Reimbursement Strategies for Employers of Community Health Workers

A Toolkit

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The authors and Mid-America Regional Council appreciate feedback and updates you might have for this publication.

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Introduction

Our health is influenced by many things, like access to healthy food, secure housing or health care. Those without adequate housing or employment, or who struggle financially, often have worse health outcomes. The environments where people are born, live, learn, work, play and worship (social drivers of health) also affect health and quality of life outcomes.[1]

As the health care industry grows its recognition that health is influenced by factors outside the clinical setting, Community Health Workers/Promotores de Salud are increasingly seen as essential members of the public health care workforce.

Health-Related Social Needs (HRSN) are factors that have an immediate adverse impact on health outcomes or management of chronic disease. For example, if an individual is unable to afford his/her utility bill, resulting in lack of electricity in the home and the individual requires home oxygen therapy for heart failure, lack of electricity could have severe health outcomes. HRSN interventions aim to address social drivers of health such as housing insecurity, food insecurity and lack of transportation. Failure to adequately address HRSNs can lead to increased health care utilization and poor health outcomes.

Community Health Workers/Promotores de Salud (CHW/Ps) provide critical support to those who have HRSNs. CHWs are trained professionals and members or representatives of the communities they serve who help people navigate the complex health and social services system. CHWs assist clients to address HRSNs by helping them access resources critical to improving their health, such as stable food supplies, transportation to medical appointments or utility and rent assistance. They can bridge cultural and language barriers between providers and clients, improve communication with care teams, and support clients to follow through with care plans. CHWs promote health equity, improve health care access and outcomes, strengthen care teams and enhance quality of life for people in low-income, underserved, vulnerable, disenfranchised and oppressed communities.

Health care is slowly shifting from a traditional fee-for-service reimbursement model to one that pays for favorable health outcomes or value-based care. In this shift, CHW/Ps are essential members of a multi-disciplinary care team to help influence health outcomes. Recognizing the slow shift from fee-for-service to value-based care, this Toolkit provides guidance for how health care providers and community-based organizations that deploy CHW/P interventions (collectively, CHW/P organizations) can receive reimbursement for CHW/Ps in both the fee-for-service and value-based care environments.

The Toolkit is designed to inform organizations on how to use existing tools or establish capacities to bill for CHW/P interventions within the current health care marketplace. It is structured to appeal to a broad audience — those who have experience in health care reimbursement and those without deep knowledge of health care reimbursement. There are chapters ranging from basic education on how health care is structured and reimbursed for in the United States to specific tools that can be used to bill for CHW/P services. Each chapter can be easily accessed depending on your CHW/P organization's knowledge and experience with health care reimbursement.

[1] www.health.gov/healthypeople/priority-areas/social-determinants-health

Community Health Workers / Promotores de Salud

Who are Community Health Workers and Promotores[2]?

According to the American Public Health Association (APHA), a CHW is:

> "A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[3]

CHWs reflect the values, culture and experiences of the community they work within. These similarities allow CHWs to develop peer-to-peer relationships of trust rather than the provider-patient relationships that are based on clinical expertise. These trusting relationships encourage open communication on health-related issues that ultimately leads to improved health care access and outcomes. This trusting relationship and natural connection is seen as the "key to building relationships with marginalized communities and easing their wariness" of the health care industry.[4]

What is their Scope of Work?

CHW/P roles and responsibilities are often tailored to meet the unique needs of their communities and generally include:[5]

- *Individual Support.* Provide encouragement and social support to assist individuals with goal setting and barrier identification within professional boundaries.
- *Care Coordination/Community Support Planning.* Assist in coordinating care by linking people to appropriate information and services.
- *Health Care Liaison.* Serve as a culturally-informed liaison between individuals and community health care systems.
- *Health Education.* Provide culturally appropriate health education to individuals, organizations and/or communities, in an effort to reduce modifiable risk factors and encourage healthy behaviors.
- *Advocacy.* Recognize gaps and advocate for individual and community health needs.

Health Equity

CHW/Ps help to promote health equity. The Centers for Disease Control and Prevention (CDC) defines health equity in the following manner:

> "Health equity is achieved when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances.' Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment."[6]

According to the CDC, groups that generally suffer from health inequity includes the following:[7]

- Racial and ethnic minorities.
- People living in rural communities.
- People with disabilities.
- People with mental or substance use disorders.
- People with less than high school education.
- People with low-income and those experiencing poverty.
- People who identify as lesbian, gay, bisexual, transgender or queer (LGBTQ).
- Populations negatively impacted by social drivers of health (SDOH).

When there is alignment of health and social care, health outcomes can be maximized in an effort to achieve health equity. CHW/Ps and CHW/P organizations that deploy CHW/P interventions are integral to the achievement of health equity by addressing health and social needs for priority populations. The shift towards value-based care requires health care organizations to incorporate a health equity strategy to ensure optimal outcomes are achieved for their target populations. Health care organizations that are developing health equity strategies should consider incorporating CHW/Ps and CHW/P organizations as part of the broader strategy to address health equity.

[2] "Promotores or Promotoras de Salud is a Spanish term used to describe trusted individuals who empower their peers through education and connections to health and social resources in Spanish speaking communities." https://mhpsalud.org/our-chw-initiatives/promotoras-de-salud/

[3] www.apha.org/apha-communities/member-sections/community-health-workers

[4] Marguerite J. Ro, Dr.P.H., Henrie M. Treadwell, Ph.D., Mary Northridge, M.S., Ph.D. "Community Health Workers and Community Voices: Promoting Good Health. A Series of Community Voices Publications." W.K. Kellogg Foundation. October 2003.

[5] https://health.mo.gov/professionals/community-health-workers/.

[6] www.cdc.gov/chronicdisease/healthequity/index.htm

[7] www.cdc.gov/nccdphp/dnpao/health-equity/health-equity-guide/pdf/health-equity-guide/HealthEquity_Infographic_H.pdf

Navigating the Toolkit

The Toolkit is designed to provide the tools for CHW/P organizations to bill health payers for CHW/P interventions. The Toolkit is structured so that information can be easily accessed depending on your CHW/P organization's knowledge and experience with health care reimbursement. The reimbursement pathways outlined in this Toolkit represent reimbursement opportunities for CHW/P interventions that exist broadly within the current health care market, not dependent on federal or state level policy change.

The Toolkit has seven chapters tailored to varying degrees of CHW/P organization knowledge of health care reimbursement:

- **Chapter I: Health Care Funding in the United States.** This chapter provides a primer on the major sources of funding for health care in the United States.
- **Chapter II: Structure of Health Care Reimbursement to Health Care Providers.** This chapter describes how health care providers are reimbursed for providing care and incentivized to improve the delivery of care within the different available reimbursement structures.
- **Chapter III: Centers for Medicare and Medicaid Services Value-based Care Initiatives.** This chapter describes the federal Centers for Medicare and Medicaid Services efforts to shift reimbursement for health care to paying for value as opposed to quantity of services delivered.
- **Chapter IV: Coding and Billing for Health Care Services.** This chapter analyzes medical services that could be delivered by a CHW/P in a health care setting and through which a CHW/P organization may request reimbursement from a health payer for CHW/Ps.
- **Chapter V: Managed Care Opportunities.** This chapter outlines opportunities for CHW/P reimbursement through managed care organizations.
- **Chapter VI: Crosswalk of Reimbursement Models.** This chapter maps the various reimbursement opportunities for CHW/Ps, outlined in Chapters II-IV, based upon the type of CHW/P organization.
- **Chapter VII: Developing a Contract Capture Strategy.** This chapter outlines strategies that CHW/P organizations may take to negotiate contracts and payment rates with health payers to fund CHW/Ps.

Appendix A includes a glossary of key terms used throughout the document.

Chapter I: Health Care Funding in the United States

Major Sources of Health Care Funding in the United States

The largest payer for health care in the United States is the federal Centers for Medicare and Medicaid Services (CMS). As the single largest payer, CMS has influence on the way in which health care services are paid. The programs publicly financed or supported by CMS include:

- Medicare.
- Medicaid.
- State Children's Health Insurance Program (SCHIP).
- Health Insurance Exchange Plans.

Followed by publicly supported programs is employer-sponsored insurance as the next largest payer of health care in the United States.

Medicare

Medicare is a national health care program that provides health coverage for people 65 and older; people under 65 with certain disabilities; or people of any age with end-stage renal disease (ESRD) / permanent kidney failure requiring dialysis or a kidney transplant. It provides a wide range of health care benefits. See ***Appendix A: Glossary of Terms*** for a detailed description.

Medicare Advantage (MA) plans are managed care organizations (MCOs) approved by CMS to manage the delivery of Medicare benefits for its enrollees. For a monthly fee from the federal government, MA plans manage beneficiary care and make payments to health care providers on behalf of Medicare. Medicare eligible beneficiaries have the option of enrolling in a MA plan each year or staying in Original Medicare, during the open enrollment period. MA plan penetration rate by county and state can be accessed on the CMS website. See ***Appendix B*** for a tip sheet on how to download.

Medicaid

Medicaid is a means-tested program for persons, including children, adults and the aged blind and disabled, that live at or below federal poverty levels, which can vary by state and family size. Medicaid is jointly funded by the federal government and the state but administered by the state with federal CMS oversight. There is a standard set of mandatory Medicaid benefits. However, each state is permitted to allow for a broader range of optional benefits. Many states contract with Medicaid MCOs to manage the delivery of health care benefits for Medicaid populations. Similar to MA plans, Medicaid MCOs receive a monthly fee per member to manage beneficiary care and make payments to health care providers on behalf of Medicaid.

