ADVANCING INTEGRATED HEALTHCARE

Clinical Strategy Meeting:

Lessons from Rhode to Equity and Community Health Worker Billing

Nov 17th, 2023

Agenda

Item	Time
Welcome & Announcements ***Paul Larson, MD, MBA, Chief of Primary Care, Lifespan Physician Group*** ***Barry Fabius, MD, CMD, FACP, Chief Medical Officer, UnitedHealthcare***	
Overview of December Meeting ***Pano Yeracaris, MD, MPH, Chief Clinical Strategist, CTC-RI***	5 min
Rhode to Equity Overview & Panel ***Moderator: Linda Cabral, MM, Senior Program Manager*** ***Panelists:*** ***Allegra Scharff, MPH, Chief of Healthcare Equity and Olmstead Coordinator, RIDOH*** ***Breanna Lemieux, Accountable Entity Program Lead, EOHHS*** ***Robyn Hall, Assistant Program Officer, Local Initiatives Support Corporation (LISC)*** ***Kinzel Thomas, MSW, LCSW, LCDP, CCHW, Vice President of Equity & Community Development, Family Service of Rhode Island*** ***Lynne Driscoll, RN, BSN, CCM, Assistant Vice President Community Health, South County Health***	55 min
CHW Billing ***Roberta Goldman, PhD, Brown University***	25 min

Announcements

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- **HIE Advisory Committee Recruitment:**
  - Appointed with the advice and consent of the Senate – gathering names before the Jan legislative session
  - Time commitment is typically one 60-90 minute meeting every other month, though it varies (sometimes the Commission meets relatively infrequently, sometimes monthly).
  - Term is 2 years, for a maximum of 3 possible terms for a total of 6 years.
  - Meetings do take place in-person (they are formal public meetings) at the Department of Health building in Providence.

Open positions include:

1. Individual with experience in HIPAA and privacy and security of health care information requirements
2. Individual who has experience in epidemiology and the use of data for public health purposes
3. Individual employed in healthcare delivery (physician or non-physician)
4. Individual who is a health care consumer or consumer advocate
5. Business or consumer representative

Current Members:

1. Shannon Shallcross (Beta X Analytics)
2. David Comella (BCBSRI, Candidate)
3. Christin Zollicoffer (Lifespan, Candidate)
4. Dan McGuire (PCHC, Chair)
5. Gulam Surti (Butler)
6. Nicholas Grumbach (Lifespan)
7. Sam Salganik (RIPIN)

Termed out:

1. David Gorelick (Lifespan)
2. Nicole Lagace (Housing Works RI)
3. Amy Nunn (Brown)
4. Michael Oliver (Claflin Company)

Clinical Strategy Comm December 15: A Roundtable Discussion to Identify 2024-2025 Areas of Focus

- What priorities have you identified in your practices, Systems of Care, and Payor organizations?
- How can CTC, as a statewide multi-payer, multi-stakeholder organization best support those priorities?
- We will also take into consideration other data (e.g. Commonwealth Fund Report) and any identified gaps in our strategic plan

Current CSC Strategic Focus

- Support Acceleration of Primary Care Capitation (APM) within Total Cost of Care Risk (strengthening team-based care)
- Improve primary care/specialist collaboration:
  - PCP/Specialist Oversight Comm - AAMC CORE Project Integra/Lifespan
- Reduce Low Value Care: (Effort focused above)
- Improve Clinician (and care team) Well-being

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CTC-RI Conflict of Interest Statement & CME Credits

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.

Claim CME Credits here:
https://www.surveymonkey.com/r/ZDZS5HG

The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 03/18/2022 to 03/18/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

Objectives

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1) Describe how community clinical linkages can advance health equity
2) Understand how cross-sector partnerships can be developed to promote population health projects
3) Identify the challenges and successes of Medicaid billing for community health worker services in RI

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Lessons from Rhode to Equity

Allegra Scharff, MPH , Chief of Healthcare Equity and Olmstead Coordinator, RIDOH

How did Rhode to Equity begin?

- In 2020 and the first six months of 2021, the RI Department of Health (RIDOH) supported a project called the ***Diabetes Health Equity Challenge***.

- The project was a learning collaborative to build clinical-community linkages and support people living with diabetes who might be especially vulnerable to equity gaps in the context of COVID-19. Under the program, geographically-based teams applied to collaboratively work to improve outcomes for people with diabetes who were at risk of poor outcomes during the pandemic.

- Funded by The RI Executive Office of Health and Human Services (EOHHS) Health System Transformation Project (HSTP), EOHHS and RIDOH partnered to expand and enhance this program as the ***Rhode to Equity*** project, which launched in July 2021

Who was Involved?

