitted comment letter in September: usaging.org/advocacy
- Final rule released last week
- Rates take effect January 1, 2024 as do many policy provisions

CMS CY 2024 Medicare Physician Fee Schedule Final Rule

- **CMS to pay for certain caregiver training services in specified circumstances**
- When practitioners train caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan.
- Medicare will pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) as part of the patient's individualized treatment plan or therapy plan of care.

CMS 2024 Medicare Physician Fee Schedule Rule

Services Addressing Health-Related Social Needs

→ CMS to pay separately “when clinicians involve certain types of health care support staff such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care.”

- **Community Health Integration** (encourages ACO partnerships with CBOs to help address health-related social needs (HRSNs) & it counts toward MIPS)

CMS 2024 Medicare Physician Fee Schedule Rule

Services Addressing HRSNs, Pt. 2

- **Principal Illness Navigation Services** (codes that could be used by CBOs under direction of physician for peer support, CHWs, care navigation)
- **Social Determinants of Health Risk Assessment** (coding and payment to physicians when needed; optional use in Annual Wellness Visit by physicians)

USAging Key Areas of Feedback

- Role of AAAs in addressing health-related social needs
 - The most effective way for the health system to address HRSNs is through contracting with social care entities
- Principal illness navigation services
 - Highlighted AAAs involvement in CMS' Community-Based Care Transition Program (CCTP)
- Payment for caregiver training services should include outsource non-medical training to AAAs
- Medicare Part B payment for services involving community health workers should address functions, not titles



USAging

Leaders in Aging Well at Home

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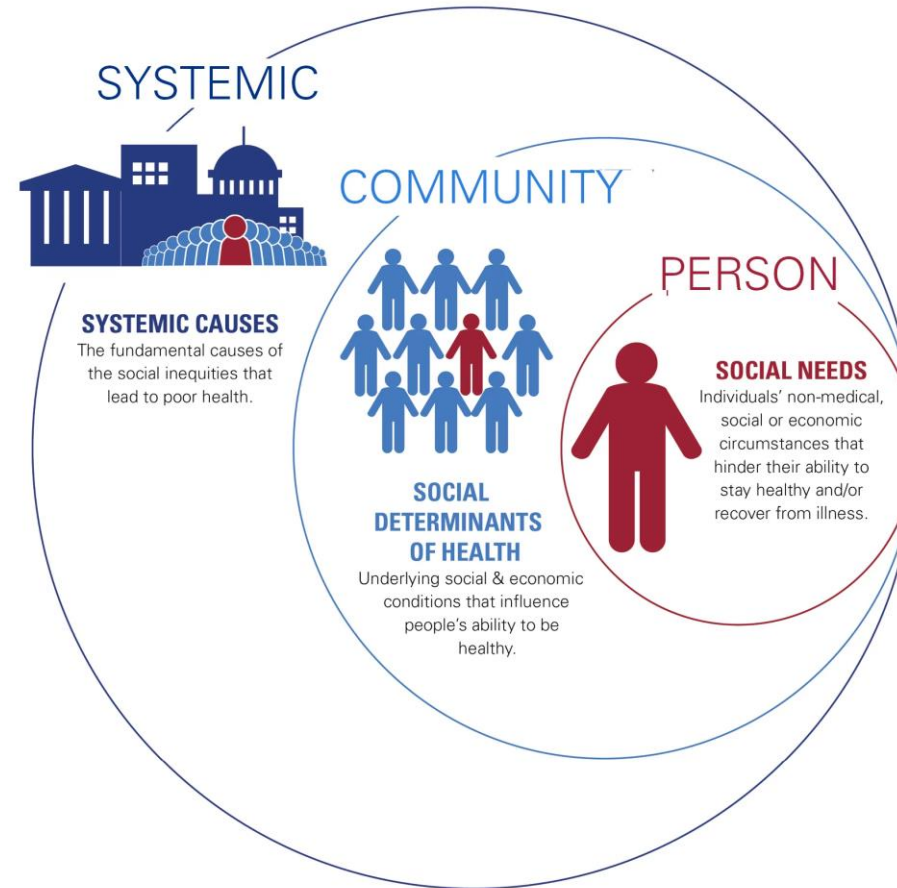
**American Hospital
Association™**

Advancing Health in America

Advancing Health of Individuals and Communities

November 13, 2023

Our framework for action



<https://www.aha.org/societafactors>

Understanding and meeting individual needs

As of 2020, a large majority of hospitals reported:

- Screening for health related social needs, including food insecurity, domestic violence, housing, and transportation issues;
- Having established programming to address those needs; and
- Partnering with an average of 4 community based organizations around these programs.

JAMA Netw Open. 2023;6(8):e2330228. doi:10.1001/jamanetworkopen.2023.30228

2023 AHA Community Health Assessment Toolkit

- Key areas of focus within this updated toolkit include:
 - Centering Health Equity with Intentionality
 - Evolved Approaches to Community Engagement
 - Meaningful Data Collection and Use
 - Strategic Integration of the CHA within the broader hospital organization
 - Intentional Engagement of Select Populations



Changes to reporting requirements

- Hospitals are being asked to report the percentage of adult admitted patients screened, and the number screening positive, for:
 - Food insecurity
 - Housing instability
 - Transportation needs
 - Utility difficulties
 - Interpersonal safety



ACCELERATING HEALTH EQUITY CONFERENCE 2024

MAY 7 - 9, 2024 | KANSAS CITY, MO



How can Area Agencies on Aging work with hospitals?

- As a data and information partner – at the patient and community level;
- As a voice of the aging and disabled communities, giving input to programmatic planning; and, potentially
- As a partner in the smooth and well-coordinated transition of care from inpatient to community settings



thanks
FOR YOUR SUPPORT