State Medicaid agencies have a variety of pathways to incorporate CHW/Ps into state Medicaid plans, such as preventive services State Plan Amendment (SPA), Health Homes SPA, and the 1115 waivers process, among others. These potential pathways will not be covered as the intent of the Toolkit is to provide CHW/P organizations with reimbursement opportunities that do not require policy change at the state or federal level. Stakeholders and advocates for policies to support CHW/P activities should monitor state Medicaid activity to submit SPAs or 1115 waivers that involve CHW/Ps and be active in any public comment periods to make sure Medicaid policymakers are aware of your interest.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) provides health coverage for children in households with incomes above state Medicaid income guidelines. Children are offered a similar benefit package to Medicaid with higher cost sharing options. The state and CMS share in the cost of SCHIP.

Health Insurance Exchange

The Health Insurance Exchange or Marketplace is a place where consumers (including individuals, families and small businesses) can shop for a commercial health insurance plan. The health plan options are offered by MCOs that take on the responsibility to manage a person's care and pay health care providers for an individual's utilization of the health system. The Marketplace includes a means-tested set of criteria that sets limits for individual premiums that can be charged by MCOs. CMS approves the health plans that can enter the exchange on an annual basis.

Employer-Sponsored Insurance

Finally, employer-sponsored insurance (ESI) is for persons who have insurance through an employer. The employer subsidizes the cost of the health insurance charged by the MCO.

We will collectively refer to Medicare (including Medicare Advantage Plans), Medicaid (including Medicaid MCOs), SCHIP, Marketplace plans, and ESI as "Payers" of health care.

Chapter II: Reimbursement to Health Care Providers

Payers of health care (e.g., Medicare, Medicaid, Employer-Sponsored) pay health care providers for health care services delivered to individuals. Funders such as Medicare or Medicaid can pay providers directly or contract with a MCO to manage the delivery of care and pay health care providers on behalf of the Payer. The Toolkit evaluates existing opportunities for CHW/P organizations to seek reimbursement for CHW/Ps through:

- Fee-for-Service.
- Value-based Care.
- Managed Care Contracting.

Fee-for-Service

Fee-for-Service (FFS) is a method of payment in which a health care provider is paid for each service or procedure performed (e.g., primary care visit). The FFS structure has an inherent incentive to pay more for poor health outcomes and an inherent disincentive for achieving favorable health outcomes. This is readily seen in the management of diabetes. When a health care team achieves favorable outcomes in managing diabetes, the person with diabetes has a low Hgb A1c and no disease complications related to their diabetes. As a result, the overall health care spending for the person with well-managed diabetes and no complications is relatively low. In contrast, the trajectory of health care spending for the person with poorly managed diabetes and numerous disease complications is relatively high. Therefore, the adverse incentive of the FFS payment system is that it provides more financial resources to health care providers that have high numbers of persons with poor health outcomes.

Value-based Care Programs

CMS defines Value-Based Programs in the following manner: "Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for.

Value-based programs also support the CMS three-part aim:

- Better care for individuals.
- Better health for populations.
- Lower cost."[8]

CMS uses Alternative Payment Models (APMs) to promote value-based care. Some organizations voluntarily participate in APMs as CMS shifts towards value-based care. CMS defines APMs in the following manner:

> *An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.*[9]

The practical application of the concept of an APM is a method of payment in which a health care provider is able to receive increased financial incentives or participate in financial risk for overall health outcomes including total cost of care and quality instead of discrete FFS payments that do not consider quality or cost in the financial model.

APMs are not exclusive to Medicare. All Payer types can pay health care providers[10] directly through a fee-for-service arrangement or through a value-based care model. A health care provider must have a direct contract with a Payer to receive reimbursement for services. The contract will define if the reimbursement model is FFS or an APM.

Goal of Value-Based Care

The goal of value-based care is to change the financial incentive from increased payments for high rates of health care consumption to financial incentives for achieving positive health outcomes. Achieving improved clinical outcomes requires having an actively engaged patient based on high levels of disease self-management and adherence to a prescribed clinical regimen, which requires continual reinforcement and disease self-management support.

CHW/Ps are uniquely positioned to achieve health equity while supporting the transition to value-based care as a conduit to improving consumer disease self-management ability, adherence to a prescribed clinical regimen and identifying and connecting to resources to address HRSNs. Often, physicians and non-physician providers (physician assistants and nurse practitioners) do not have the time to deliver to each person the necessary support to encourage the expanded use of disease self-management and clinical management adherence. In addition, groups that suffer disproportionately from health inequity may require targeted community interventions to address health and social factors that contribute to poor health outcomes. As health care providers increasingly shift to value-based care, the role and importance of CHW/Ps will increase in a correlating manner.

Intersection of Fee-for-Service and Value-based Care

Health care services are reimbursed when a provider submits a claim for services to a Payer (i.e., Medicare, Medicaid, ESI plan). To receive reimbursement, the claim must list the demographics of the person that received the service, the information for the rendering provider, the diagnosis that was being treated, and a listing of the service that was provided, using a series of accepted diagnosis and procedure codes. See ***Coding and Billing for Health Care Services*** section for a detailed description of coding and submitting claims.

In FFS, the provider is reimbursed a negotiated rate related to the procedure code. In value-based care, the provider continues to submit claims for procedures codes for documentation and reporting purposes and participates in a financial incentive model based upon a set of defined outcomes related to cost and quality. A continuum of reimbursement structures exists from a true no-risk FFS model to the health care provider

participating in a full-risk capitated payment model with downside risk when poor health outcomes are achieved for the target population. See below for a description of the range of reimbursement models, from least to greatest financial risk to health care providers:

- *Fee-for-Service:* Reimbursement to health care providers for health care services on a unit basis with no financial consequence for poor outcomes for the individual or a population served by the health care organization[11].
- *Pay-for-performance*: Fee-for-service reimbursement for units of service with an additional opportunity to earn a financial bonus when certain quality measures are obtained.
- *One-sided Risk Model:* An alternative payment model where a health care organization strives to reduce total cost of care and improve health outcomes for a defined population. When the health care organization is successful in reducing the total cost of care below a defined baseline cost measure, the health care organization is eligible for shared savings. If the health care costs increase, the health care organization does not incur a financial penalty when they are not able to achieve a reduction in total cost of care. Therefore, the risk only applies to one side of the relationship between the health care organization and the Payer.

- *Two-sided Risk Model*: An alternative payment model where a health care organization strives to reduce total cost of care and improve health outcomes for a defined population. When the health care organization is successful in reducing the total cost of care below a defined baseline cost measure, the health care organization is eligible for shared savings. If the health care costs increase, the health care organization will incur a financial penalty when they are not able to achieve a reduction in total cost of care. Therefore, the risk applies to both sides of the relationship between the health care organization and the Payer.
- *Capitated payment model/per member per month (PMPM)*: a health care organization receives a set monthly fee for all care provided to a population of beneficiaries and is fully at risk for cost and quality.

All Payers can choose to reimburse health care organizations along the continuum of reimbursement structures outlined above, based on their quality goals. Specific CMS efforts to advance value-based care along this continuum of payment to health care providers are outlined in Chapter III.

[8] The Centers for Medicare and Medicaid Services. 2022. Available Online: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

[9] https://qpp.cms.gov/apms/overview

[10] Health care providers can include, for example, hospitals, primary care physicians, federally qualified health centers, etc.

[11] In this section, health care organization refers to both MCOs, in terms of their relationship with Medicare or Medicaid, and health care providers, in terms of their relationship with Payers.

Chapter III: Centers for Medicare and Medicaid Services Value-based Care Initiatives

Center for Medicare and Medicaid Innovation

The passage of the Affordable Care Act (ACA) created the Centers for Medicare and Medicaid Innovation (CMS Innovation Center).

The CMS Innovation Center is charged with testing different payment models to shift from FFS. CMS Innovation Center introduced alternative payment models (APMs) that shift the payment model from FFS to models that pay for outcomes.

In 2022, the CMS Innovation Center released the Innovation Center Strategy Refresh.[12] The strategy includes the following value-based care goals:

- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

The established goals of moving all Medicare and Medicaid beneficiaries into a relationship with accountability will require universal adoption of health equity strategies that allow health care organizations to strive for improved health outcomes and reduced total cost of care for the entire population of beneficiaries they serve. Value-based care and adoption of APMs are essential components for meeting the CMS Innovation Center goals.

In order to advance APMs to health care providers, the CMS Innovation Center spearheads the development and testing of new value-based payment models. It designs and tests innovation models organized into seven categories: Accountable Care; Episode-based Payment Initiatives; Primary Care Transformation; Initiatives Focused on the Medicaid and CHIP Population; Initiatives Focused on Medicare-Medicaid Enrollees; Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models; and Initiatives to Speed the Adoption of Best Practices. Models active in 2022 relate to Accountable Care and Episode-based Payment Initiatives.

Accountable Care

Accountable Care Organizations and similar care models are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, as well as high-quality and efficient service delivery. Models active in 2022 include Accountable Care Organizations and Accountable Care Organization Realizing Equity, Access and Community Health.

Accountable Care Organizations (ACOs)

"ACOs are groups of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high-quality care to the Medicare beneficiaries they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program."[13]

Accountable Care Organization Realizing Equity, Access, and Community Health Model[14]

Beginning in 2023, CMS is transitioning the Global and Professional Direct Contracting Model (GPDC) Model[14] to the ACO REACH Model (Accountable care Organization Realizing Equity, Access and Community Health) "to better align the name with the purpose of the model: to improve the quality of care for people with Medicare through better care coordination, reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved."[15] When a REACH ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. Participants are required to have a defined strategy to address health equity.