Components of the 6 Place-Based Teams:

1. Health Equity Zone
2. Person with lived experience of inequities (PLE)
3. Accountable Entity (AE)
4. Clinic/primary care leaders
5. Community Health Team Community Heath Workers (added via CDC grant) – *through August 2024*

Team Support:

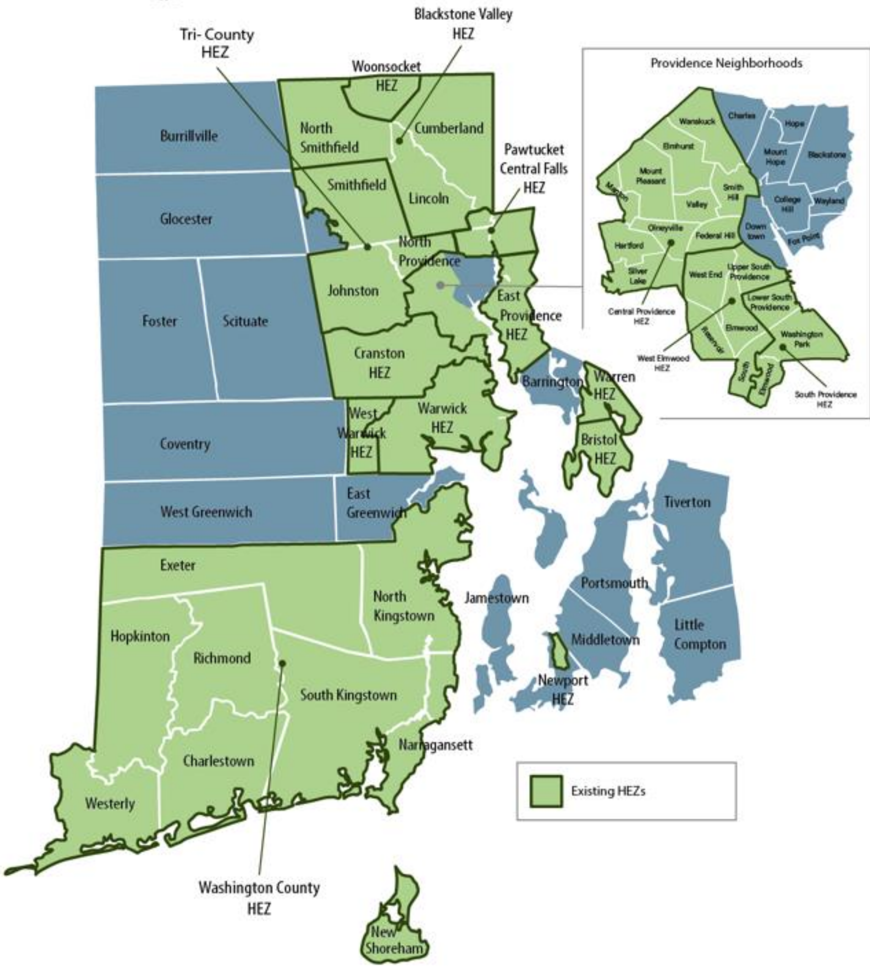
Health Equity Content Experts:

- WE in the World who helped develop the Pathways to Population Health tools in the context of 100 Million Healthier Lives

Rhode to Equity Facilitators:

- Care Transformation Collaborative of Rhode Island/Rhode Island Department of Health
- Person with Lived Experience Coaches

Rhode Island Health Equity Zone Initiative



Accountable Entity

An Accountable Entity (AE) is Medicaid's version of an Accountable Care Organization (ACO), in which integrated providers and healthcare networks that are grounded in primary care, are accountable for their attributed Medicaid patient population's total cost of care, quality of care, and health outcomes

R2E TEAMS

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LISC
LOCAL INITIATIVES SUPPORT CORPORATION

Pawtucket/ Central Falls

- Integra/Care New England
- Local Initiatives Support Corporation
- Family Services of RI

Central Providence

- ONE Neighborhood Builders
- Providence Community Health Center

Woonsocket

- Thundermist Health Center

02907/ West Elmwood

- West Elmwood Housing Corporation
- Family Services of RI
- Prospect Charter Chare
- Providence Community Health Center

Washington County

- Thundermist Health Center
- Integra Community Care
- South County Hospital

East Providence

east bay community action program

- East Bay Community Action Program
- Integrated Healthcare Partners

Integrated Healthcare Partners

Our Patients = Our Community

HEZ	BVCHC	Coastal	IHP	Integra	PCHC	Prospect	Thundermist	Total AE Patients Per HEZ
Blackstone Valley	892	540	371	2,968	346	1,623	1,394	8,134
Bristol	29	112	295	489	125	335	64	1,449
Central Providence	749	856	2,439	4,675	23,810	3,227	705	36,461
Cranston	201	1,618	3,518	4,424	4,131	2,350	1,035	17,277
East Providence	233	1,190	1,575	2,324	1,568	1,090	184	8,164
Newport	<15	162	1,959	151	76	65	95	2,508
Pawtucket/Central Falls	11,134	1,849	889	10,603	3,436	2,844	941	31,696
South Providence	87	206	333	883	5,238	626	107	7,480
Tri-County	569	1,134	4,105	4,594	4,170	3,370	978	18,920
Warren	<15	91	364	487	47	370	34	1,393
Warwick	86	2,061	2,836	4,212	826	1,122	1,546	12,689
Washington County	18	2,170	4,942	4,923	266	884	3,819	17,022
West Elmwood	175	280	990	1,483	10,532	1,337	256	15,053
West Warwick	44	749	755	2,257	370	304	3,069	7,548
Woonsocket	227	198	432	2,725	606	983	11,084	16,255
Data through March 2023								**202,049**

What were the project strategic goals & objectives?

1. To enhance place-based teams with local partners and community residents to improve population health with an equity lens

2. Apply evidence-based Pathways to Population Health tools to more effectively build community-clinical linkages that reduce health disparities (physical and behavioral) and their social drivers.

3. Use clinical and community data to identify population health needs, test strategic actions, and build sustainable community solutions

Pathways to Population Health

1. Tools developed by 100+ health care and public health organizations and adopted by 250+

2. Useful in aligning assets to advance population and community health with an equity lens

- Reflect, sustain, scale or change
- Identify next area of focus

- Score & review the Compass Assessment
- Complete/reassess Stakeholder Engagement Map

- Including 4 portfolios of work (upstream, midstream, downstream, groundwater)

- Map Assets
- Complete 7 Stories
- Review Data
- Risk Stratify your population

Understanding out Equity Baseline

		Not yet started	Starting: "We're in the early stages and are still figuring things out"			Gaining skill: "We're getting the hang of this!"			Sustaining: "This is who we are and how we do our work"		
A. Identify and understand inequities in our community and work		We have not yet identified inequities in our community and work.	We sometimes use data to identify inequities in our community and work. We sometimes have conversations to understand if those inequities are linked to a lack of fairness and justice.			We use data to identify inequities in our community and work. We have open conversations to understand if those inequities are linked to a lack of fairness and justice.			We have formal systems and policies to identify and understand inequities in our community and work, including having open conversations to understand if those inequities are linked to lack of fairness and justice.		
	Not Sure or NA	1	2	3	4	5	6	7	8	9	10

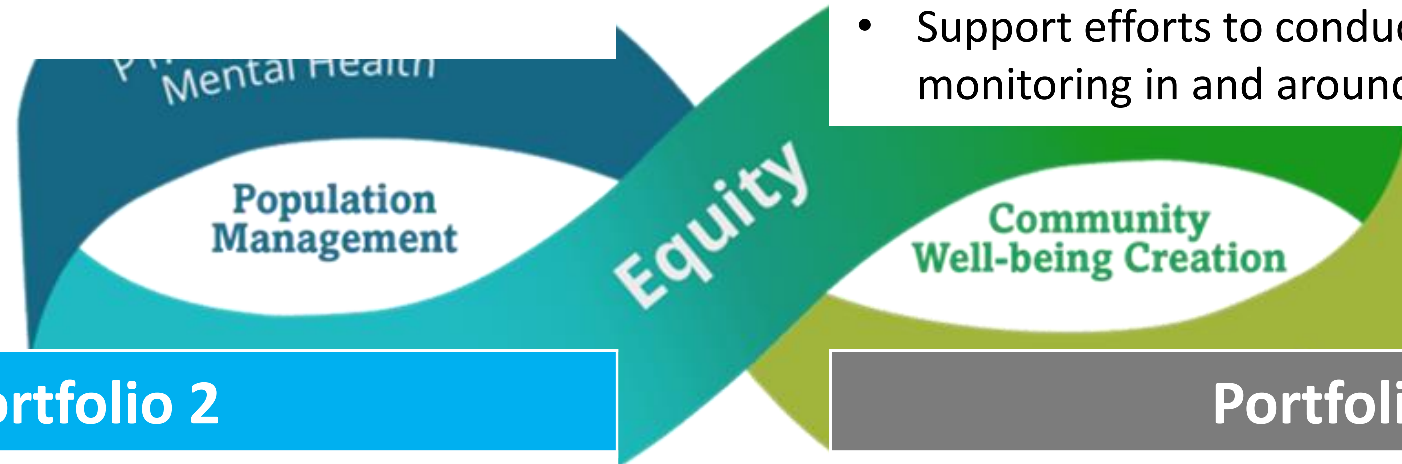
https://www.publichealthequity.org/assess

Portfolio 1

- Hire and train Community Health Advocates to work with high-risk patients (those who have been hospitalized for Asthma)

Portfolio 3

- Host community education efforts with American Lung Association and residents to inform them of air quality issues and to encourage advocacy.
- Support efforts to conduct air quality monitoring in and around the HEZ.