There are three types of direct contracting entity (new CMS term for ACO) models including Standard (serves Original Medicare patients only), New Entrant (serves Original Medicare patients and includes providers who may not have participated in a previous ACO initiative), High Needs Population (serves Original Medicare patients with complex needs).

Episode-Based Payment Initiatives

Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter. Models active in 2022 include the Kidney Care Choices and Bundled Payment for Care Improvement Advanced models.

Kidney Care Choices (KCC) Model

Kidney Care Choices (KCC) is designed to reduce cost and improve care for patients with late-stage chronic kidney disease and ESRD. It "builds upon the existing Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model structure — in which dialysis facilities, nephrologists and other health care providers form ESRD-focused accountable care organizations to manage care for beneficiaries with ESRD — by adding strong financial incentives for health care providers to manage the care for Medicare beneficiaries with chronic kidney disease (CKD) stages 4 and 5 and ESRD, to delay the onset of dialysis and to incentivize kidney transplantation. The model

will have four payment options: CMS Kidney Care First (KCF) Option, Comprehensive Kidney Care Contracting (CKCC) Graduated Option, CKCC Professional Option and CKCC Global Option."[16]

Bundled Payment for Care Improvement Advanced (BPCI-Advanced) Model

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model "aims to support health care providers who invest in practice innovation and care redesign to better coordinate care and reduce expenditures, while improving the quality of care for Medicare beneficiaries."[17] The goals of the model are "Care Redesign, Health Care Provider Engagement, Patient and Caregiver Engagement, Data Analysis/Feedback, and Financial Accountability."[18] BPCI Advanced will operate under a bundled payment methodology tied to quality measures.[19]

Medicare Alternative Payment Models

The following Advanced Alternative Payment Models have been deployed by CMS in Medicare as of 2022[20]:

- End-Stage Renal Disease Quality Incentive Program (ESRD QIP).
- Hospital Value-Based Purchasing (VBP) Program.
- Hospital Readmission Reduction Program (HRRP).
- Value Modifier (VM) Program (also called the Physician Value-Based Modifier or PVBM).
- Hospital Acquired Conditions (HAC) Reduction Program.
- Skilled Nursing Facility Value-Based Program (SNFVBP).
- Home Health Value Based Program (HHVBP).

CMS is implementing the following alternative payment models:

- Merit Incentive Payment System (MIPS).
- Advanced Alternative Payment Models.

CMS defines an Advanced Alternative Payment Model in the following manner:

- "Requires participants (providers) to use certified electronic health record (EHR) technology;
- Provides payment for covered professional services based on quality measures comparable to those used in the MIPS quality performance category; and
- Either: (1) is a Medical Home Model expanded under CMS Innovation Center authority OR (2) requires participants to bear a significant financial risk."[21]

For more information on these initiatives, timelines and the intersection with other CMS quality efforts: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.

CHW/Ps in Value-based Care

APMs encourage health care organizations to redesign care delivery models and offer incentives and waivers to allow for new care models that will lead to meeting the goals of improving health outcomes and reducing total cost of care. As health care organizations enter into APMs, there is increased adoption of multi-disciplinary care team approaches to address the medical, social and behavioral health needs of the target population.

CHW/Ps are increasingly seen as an essential member of a multi-disciplinary care team that works in a value-based care environment. Members of a multi-disciplinary care team are financially sustainable in value-based payment models by incorporating their costs into the reimbursement strategy. If value-based care will provide financial rewards for achieving defined outcomes, then all members of the care team that are required to achieve these defined outcomes must be covered by the financial payment model. Therefore, a specific method to categorize a direct individual reimbursement for CHW/Ps participation in a multi-disciplinary care model is not required because the value-based payment model provides compensation for a modification in the care team to achieve the expected health outcomes for the target population. See ***Appendix L*** for an example incorporating a CHW/P into a VBP model.

Therefore, a specific method to categorize a direct individual reimbursement for CHW/Ps participation in a multi-disciplinary care model is not required because the value-based payment model provides compensation for a modification in the care team to achieve the expected health outcomes for the target population. See ***Appendix L*** for an example incorporating a CHW/P into a VBP model.

[12] https://innovation.cms.gov/strategic-direction-whitepaper

[13] https://innovation.cms.gov/innovation-models/aco

[14] https://innovation.cms.gov/innovation-models/aco-reach

[15] Ibid.

[16] https://innovation.cms.gov/innovation-models/kidney-care-choices-kcc-model

[17] https://innovation.cms.gov/innovation-models/bpci-advanced

[18] Ibid.

[19] Ibid.

[20] https://innovation.cms.gov/innovation-models/qpp-information

[21] Ibid.

Chapter IV: Coding and Billing for Health Care Services

Health care services are reimbursed when claims for services are submitted to the Payer. The reimbursement claim must list the demographics of the person that received the service, the information for the rendering provider, the diagnosis that was being treated, and a listing of the service that was provided. The list of services rendered to the beneficiary is commonly referred to a Common Procedural Therapy or CPT® code. Coding is required in both FFS and value-based (VBP) reimbursement models.

Code Sets

- Diagnosis Codes. The method to identify the diagnosis or diagnoses is a series of accepted diagnosis codes, known as the ICD-10 Codes. ICD-10 is the 10th revision of the International Statistical Classification of Disease and Related Health Problems.
- Service Codes. The service that was rendered defines the reimbursement. The method of transmitting or identifying for the Payer the service that was rendered is through the listing of Common Procedural Therapy codes or Health Care Common Procedure Coding System (HCPCS) codes.
    - Common Procedural Therapy codes is the registered trademark of the American Medical Association (AMA) and all the CPT codes are the copyright material of the AMA. To modify, add or change a CPT code, a request must be submitted to the American Medical Association for consideration. AMA submits revisions to the CPT code set annually. Medicare, Medicaid and commercial health plans can elect to reimburse a select code for service listed in the CPT code set. However, Medicare, Medicaid and commercial health plans are not required to reimburse all services that are listed in the CPT code set.
    - Health Care Common Procedure Coding System is an alternative code set for services that are not listed in the CPT code set. Payers can use this coding system if they want to provide reimbursement for a specific service that is not identified in the CPT code set.

To receive reimbursement from a Payer for services, there must be a service code defined by CPT or some other method that identifies the service and the reimbursement rate for the service. Health care services are highly regulated. The regulatory requirements define that all services rendered be tracked, monitored and available for audit at the level of the beneficiary. The payment of services that define a code for the service, a code for the diagnosis, and details on the date of service and rendering provider allow the health plan to stay in compliance with these regulatory requirements.

Categories of Services that Could be Delivered by Community Health Workers

Appendix C lists categories of services and the associated CMS Medicare Learning Network guide that lists the service descriptions and associated HCPCS and CPT codes for these services. These codes define services that are reimbursable by the Medicare program and require a rendering health care provider to deliver services while overseeing a multi-disciplinary care team. A multi-disciplinary care team can include CHW/Ps. When CHW/Ps are operating in a multi-disciplinary care team, the CHW/P service/intervention is performed under direct or general supervision of the rendering health care provider, leading the multi-disciplinary care team.

The American Medical Association owns the copyright to CPT. When the AMA defines a new or existing CPT code, it is at the discretion of the Payer to adopt and reimburse this code. If a Payer reimburses a CPT or HCPCS code, the reimbursement rate is defined by the Payer, resulting from an individual business negotiation between the Payer (i.e., MCO) and the rendering health care provider. Each code has its own regulatory requirements and those would need to be consulted prior to implementation.

Multidisciplinary Care Teams and Billing

A rendering provider submits claims for reimbursement for services performed by the rendering provider and for members of the care team that rendered services under direct or general supervision, in accordance with applicable *incident to* rules. Claims for reimbursement are submitted to the Payer that is responsible for covering the cost of that individual's care. The services performed by the members of the care team must be medically necessary, delivered according to a plan of care and aligned with applicable *incident to* rules.

Not all members of a multi-disciplinary care team can be listed as the rendering provider. For example, though registered nurses are often cited as integral to the delivery of health care services, they are universally not eligible to be listed as an independent rendering provider, for most health care services. Despite the essential role of nurses in the care delivery process, there is not an individual billing code or set of codes that directly reimburses for most services independently rendered by a registered nurse or licensed practical nurse providing direct care services, unless there is appropriate supervision by an eligible rendering provider. Nurses have a defined role in a multi-disciplinary care team and their costs are incorporated into the FFS or APM that has been negotiated between the health care organization and the Payer. Even though there are not defined payments and codes for the work of a registered nurse or licensed practical nurse working as part of a care team, these professionals are deemed essential to the health care delivery process. Since nurses are essential to the health care delivery process, the cost of the nurses is covered by the collective reimbursement obtained through the service code defined by the rendering provider.

The broader realization of the impact of SDOH and HRSN on health care utilization and adverse health outcomes has highlighted the importance of developing interventions to address HRSNs. HRSNs

generally occur outside of the clinical setting but have a direct impact on the outcomes of prescribed health interventions. The CHW/P is often the person on a multi-disciplinary care team that is best equipped to address HRSNs, particularly when interventions to address HRSNs must be implemented in community settings. In the same manner that nurses are deemed critical to the delivery of interventions in clinical settings, CHW/Ps are essential to addressing HRSNs and the cost to deploy CHW/P interventions should be incorporated into the multi-disciplinary care team reimbursement structure and, when applicable, services that can be rendered under general or direct supervision and in accordance with *incident to* rules should be appropriately documented and included in the claims submission process.

The role of CHW/Ps directly impacts health equity requirements for success in an overall population health strategy. As an essential component of the multi-disciplinary care team, interventions deployed by CHW/Ps can support direct provider services and *incident to* services (see below).