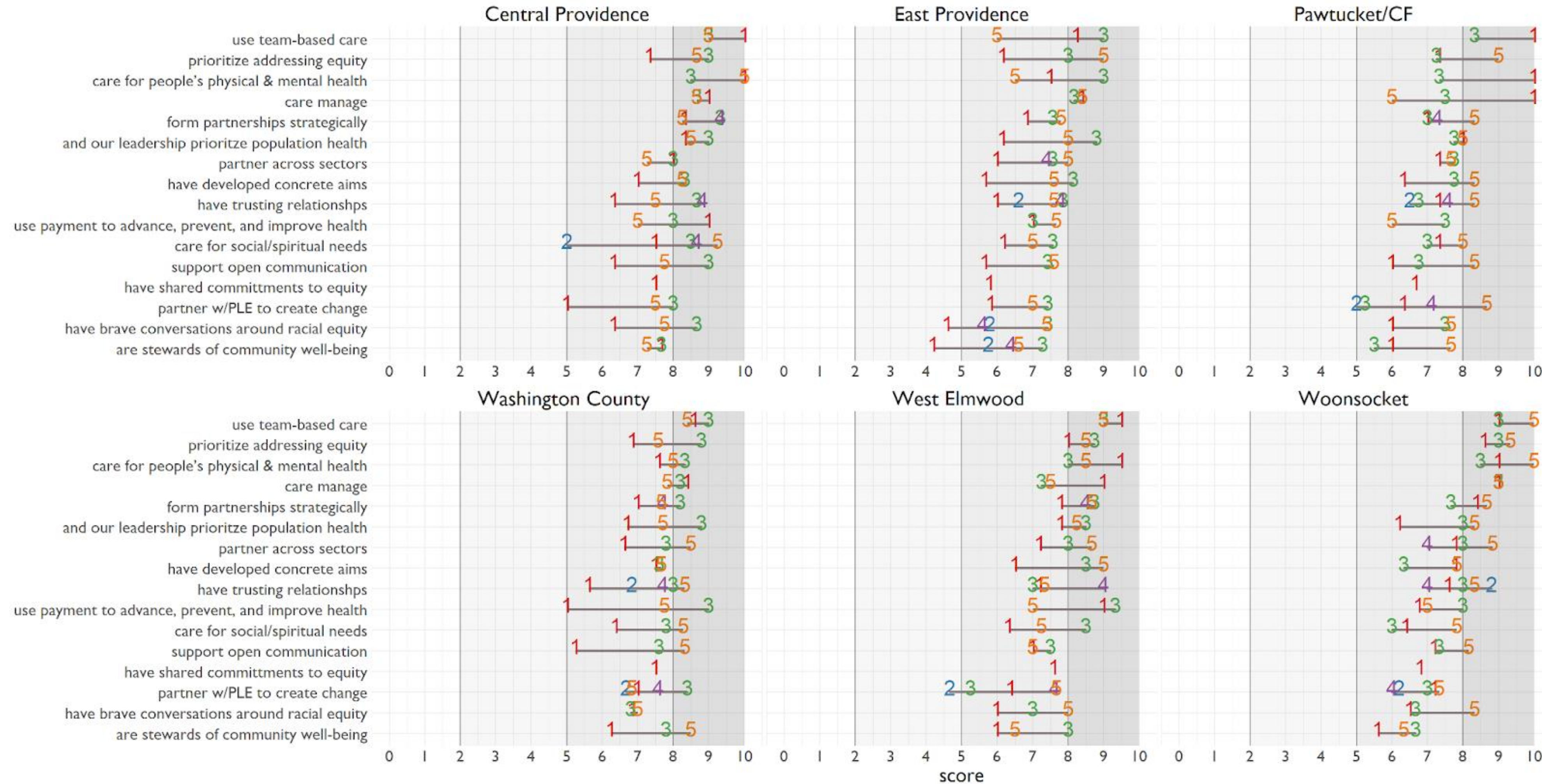
Portfolio 2

- Reduce the risk of asthma clients going to the hospital by running HARP/Breath Easy at Home health housing interventions with rising risk population

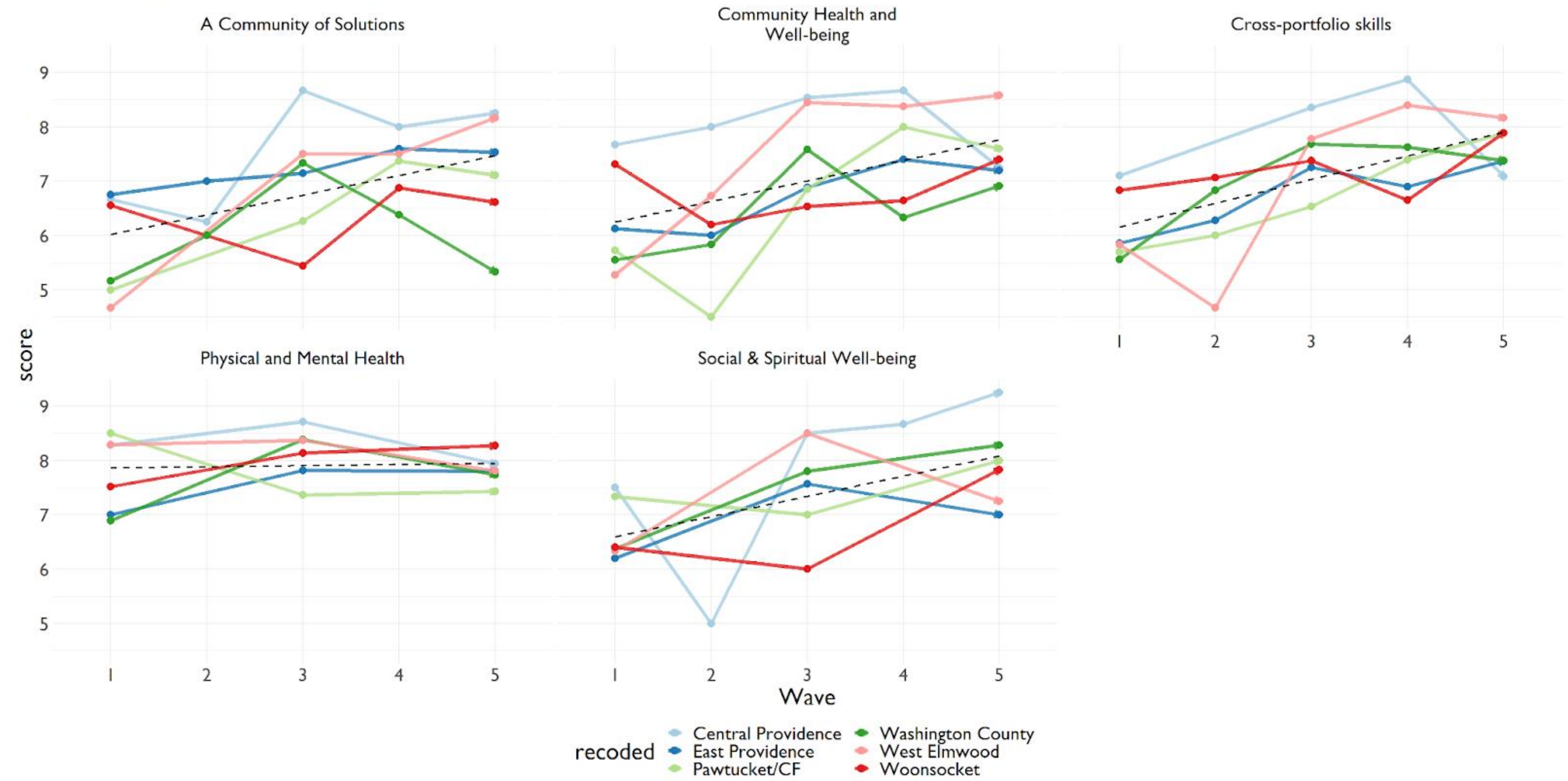
Portfolio 4

- Collaborate with Central Providence HEZ to train CHAs and community advocates on land use, zoning and the upcoming comprehensive planning process in the City of Providence

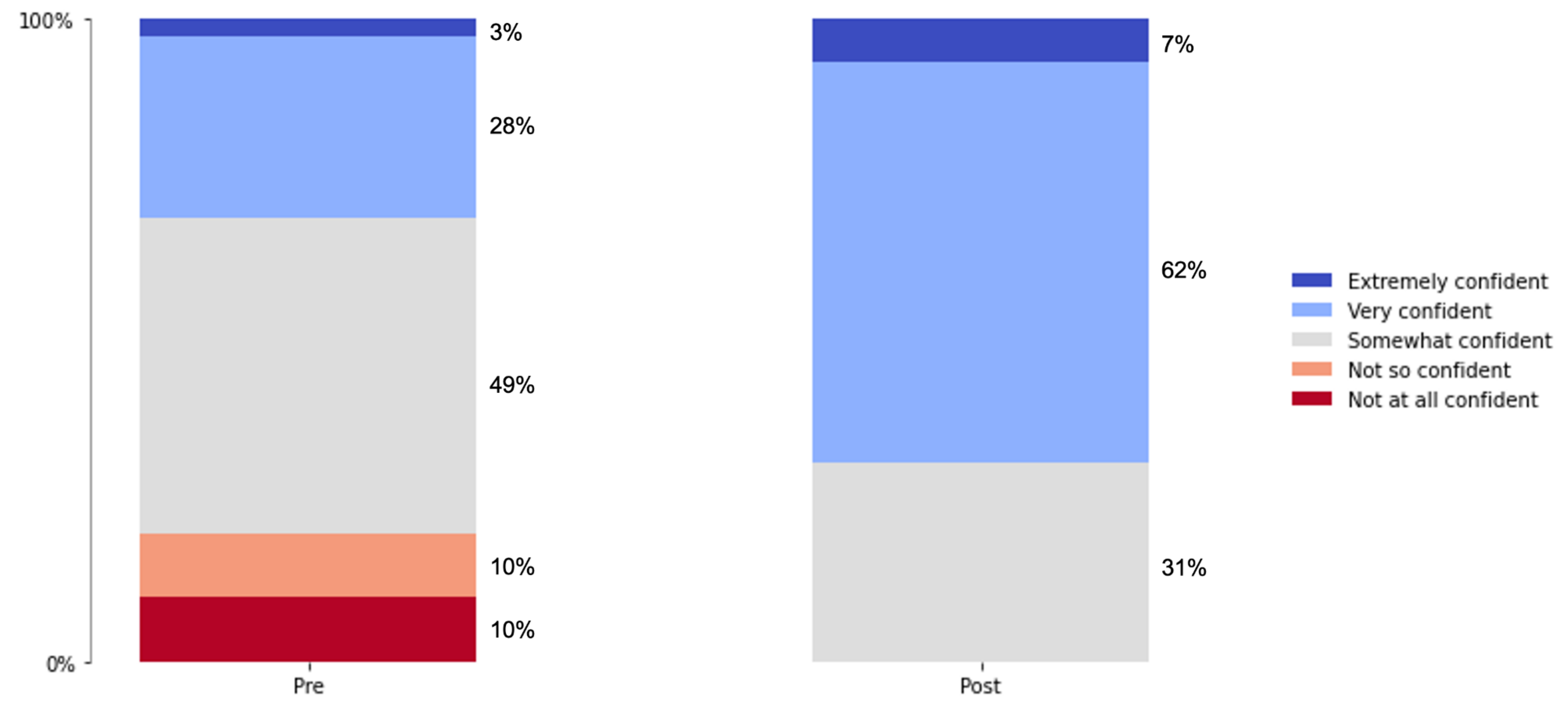
What did we learn?