Claims and Reimbursement

For most health care services, the multi-disciplinary care team is led by a physician or non-physician provider (NPP). Generally accepted non-physician providers include physician assistants and advanced practice nurse practitioners. When a registered nurse, licensed practical nurse or medical assistant operates as part of a multi-disciplinary care team or provides eligible *incident to* services (see below), the code for the service rendered may be submitted under the National Provider Identifier (NPI) of the rendering provider, if all other requirements of *incident to* rules are met. In all cases, the supervisory oversight of the multidisciplinary care team must be maintained by clinicians that are leading or part of the multi-disciplinary care team and working towards a defined care plan and providing medically necessary services.

Incident To Services

CMS updated the definition for *incident to* services to further define the role of auxiliary personnel in the delivery of *incident to* services. All services based on a supervising practitioner's judgment can be delegated. All services can be under direct and some, based on rule change, can be done under general supervision, as long as they adhere to the *incident to* rules.

To further draw upon the applicability of the *incident to* services rule to CHW/Ps, it allows supervising practitioners to delegate certain services to CHW/Ps (unlicensed providers) that can be delivered under general — not direct — supervision meaning the supervising practitioner does not need to be directly supervising the CHW/P during the provision of the service.

The CMS definition of *incident to* services as it relates to Medicare is the following:

> "In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Designated care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided *incident to* the services of a physician (or other practitioner). The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for *incident to* services."[22]
>
> "Auxiliary personnel means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee or independent contractor of the physician (or other practitioner), or of the same entity that employs or contracts with

the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide *incident to* services, including licensure, imposed by the state in which the services are being furnished."[23]

Designated care management services include but are not limited to Transitional Care Management,[24] Chronic Care Management,[25] Principal Care Management, Behavioral Health Integration care management,[26] and Collaborative Care Management[27] are services that can be rendered by auxiliary personnel, under general supervision, when all other *incident to* services rules are met.

All other Payers, such as Medicaid, Medicaid Managed Care, Health Insurance Exchange Plans and Employer-Sponsored Insurance plans may follow the *incident to* services rule.

Care Planning and CHW/Ps

To make multi-disciplinary care teams more efficient, the person on the care team that is most capable of addressing the need should be deployed to apply the intervention. The intervention should be part of the person-centered plan and rendered under the supervision of the rendering provider.

In this same manner, interventions to address HRSNs and supporting beneficiaries with overcoming real or perceived barriers to adhering to a prescribed treatment regimen can often be optimally performed by a CHW/P. When the intervention that will have the greatest impact on addressing HRSNs or treatment adherence is performed by a CHW/P, then the supervising rendering provider will include this intervention in the treatment planning and submit claims for the service(s) that include the cost of the CHW/P in the reimbursement. The service could be included as *incident to* as long as the requirement for auxiliary personnel and all other *incident to* regulatory requirements are met.

This approach of covering the cost of all members of the multi-disciplinary care team mirrors the industry standard for covering the cost of services provided by registered nurses, licensed practical nurses and medical assistants that are operating as auxiliary or clinical staff and providing medically necessary services that are delivered with the intent of achieving improved health outcomes. See *Appendix L* for an example of incorporating a CHW/P into a fee-for-service reimbursement structure.

Requirements to be a Rendering Provider

In order to be a rendering provider to submit claims for reimbursement for health care services, the individual or organization must consult the regulations of the Payer. Each Payer may have specific requirements to credential a provider or supplier. However, the general requirements to enroll as a rendering provider include the following:

1. Have a National Provider Identifier (NPI).
2. Meet all licensure and regulatory requirements imposed by the state, territory, or the District of Columbia, in which services are being rendered.
3. Assume responsibility for all liability of services delivered.
4. Meet liability insurance limits specified by the Payer, such as professional liability, cybersecurity, workers compensation and general liability.

5. Have met all credentialing requirements of the Payer.
6. Have the ability to file claims to Payer. Most Payers require claims to be submitted electronically or through a claims submission clearinghouse. Electronic claims submission requires adopting a secure information technology (IT) platform with the ability to create a claim, file associated claims and reconcile remittance reports resulting from the claims adjudication process.

As an example, for more detail on how to enroll as a Medicare provider, please see ***Appendix D***.

Community-Based Organizations and Claims

While there are rendering health care providers that employ CHW/Ps and have the capability to include the cost of CHWs in their negotiated rates with Payers, many CHW/Ps are employed by community-based organizations (CBOs). CBOs are well-positioned to help address HRSNs and SDOH as they have direct relationships to the communities they serve, but many CBOs are not qualified rendering providers of care. In addition, many CBOs lack the required infrastructure and IT systems that are required to deploy interventions to address HRSNs and align services with health care that complies with HIPAA and other data exchange requirements.

In order to overcome barriers to align health and social care, increasingly CBOs are organizing as part of a network of CBOs that have formed a delivery system of HRSN interventions. A network of CBOs organized to address social drivers of health could be recognized as a Community Care Hub. A Community Care Hub is a lead entity that implements and supports a network of CBOs through centralized administration, financial management, sourcing Payer contracts/revenues for the network, quality assurance activities and governance. Through the organization of a network or community hub, the network of CBOs can leverage economies of scale and pool resources to enable improved alignment with health care organizations. These networks of CBOs are formed under a single organizing entity that is commonly called a Community Care Hub. The services of the Community Care Hub generally include the following:

- Capacity to implement a centralized referral process for all participating CBOs through a single-entry point.
- Comprehensive SDOH screening.
- Person-centered planning defining all resources that are required to meet identified needs.
- The ability to submit claims to a Payer, and to blend and braid public, private, health care and philanthropic funding.
- Evaluation of deployed HRSN interventions to determine the impact of the interventions on health outcomes.
- Closed-loop reporting to ensure data sharing with the referral source documenting services deployed and outcomes of the interventions deployed.

For a CBO to participate in the process of submitting claims for reimbursement of services provided by CHW/Ps, there are two options:

1. *Become an eligible rendering provider with a Payer(s)*. Under this option, the CBO would need to meet the requirements listed in the Section titled **Requirements to be a Rendering Provider**. A CBO that becomes a rendering provider is eligible to submit reimbursement for a limited set of billing/procedure codes that do not require clinical supervision.
2. *Align with an existing rendering provider.* Under this option, the CBO could form a contractual relationship with a rendering provider to provide CHW/P support to the provider's multidisciplinary care team. The contract would detail, at a minimum:
    a. *Scope of services* to be provided by the organization that employs CHW/Ps.
    b. *Business Associate Agreement and requirements regarding the management of Protected Health Information (PHI).*
    c. *Payment rates and structure.* This includes both amount and payment structure, such as FFS, per member per month (PMPM), or shared savings. Generally, a more flexible payment structure such as a PMPM allows CHW/Ps to employ a broad scope of practice and to be more impactful to a beneficiary's health as opposed to providing discrete services in a time-limited period.
    d. *Documentation and reporting.* This would detail how the CBO would document services and submit information to the rendering provider to support the claims process for reimbursement.
    e. *Meet all necessary professional liability, general liability and cyber insurance requirements.*

[22] www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.26

[23] Ibid.

[24] www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

[25] www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

[26] www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[27] Ibid.

Chapter V: Managed Care Opportunities

In addition to reimbursement models linked to the provision of clinical care, MCOs have the flexibility to offer additional non-medical services to support their members, such as CHW/P interventions in the community to address SDOH needs. Rules differ whether the MCO is a Medicaid MCO, MA plan or other Payer type. Generally, Medicaid, Marketplace and ESI MCOs have greater flexibility to offer non-clinical supportive services.

CHW/P Organizations can contract directly with MCOs to offer CHW/P interventions to improve the health and quality of life of their members. Reimbursement under the contracts can be structured in a variety of ways, including:

- Fee-for-Service: discrete reimbursement each time a CHW/P interacts with a member.
- Per Member Per Month: monthly fee per member for CHW/P services.
- Pay-for-Performance: opportunity to receive performance payments, such as shared savings, for savings that result from CHW/P interventions.
- Case Rate: single fee per member of all CHW/P services over a period of time.
- Working as part of a multi-disciplinary care team with an eligible rendering provider that exerts general or direct supervision, per applicable *incident to* rules.

Furthermore, both Medicare and Medicaid are recognizing the importance of integrating supportive services into reimbursement models to improve access to critical community services for beneficiaries. The following are some emerging opportunities in Medicaid and Medicare managed care.