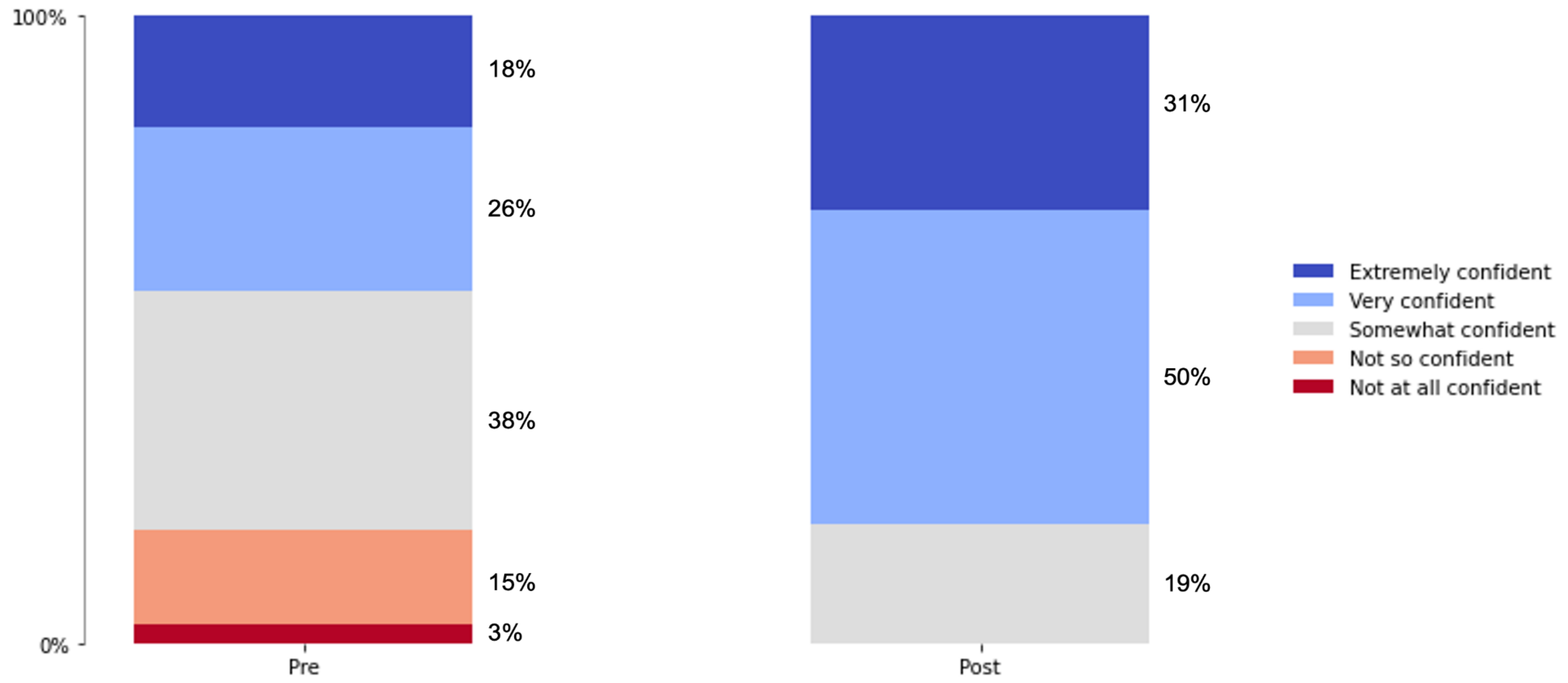


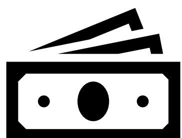
Changes over time: Organization-level
Wave 1 (July 2021), Wave 2 (January 2022), Wave 3 (June 2022),
Wave 4 (January 2023), Wave 5 (June 2023)
Central Providence
East Providence
Pawtucket/CF
Washington County
West Elmwood
Woonsocket
use team-based care
prioritize addressing equity
care for people's physical & mental health
care manage
form partnerships strategically
and our leadership prioritze population health
partner across sectors
have developed concrete aims
have trusting relationshps
use payment to advance, prevent, and improve health
care for social/spiritual needs
support open communication
have shared committments to equity
partner w/PLE to create change
have brave conversations around racial equity
are stewards of community well-being
score