Medicare Advantage Opportunities

Medicare introduced the following opportunities to connect MA beneficiaries with supportive services:

- "**Special Supplemental Benefits for the Chronically Ill (SSBCI)** are an expanded set of Medicare benefits that may be extended to those that are chronically ill. "SSBCI include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees."[28] On April 24, 2019, the CMS Medicare Drug and Health Contract Administration Group released a memo to all Medicare Advantage organizations with the subject line: Implementing Supplemental Benefits for

Chronically Ill Enrollees. In this memo, CMS provided a list, that is not exhaustive, of possible SSBCI benefits. The list included in this CMS memo includes the following:

- **Meals (beyond limited basis):** Existing guidance in Chapter 4 of the Medicare Managed Care Manual provides that meals are a primarily health related benefit (PBP[29] category B13c) in limited situations: when provided to enrollees for a limited period immediately following surgery, or an inpatient hospitalization, or for a limited period due to a chronic illness. In those situations, a meals supplemental benefit is permissible if the meals are: 1) needed due to an illness; 2) consistent with established medical treatment of the illness; and 3) offered for a short duration. Meals may be offered beyond a limited basis as a non-primarily health related benefit (PBP category B19b/13i) to chronically ill enrollees. Meals may be home- delivered and/or offered in a congregate setting.
- **Food and Produce**: Food and produce to assist chronically ill enrollees in meeting nutritional needs may be covered as SSBCI. Plans may include items such as (but not limited to) produce, frozen foods and canned goods. Tobacco and alcohol are not permitted.
- **Transportation for Non-Medical Needs**: Transportation to obtain non-medical items and services, such as for grocery shopping, banking and transportation related to any other SSBCI, is a non-primarily health related benefit. Such transportation may be reimbursed, arranged or directly provided by an MA plan as a SSBCI.
- **Pest Control**: Pest eradication services that are necessary to ensure the health, welfare and safety of the chronically ill enrollee. Services may include pest control treatment(s) or products that may assist the enrollee in the pest eradication (e.g., traps, pest control sprays, cleaning supplies).
- **Indoor Air Quality Equipment and Services**: Equipment and services to improve indoor air quality, such as temporary or portable air conditioning units, humidifiers, dehumidifiers, High Efficiency Particulate Air filters and carpet cleaning may be covered as SSBCI. Plans may also include installation and servicing of equipment as part of the benefit.
- **Social Needs Benefits**: Access to community or plan-sponsored programs and events to address enrollee social needs, such as non-fitness club memberships, community or social clubs, park passes, and access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function, are non-primarily health related benefits that may be covered as SSBCI.
- **Complementary Therapies**: Complementary therapies offered alongside traditional medical treatment may be offered as non-primarily health related SSBCI. Complementary therapies must be provided by practitioners who are licensed or certified, as applicable, in the state in which they practice and are furnishing services within the scope of practice defined by their licensing or certifying state. Alternative therapies that are considered primarily health related may be offered by an MA plan as a supplemental benefit in PBP category B14c.
- **Services Supporting Self-Direction**: Services supporting self-direction allow enrollees to have the responsibility for managing all aspects of health care delivery in a person-centered planning process; while such services are a non-primarily health related benefit, they may have a reasonable expectation

of improving or maintaining the health or overall function of the chronically ill enrollee. Plans may provide services to assist in the establishment of decision-making authority for health care needs (e.g., power of attorney for health services) and/or may provide education such as financial literacy classes, technology education and language classes. Interpreter services may also be provided to enrollees to facilitate encounters with health care providers. Plans may not include expenses for funerals as a covered benefit. Primarily health related education (e.g., Health Education, Medical Nutrition Therapy) that is consistent with existing guidance (see Chapter 4, section 30.3) for primarily health related supplemental benefits may be offered by an MA Plan as a supplemental benefit in PBP category B14c.

- **Structural Home Modifications**: Structural modifications to the home that may assist in the chronically ill enrollee's overall function, health or mobility are permitted if those items and services have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee (e.g., widening of hallways or doorways, permanent mobility ramps, easy-use doorknobs and faucets).
- **General Supports for Living**: General supports for living such as housing may be provided to chronically ill enrollees if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. General supports for living may be provided for a limited or extended duration as determined by the plan. The benefit may include plan-sponsored housing consultations and/or subsidies for rent or assisted living communities. Plans may also include subsidies for utilities such as gas, electric and water as part of the benefit. These benefits should be entered in Section B19b/13i of the PBP under 'Transitional Supports.'"[30]

It should be noted that many of the proposed interventions that can be included as SSBCI benefit are withing the scope of organizations that employ or deploy CHW/P services. See ***Appendix E*** for more information.

Medicaid Managed Care Opportunities

- **Medicaid In lieu of Services**: Medicaid MCOs can propose alternative services to be provided in lieu of a standard Medicaid benefit. However, an in lieu of service cannot cause an increase to utilization and is dependent on state policy. Depending on the service, CHW/Ps may be appropriate to deliver those services. See here for information on the Kansas Medicaid in lieu of policy. It is anticipated that CMS is developing guidance on Medicaid in lieu of services.

[28] www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

[29] Plan Benefit Package

[30] www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

Chapter VI: Crosswalk of Different Reimbursement Models

The Toolkit outlines a variety of different payment models existing CHW/P Organizations can leverage to build a sustainable reimbursement structure for CHW/Ps. The opportunities differ whether an organization is a health care provider, hospital or CBO. The available payment models include:

- Fee-for-Service reimbursement from Payers for discrete services provided *incident to*.
- Participation in APMs.
- Contracts with MCOs for CHW/Ps to provide supportive services to their members.

The crosswalk outlines which reimbursement opportunities are available to the various types of CHW/P organizations.

Potential Revenue Sources for CHW/Ps through Health Payers					
CHW Organization Type	**Fee-for Service Reimbursement**[31]	**Medicaid Managed Care**	**Medicare Advantage (MA)**	**ESI or Marketplace Plans**	**Medicare Alternative Payment Models (ACO models and Episode-based Payment Initiatives)**
Community-based Organization	Contract with health provider for a portion of the FFS rate of specific services billed to Payers as *incident to*	Contract for CHW/Ps to provide supportive services to enrolled managed care members CHW/Ps can offer approved in lieu of services, depending on policies as defined by the state Medicaid agency.	Contract for CHW/Ps to provide supportive services to enrolled managed care members through SSBCI or regular supplemental benefits Contract with an enrolled Medicare health provider for FFS reimbursement for *incident to*.	Contract for CHW/Ps to provide supportive services to enrolled managed care members Contract with a network health provider for FFS reimbursement for *incident to*.	Contract with ACO/ health provider for CHW/Ps to provide supportive services to attributed Medicare members Contract with participating Medicare health provider for FFS reimbursement for *incident to.*

Potential Revenue Sources for CHW/Ps through Health Payers — continued					
CHW Organization Type	**Fee-for Service Reimbursement**	**Medicaid Managed Care**	**Medicare Advantage (MA)**	**ESI or Marketplace Plans**	**Medicare Alternative Payment Models (ACO models and Episode-based Payment Initiatives)**
Federally Qualified Health Center	Bills Payers directly for health care services. Has the ability to deliver *incident to* services.	Contracts with Medicaid MCO to become a network provider and bills directly for *incident to*. Contract with Medicaid MCO for CHW/Ps to provide supportive services to members	Contracts with MA plan to become a network provider and bills directly for *incident to*. Contract for CHW/Ps to provide supportive services to enrolled managed care members through special supplemental benefits or regular supplemental benefits.	Contracts with MCO to become a network provider and bills directly for *incident to*. Contract with MCO for CHW/Ps to provide supportive services to members.	Can directly participate in Medicare APM, using either operating funds or value-based payments to cover the cost of the CHW/Ps. Contract with providers participating in VBP model for CHW/Ps to provide supportive services to attributed Medicare beneficiaries.
Hospital	Bills Payers directly for *incident to*.	Contracts with Medicaid MCO to become a network provider and bills directly for *incident to* services. Contract with Medicaid MCO for CHW/Ps to provide supportive services to members.	Contracts with MA plan to become a network provider and bills directly for *incident to* services. Contract for CHW/Ps to provide supportive services to enrolled managed care members through special supplemental benefits or regular supplemental benefits.	Contracts with MCO to become a network provider and bills directly for *incident to*. Contract with MCO for CHW/Ps to provide supportive services to members.	Can directly participate in Medicare APM, using either operating funds or value-based payments to cover the cost of the CHW/Ps. Contract with providers participating in VBP model for CHW/Ps to provide supportive services to attributed Medicare beneficiaries.

Potential Revenue Sources for CHW/Ps through Health Payers — continued					
CHW Organization Type	**Fee-for Service Reimbursement**	**Medicaid Managed Care**	**Medicare Advantage (MA)**	**ESI or Marketplace Plans**	**Medicare Alternative Payment Models (ACO models and Episode-based Payment Initiatives)**
Individual Health Provider or health practice	Bills Payers directly for *incident to*.	Contracts with MCOs to provide services. Could provide Managed Care members access to CHW/P by contract. Contracts with Medicaid MCO to become a network provider and bills directly for *incident to*.	Contracts with MA plan to become a network provider and bills directly for *incident to*. Contract for CHW/Ps to provide supportive services to enrolled managed care members through special supplemental benefits or regular supplemental benefits.	Contracts with MCO to become a network provider and bills directly for *incident to*. Contract with MCO for CHW/Ps to provide supportive services to members	Can directly participate in Medicare APM, using either operating funds or value-based payments to cover the cost of the CHW/Ps. Contract with providers participating in VBP model for CHW/Ps to provide supportive services to attributed Medicare beneficiaries.

[31] Health providers can bill various Payers through FFS mechanisms including Medicaid, Original Medicare, Medicaid Managed Care Organizations, Medicare Advantage, Health Insurance Exchange Plans, or Employer-sponsored Insurance.

Chapter VII: Developing a Contract Capture Strategy

In the CMS Innovation Center Strategy Refresh,[32] the CMS Innovation Center established the following goals:

- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

Given the recent Strategy Refresh announced by CMS, there is increasing adoption of value-based programs and APMs by health care organizations, including health plans, Medicaid MCOs, health systems and health care providers. When the hospital and participating providers accept risk for poor health outcomes and increased health care utilization in an alternative payment model, there are clear financial incentives to adopt a multi-disciplinary approach to addressing the whole-person care needs of the target population. As participating providers accept more risk, they will have a direct financial incentive to ensure that they achieve the likely desired outcome (quality + financial outcomes).

This section outlines how a CHW/P organization — whether a health care provider, supplier, CBO or Community Care Hub — can develop and deploy a contract capture strategy with a hospital, health system or MCO participating in an APM. These models represent a growing opportunity for CHW/P organizations to capture new revenue sources to sustain the CHW/Ps in their organizations. The nature of the VBP reimbursement structure is also conducive to CHW/P scope of work, as it allows for a more flexible reimbursement structure supportive of the broad CHW/P scope of practice.