Change Across Portfolios
Wave 1 (July 2021), Wave 2 (January 2022), Wave 3 (June 2022),
Wave 4 (January 2023), Wave 5 (June 2023)
A Community of Solutions
Community Health and Well-being
Cross-portfolio skills
Physical and Mental Health
Social & Spiritual Well-being
score
Wave
recoded
Central Providence
East Providence
Pawtucket/CF
Washington County
West Elmwood
Woonsocket

How confident are you in identifying areas of continued sustainability and collaboration with AEs and MCOs?

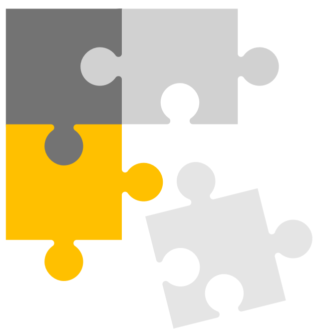



How confident are you in identifying areas of continued sustainability and collaboration with the Health Equity Zone (HEZ) and the communities they serve?
100%
0%
18%
26%
38%
15%
3%
Pre
31%
50%
19%
Post
Extremely confident
Very confident
Somewhat confident
Not so confident
Not at all confident



- In West Elwood (02907) the R2E team was able to **leverage funding** from Green and Healthy Homes Initiative and UnitedHealthCare (MCO) to continue work past original funding period by working on supporting pediadric patients with unmanaged asthma by Established relationship with the Home Asthma Response Program (HARP) to make direct referrals for poorly managed asthma and certifying their Community Health Advocates to work on asthma home visiting (p1-p2). West Elmwood also worked to prevent asthma by partnering with brown to assess air quality issues (p3) towards future education and advocacy (p4)

- In south county, the R2E team reduced the **Reduced Length of Stay for BH at South County Hospital** by providing peer services in the hospital (p1-p2) while also working with the johnny cake center to increase housing options to reduce bh hospital admissions.



- In Woonsocket, the R2E team worked to improve behavioral health of residents **in all 4 portfolios** including Integrating CHWs in the schools to support students and families in need (p2) and advocating for achieving a restorative justice framework for the school department (P4)

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Panel

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Breanna Lemieux, Accountable Entity Program Lead, EOHHS

Robyn Hall, Assistant Program Officer, Local Initiatives Support Corporation

Kinzel Thomas, MSW, LCSW, LCDP, CCHW, Vice President of Equity & Community Development, Family Service of Rhode Island

Lynne Driscoll, RN, BSN, CCM, Assistant Vice President Community Health, South County Health

MEDICAID BILLING FOR COMMUNITY HEALTH WORKER (CHW) SERVICES IN RHODE ISLAND

Findings from a Qualitative Evaluation Study

conducted by Mardia Coleman, MS and Roberta E. Goldman, PhD

on behalf of EOHHS, RIDOH and CTC-RI

November 17, 2023

BACKGROUND

- In 2021, RIDOH received a CDC Community Health Worker grant to support growth, sustainability, and innovation of RI's CHW workforce.
- On July 1, 2022, CHW services became a Medicaid reimbursable service in RI.
- Billing entities had to enroll to be a Medicaid CHW provider and become a trading partner.
- For CHW services to be Medicaid billable, a recommendation is required from a licensed professional of the healing arts.
- CHW services are billable in 15-minute units; up to 96 units/day.
- Gainwell Technologies is responsible for claims management on behalf of RI.

EVALUATION STUDY GOAL

- Use qualitative interviews to explore participating medical and community-based organizations' and independent CHWs':
  - Experiences with Medicaid CHW billing
  - Factors that facilitate success and should be maintained or enhanced
  - Challenges organizations encounter
  - Recommendations for changes EOHHS and RIDOH can make to further support existing and new organizations in their adoption of Medicaid CHW billing

METHODS

- Literature review
- Review of RI-specific CHW Medicaid billing documents, guidelines, manuals
- Key informant qualitative interviews in RI and elsewhere in the US (n=9)
- Qualitative interviews with employees of:
  - 2 medical organizations (n=6)
  - 3 community-based organizations (n=6)
- Qualitative interviews with independent CHWs in RI (n=4)
- Qualitative data analysis for content and patterns, and to formulate recommendations

FINDINGS: SUPPORT FROM GAINWELL TECHNOLOGIES

- **Theme: Gainwell Technologies' customer support and technical assistance is highly appreciated**
  - Billing software - PES
  - Resources provided to support billing processes, including the *RI Medicaid, Community Health Workers, Versions 1 and 2* manuals, PowerPoint presentations, initial 1.5 hour training session, problem-solving responses to calls

"When I was entering my very first claim it was literally a one-on-one with [staff name]. She's at Gainwell Technology. Oh my gosh, just a wonderful, wonderful person.
And we walked through the process, and I took notes, and thereafter I was off and running."