Incentive for Hospital or Health System

When hospitals enter risk-bearing VBP models or advanced APMs, they have a renewed financial interest in reducing the likelihood of readmissions and lowering the total cost of care because of potential financial penalties related to increased cost for the target population. Many APMs are extending beyond hospital readmissions and focusing on total cost of care that include all services rendered during a defined period of time. The financial risk of VBP models or Advanced APMs is an incentive to redesign the model of care and extend resources into community settings to curtail the trajectory of costs for vulnerable populations.

An organization, such as a CHW/P organization or Community Care Hub, that also has a proven track record of demonstrating positive results in addressing HRSN and supporting health equity goals will be an essential asset to hospitals, health care providers or health plans that participate in a VBP model or implement an Advanced APM. CHW/P organizations that can demonstrate this effectiveness and deliver consistent results have an opportunity to contract directly with participating hospitals to provide, for example, care transitions services. Essential components of establishing the value of the services rendered to address HRSN or health equity goals include clearly defining the proposed interventions, referral process, market segmentation strategy to enroll the target population, method of tracking intervention deployment, evaluating the impact of deployed interventions and closed-loop reporting.

Negotiating to Participate in Alternative Payment Models

Health care contracting is very different from operating grant-based health improvement programs. For many non-profit and/or local government supported community agencies, successful health care delivery contracting often requires changing systems, processes and enduring a complete culture change. An optimal contracting model is critical to support CHW/P organizations and lay the groundwork to receive reimbursement from multiple Payers in a defined market.

A successful contract capture strategy includes defining the CHW/P intervention, establishing the delivery model, assessing the ROI for the intervention and implementing a defined quality assurance and continuous quality improvement program to ensure that the intervention can deliver on the defined ROI with documented improvements to the intervention over time.

When negotiating directly with a participating health system, health care provider organization or health plan, the CHW/P organization should clearly define:

- the target population identified through a market analysis,
- the services/intervention to be rendered,
- referral process,
- segmentation strategy to enroll the target population,
- expected outcomes and the CHW/P organization's value proposition,
- method of tracking intervention deployment/closed look reporting,
- method of evaluating the impact of deployed interventions, and
- payment terms, including the level of risk your organization is willing to take.

Maintaining a contract with a health care organization will be contingent upon the CHW/P organization's ability to provide high quality services, meet the expected outcomes and share meaningful data on beneficiaries — individually and in aggregate. CHW/P organizations should continuously seek to secure additional contract opportunities to ensure long-term sustainability through the deployment of a multi-payer strategy and tracking the Payer mix (percentage of revenue earned from each Payer type) to ensure that there is a balanced revenue capture strategy supported by multiple Payers.

Understanding the Target Population

Market segmentation is the process of targeting services to a segment of the population for purposes of delivering services to beneficiaries that have a greater need or desire to utilize the service being offered.

By segmenting the population, the CHW/P organization provides greater clarity on the population types that will benefit the most from the intervention and have the greatest potential ROI. Below is an example of how to identify target populations that have the greatest need for CHW/P intervention in a VBP model.

Example: Identifying a Target Population for Care Transitions

Certain populations have a higher risk of hospital readmission than other populations. Targeting care transition interventions to populations that have the highest risk of readmission will lead to improved health outcomes, increased efficiency in service delivery, greater return on investment results, and potentially increased referral volume. By targeting services to a specific target population, you can focus the hospital or health system on identifying all members of that target population and establishing a definitive referral process for a discharge-based care transition intervention.

According to the CMS Chartbook 2017 data,[33] the population with the greatest risk of hospital readmission and the highest per capita costs to the Medicare program are persons with 4+/6+ chronic conditions:

- 81% - Persons with 6+ chronic conditions.
- 13% - Persons with 4+ chronic conditions.
    - Combined: 94% of readmissions are for persons with 4+/6+ chronic conditions.

In this case, a CHW/P organization can market its CHW/P interventions to assist with care transitions from hospitalizations back to the community for the hospital or health system's highest risk Medicare population and aim to help the hospital or health system reduce its overall hospital readmission rate and reduce costs.

Quality Assurance and Return on Investment

An essential component of contract capture strategy is continuous quality improvement (CQI) and quality assurance (QA). QA is a method to assess process and outcome measures for a program. CQI is the identification of areas that require quality improvement and the implementation of strategies to address areas that require quality improvement, based on the objective QA process.

Carrying forward the above example, for a CHW/P intervention to address HRSN for a target population, the CHW/P organization should implement both CQI and QA programs, track and report this data internally, and share the information with relevant stakeholders. QA metrics that inform CQI should include both process and outcome measures.

Examples of process and outcome measure categories, which can vary based on implementation model, include:

- Outreach and engagement effectiveness.
- Timeliness of completing an enrollment.
- Comprehensive HRSN screening monitoring.
- Rank order of identified needs for the target population.
- Availability of resources to address HRSN based on the priority of needs among the target population.
- Percentage of participants that complete the defined intervention.
- Time period between identification of HRSN factors and date that an intervention was deployed to address an identified HRSN need.
- Percentage of participants that refuse participation.
- Pre- and Post-utilization regarding total cost of care of enrolled participants.
- Closed loop reporting percentage.

QA measures should be tracked and reported at defined intervals, preferably monthly. CHW/P organizations should develop quality improvement interventions aimed at improving the defined QA metrics, as needed, and having transparency in monitoring and reporting objective outcomes.

The purpose of the CQI is to determine opportunities for improvement using a written plan that describes and documents a systematic review of the entities' process and outcome data, for example, a Plan, Do, Study, Act process improvement cycle.

Checklists for Negotiation and Contracting

Appendices F-K provide tools and checklists for CHW/P organizations to develop proposals and negotiate contracts with Payers and health care organizations to deploy CHW/P interventions for reimbursement.

- ***Appendix F:*** **Steps to Completing a Market Analysis**
- ***Appendix G:*** **Steps to Determining Your Value Proposition**
- ***Appendix H:*** **General Payer Contract Negotiation Checklist**
- ***Appendix I:*** **Managed Care Organization Negotiation Checklist**
- ***Appendix J:*** **Steps to Accountable Care Organizations Negotiations**
- ***Appendix K:*** **Steps to BPCI-A (Bundled Payment) Negotiations**

[32] https://innovation.cms.gov/strategic-direction-whitepaper

[33] 2017 Medicare Current Beneficiary Survey Annual Chartbook and Slides | CMS

Appendix A: Glossary of Terms

1. **Alternative Payment Models**: An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.[34]
2. Advanced Alternative Payment Models: APMs, in Medicare, offer a 5% incentive for achieving threshold levels of payments or patients through Advanced APMs.[35]
3. **Chronic Care Management**: Under the Medicare physician fee schedule, CMS reimburses for chronic care management (CCM) services as a component of primacy care. CCM services, provided to individuals with multiple chronic conditions, include the following core service elements: initiating visit, structured recording of patient information using certified electronic health record technology, 24/7 access and continuity of care, comprehensive care management, comprehensive care plan, management of care transitions, home and community-based care coordination, enhanced communication opportunities, patient consent to participation in CCM, and medical decision-making.[36]
4. **Community Care Hub**: A Community Care Hub is a lead entity that implements and supports a network of CBOs through centralized administration, financial management, sourcing Payer contracts/revenues for the network, quality assurance activities and governance.
5. **Employer-sponsored Insurance**: Employer-sponsored Health Insurance is a health care plan, typically through a managed care organization, that employers provide for the company's workforce and their dependents. The employer chooses the plan, determining what it covers. Employers and employees typically share the cost of health insurance premiums.[37]
6. **Fee-for-Service**: "A method in which doctors and other health care providers are paid for each service performed."[38]
7. **Health Care Provider**: In this Toolkit, we use this term to refer broadly to providers of health care services, including, for example, a doctor, dentist, chiropractor, podiatrist, clinical psychologist, optometrist or nurse practitioner, who are authorized to practice in a state and performs within the scope of their practice as defined by state law.
8. **Health Plan**: In this Toolkit we use this term to refer broadly to an organization that arranges and pays for health care services on behalf of individuals.
9. **Health-related Social Needs**: Health-Related Social Needs (HRSN) are factors that have an immediate adverse impact on health outcomes or management of chronic disease, such as access to healthy food, secure housing, or health care.
10. **Managed Care Organization**: A Managed Care Organization (MCO) is a health plan that manages the cost, utilization and quality of health care services delivered to its members. In Medicaid, state health agencies contract with MCOs to provide for the delivery of Medicaid health benefits and additional services for which they pay the MCO a set per member per month (capitation) payment for these services.[39] In Medicare, CMS contracts with MCOs (Medicare Advantage plans) to provide for the delivery of Medicare benefits to Medicare enrollees, including Part D coverage in many cases.[40]

11. **Medical Loss Ratio**: The Affordable Care Act requires that managed care organizations (MCOs) spend at least 85% of their revenues on medical care and no more than 15% on administrative activities.
12. **Medicare:** Medicare is a national health care program that provides health coverage for people 65 and older; people under 65 with certain disabilities; or people of any age with end-stage renal disease (ESRD)/ permanent kidney failure requiring dialysis or a kidney transplant. It consists of four parts of Medicare health care benefits:
    a. **Part A**: Covers inpatient hospital, skilled nursing facility care, home health and hospice.
    b. **Part B**: Covers doctor services, medical office visits, screenings, therapy, preventive services, outpatient services, emergency care, ambulance care, medical supplies and durable medical equipment.
    c. **Part C**: Medicare Advantage — Medicare benefits are delivered through a managed care organizations called Medicare Advantage (MA) plan. All MA plans must cover all Part A and Part B services.
    d. **Part D**: Prescription pharmacy benefits.
13. **Rendering Health Care Provider**: This term refers to the health provider that delivers the service to an individual.
14. **Social Drivers of Health**: The environments where people are born, live, learn, work, play and worship that affect health and quality of life outcomes.[41]
15. **Special Supplemental Benefits for the Chronically Ill (SSBCI)**: An expanded set of Medicare benefits that may be extended to those that are chronically ill. "SSBCI include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees."[42]
16. **Transitional Care Management (TCM)**: In Medicare, transitional care management is services that are offered for 30 days when an individual is discharged from a hospital inpatient stay. These services are designed to help a patient transition back to a community setting after a stay at certain facility types.[43]
17. **Value-based care**: A system of payment for health care services that prioritizes quality of care provided over the number of discrete services delivered by a health provider.

[34] https://qpp.cms.gov/apms/overview

[35] Ibid.

[36] www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

[37] www.edenhealth.com/blog/employer-sponsored-health-insurance/#:~:text=Employer%2DSponsored%20Health%20Insurance%20is,cost%20of%20health%20insurance%20premiums

[38] www.healthcare.gov/glossary/fee-for-service/

[39] www.medicaid.gov/medicaid/managed-care/index.html

[40] www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans

[41] https://health.gov/healthypeople/priority-areas/social-determinants-health

[42] www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

[43] www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Appendix B: Medicare Advantage Plan Market Share Analysis

Purpose:

The Centers for Medicare and Medicaid Services (CMS) provides monthly data on Medicare Advantage enrollment in the United States by county. This tip sheet provides an overview on how to conduct a market analysis to determine the top Medicare Advantage plans, by enrollment in a specific county

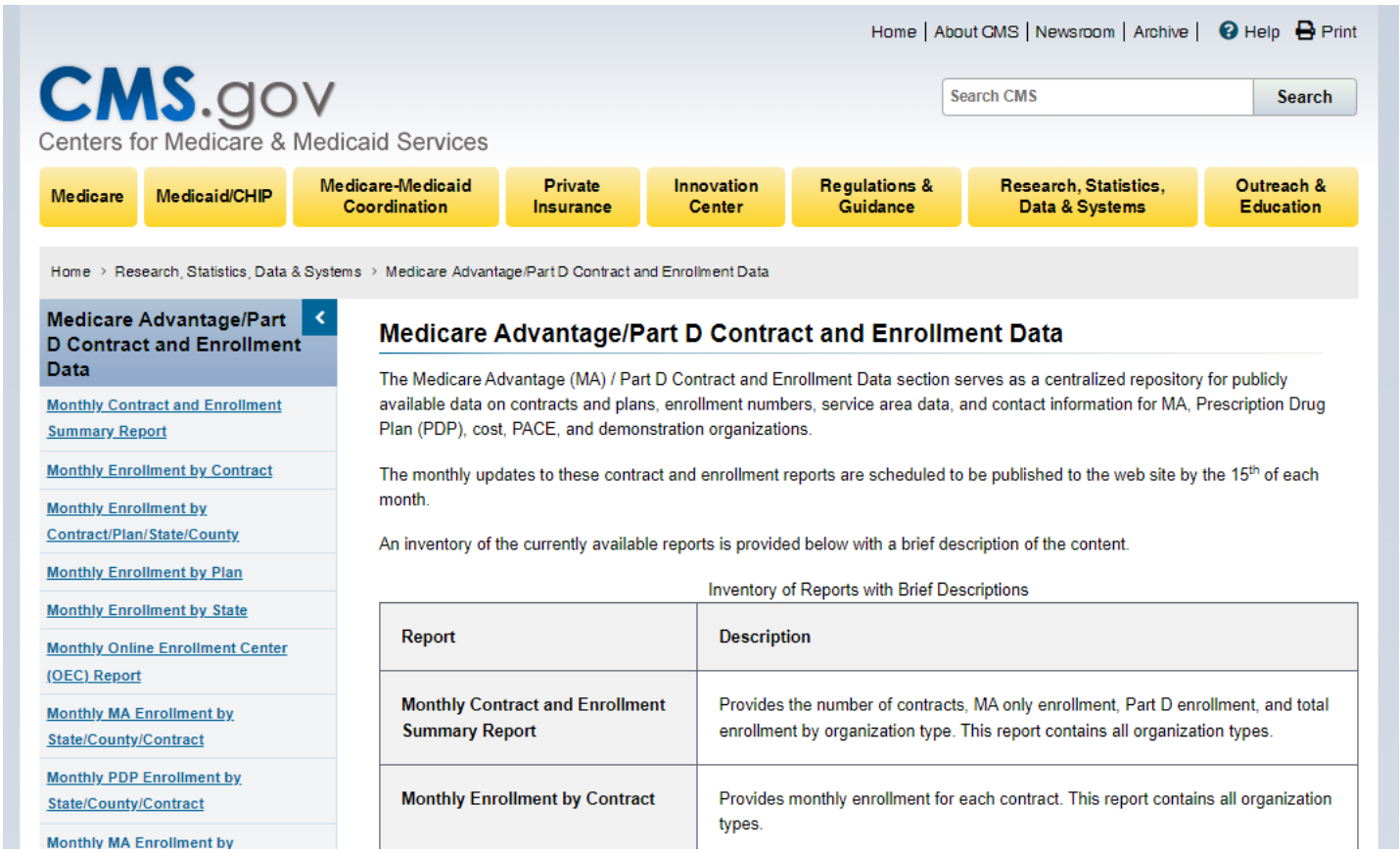
Background:

Medicare Advantage, also known as Medicare Part C, provides an option for Medicare beneficiaries to enroll in a managed care plan to administer their Medicare benefits. Medicare Advantage (MA) plans have different levels of market share depending on the specific market. If a community-based organization (CBO) wishes to provide reimbursable services to a beneficiary that is enrolled in an MA plan, then the organization must contract directly with the Medicare Advantage plan prior to initiating services for the target population.

Procedure:

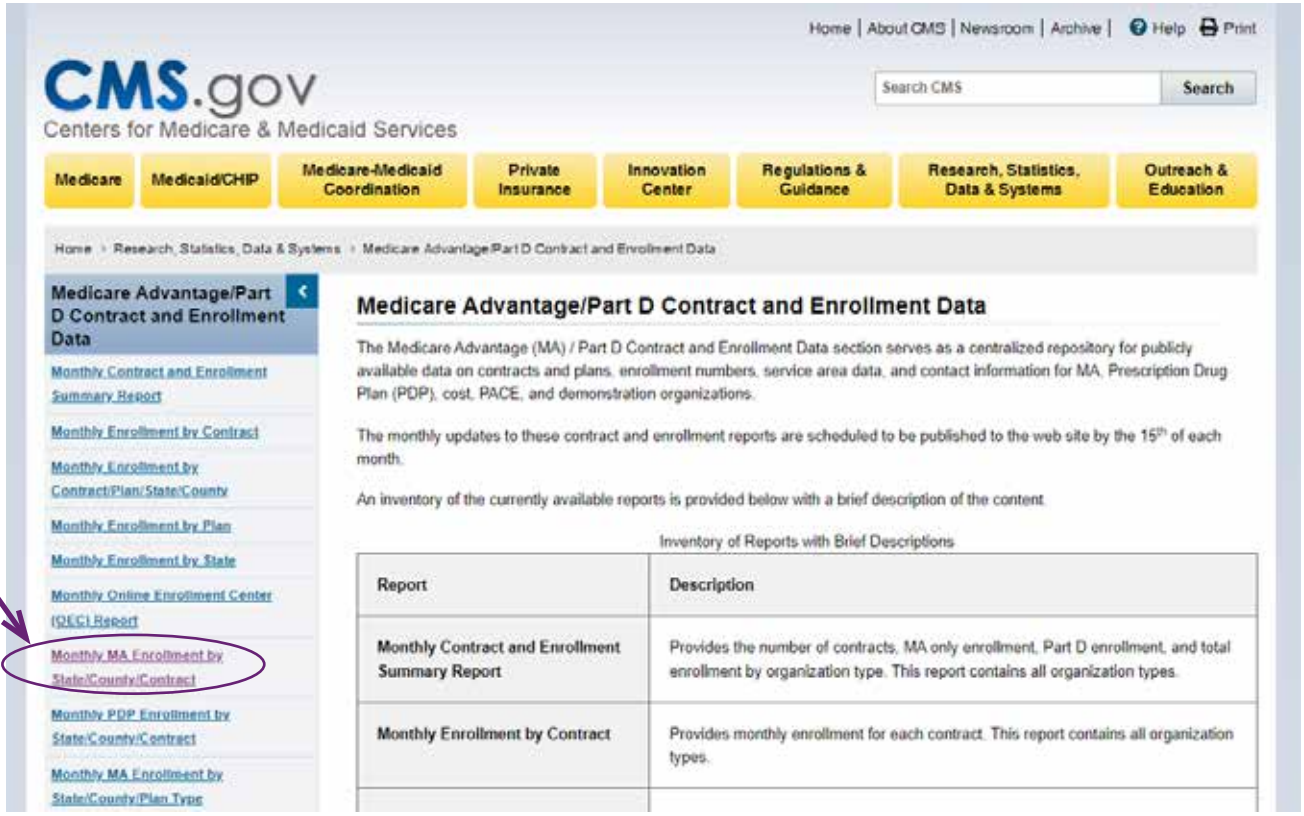
1. First, access the CMS website dedicated to providing Medicare Advantage plan and Medicare Part D enrollment using the following link:
   https://www.cms.gov/MCRAdvPartDEnrolData/01_Overview.asp#TopOfPage