RECOMMENDATIONS FOR SUPPORT FROM GAINWELL TECHNOLOGIES

- **Recommendations**
  - Expand support hours to include some evening and weekend times.
  - Solicit and incorporate user input and user testing on future iterations of the manual and training materials to make them more user-friendly; include how-to videos in next versions.
  - Create a web-based resource regularly updated with billing information and guidelines.
  - Include information in the manual about what to expect regarding EHR modifications.
  - Support development of a technical support peer user group.

FINDINGS: BILLING-RELATED ISSUES

- **Theme: Despite available support, some struggle with a variety of billing issues.**
  - Modifying the EHR in preparation for billing can be time-consuming.
  - Obtaining Medicaid numbers can be difficult/problematic.
  - Most rely on CHW service recommendations from medical providers which can be time-consuming to obtain.
    - Most do not consider getting recommendations from other licensed professionals of the healing arts.
  - Standing orders for CHW services are rarely in place.
  - Retrospective billing is not often attempted.
  - Misinformation about billing protocols is spread through word-of-mouth.

FINDINGS: BILLING-RELATED ISSUES

- Oversight of service unit documentation, billing, and claims supervision are extremely time-consuming.

"We have billers who look at every claim, who look at every visit. And they actually do the coding, although the community health workers add a T code. But there's a billing person who looks at every claim and scrubs it and gets it ready to go out the door."

- Confusion about what constitutes collateral services reigns, and results in underbilling.

"And now we watch the national webinars on [CHW Medicaid billing], and they're talking about, 'Well, we pray together.' And we're like, 'You're billing for praying with somebody?' If you're looking up research for clients, it's a lot more legit than praying! But they say praying is okay on the national webinar."

RECOMMENDATIONS FOR BILLING-RELATED ISSUES

- **Recommendations**
  - Establish a widely-advertised, easily accessible “go-to” online location for updated, detailed information about CHW Medicaid billing.
  - Create a separate manual and/or provide concrete examples in the manuals explaining what acceptable collateral services are and are not.
  - Include in the manual specific directions and examples regarding how to use standing orders.
  - Create a ”Help” function embedded into the Gainwell billing software.
  - Alleviate the difficulties of retrieving Medicaid numbers.
  - Allow use of Medicaid MCO numbers for billing.

FINDINGS: IMPACT OF MEDICAID CHW REIMBURSEMENT ON ORGANIZATIONS

- **Theme: While providing some financial support, CHW Medicaid billing may have mixed impact on organizations.**
- Some organizations have always documented CHW services in 15-minute units, as is now required for Medicaid billing.
- For others, conceptualizing services in 15-minute units created a not-entirely welcome change of thinking.
- Some chafe at having to document units rather than focusing on providing the totality of services each patient/client needs.
- Some CBOs may be unable to bill for initial encounters because they do not, cannot, or are reluctant to ask for the Medicaid number at this vulnerable point in time for the client.
- Mission-driven organizations may be concerned about the need to broaden their focus to provide full-spectrum CHW services.

"Like if CHWs are out in the community and they're just thinking in units, it is counterintuitive to the work they're doing."

"If we continue down this path, are we still being true to who we are as an organization, or are we now trying to be more of a different kind of entity?"

FINDINGS: MEDICAID REIMBURSEMENT AND CHW SERVICES SUSTAINABILITY

- All interviewed medical and community organizations reported Medicaid billing will supplement, but not replace, other funding sources, i.e., contracts, grants and philanthropy.
- All interviewed organizations and most CHWs believe RI Medicaid reimbursement rates are too low to cover all costs of providing quality CHW services, i.e., training, service supervision, documentation and claims supervision, data management, and emotional support for CHWs working in challenging situations.
- Particular disappointment exists among CBOs at the low reimbursement rate for group-based health education classes.
- Preference for incorporating CHW services into alternate payment models, e.g., bundled payments or value-based contracting.

RECOMMENDATIONS FOR MEDICAID REIMBURSEMENT AND CHW SERVICES SUSTAINABILITY

- **Recommendations to promote sustainability**
  - Reconsider fee-for-service model and reimbursement rates.
  - Ensure restructuring provides sustainable reimbursement rates for new, individual and group categories to support a broad range of services and all associated administrative costs.
  - However, ensure any alternative payment models do not exclude CBOs and independent CHWs.

CONCLUSIONS

- RI recognizes the importance of CHW services and supports services through Medicaid CHW billing.
- EOHHS and Gainwell have largely succeeded in making Medicaid provider enrollment and the mechanics of billing easy to understand and implement. Each has provided excellent user support services.
- Enhanced strategies for clarifying CHW billing issues, including manual redesign, provision of accessible online protocol updates, and peer-to-peer support networking, are encouraged.
- CHW employers believe Medicaid reimbursement can provide a stable source of funds for services but will not entirely replace other funding.
- Reimbursement rates and the FFS payment system should be re-evaluated.

Evaluation & CME Credits

Please complete the evaluation in order to claim CME credits!

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https://www.surveymonkey.com/r/ZDZS5HG

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