   The following screenshot shows the CMS webpage that is accessed using the link above:



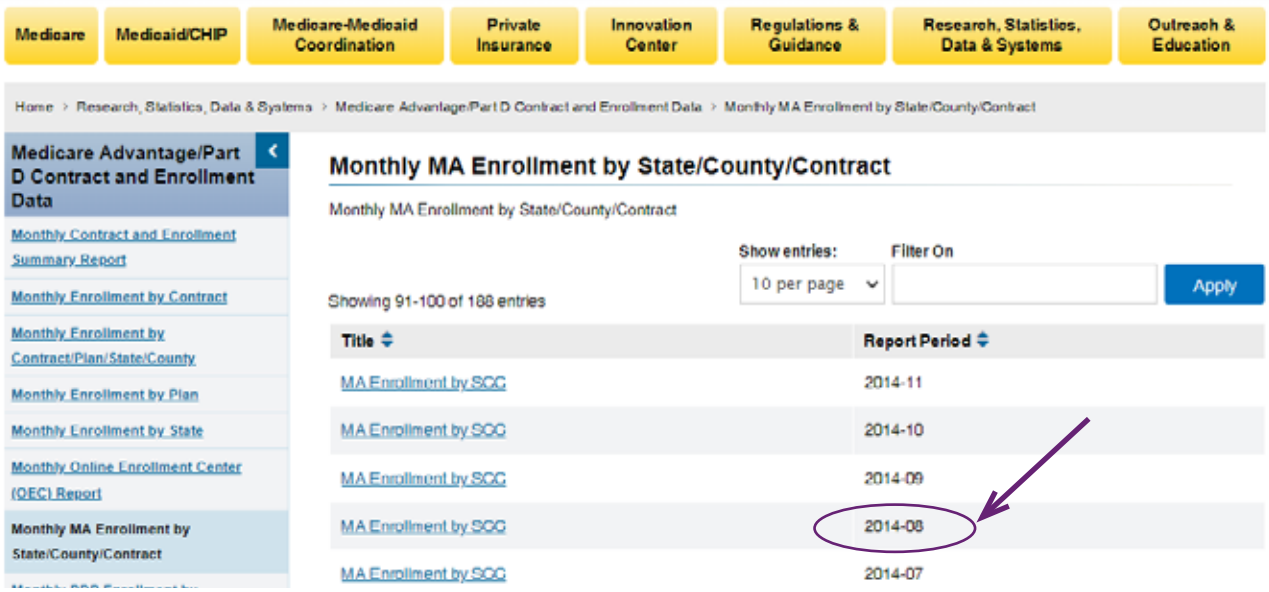
2. Once at the webpage, you will see a series of options along the left side of the page. In order to determine the Medicare Advantage penetration numbers in the requested county, you will access the following table:

   Monthly_MA_Enrollment_by_State/County/Contract

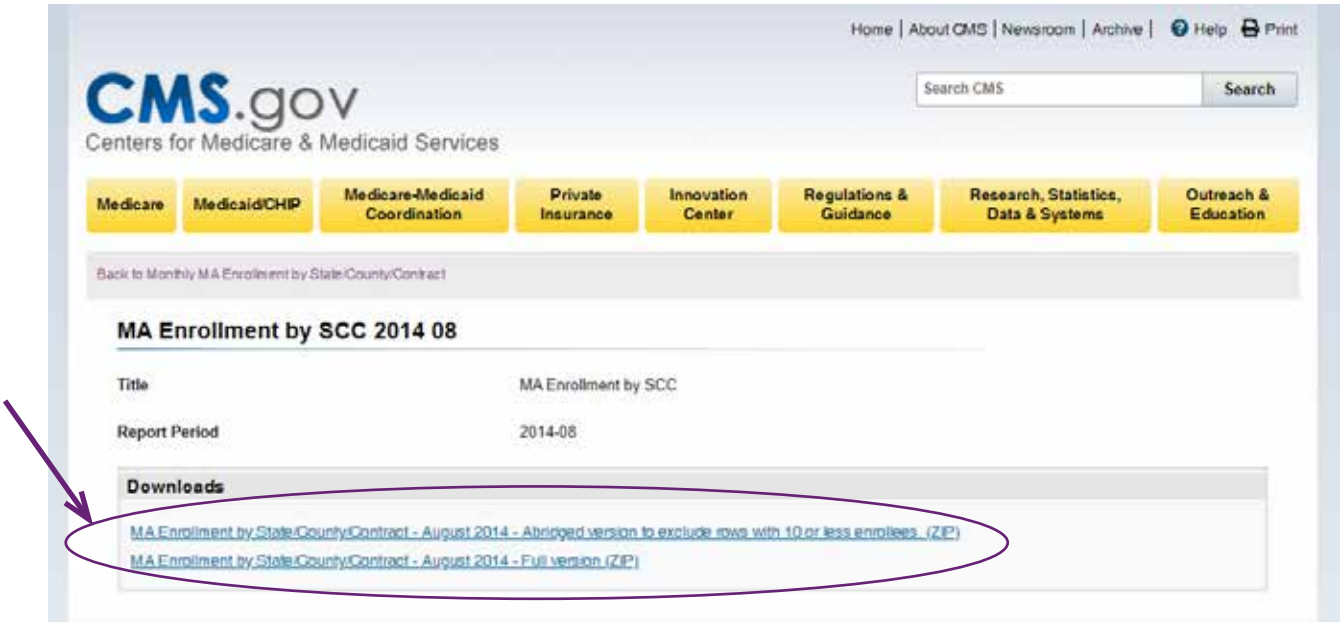


3. When you click on the link to Monthly_MA_Enrollment_by_State/County/Contract you will note that there is a listing of available files. The available files are listed by month.

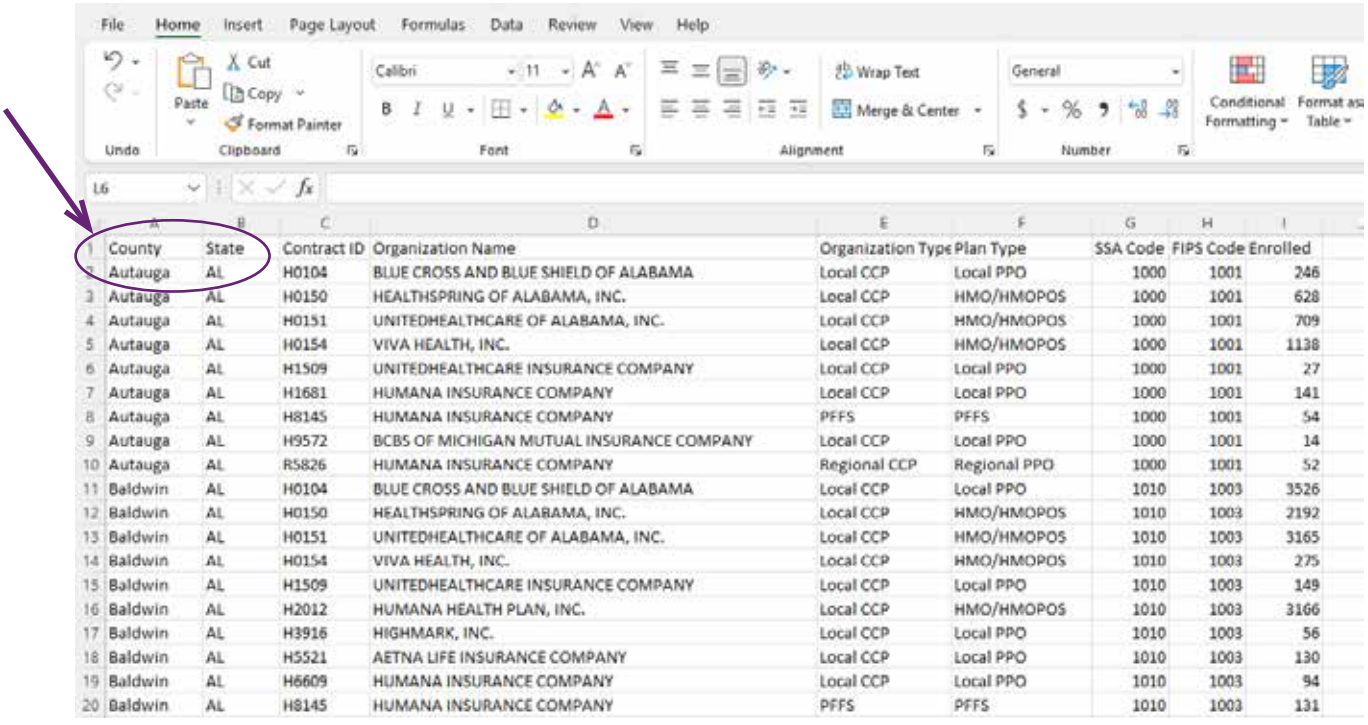
   The following screenshot shows the CMS webpage listing available files listed in chronological order using based on date (YYYY-MM):



4. Identify the month for which you would like to view the MA plan enrollment data.
5. When you click on this link you will be prompted to download a CSV File. When prompted, accept the request to download the requested file. NOTE: Choose the "Abridged" file to filter out any plan with fewer than 10 enrollees.



6. Open the downloaded file.
7. When you open the downloaded file, you will note that it is a large file and that the data is categorized in alphabetical order by county and then by state.
8. Scroll to the state and county that you wish to analyze.

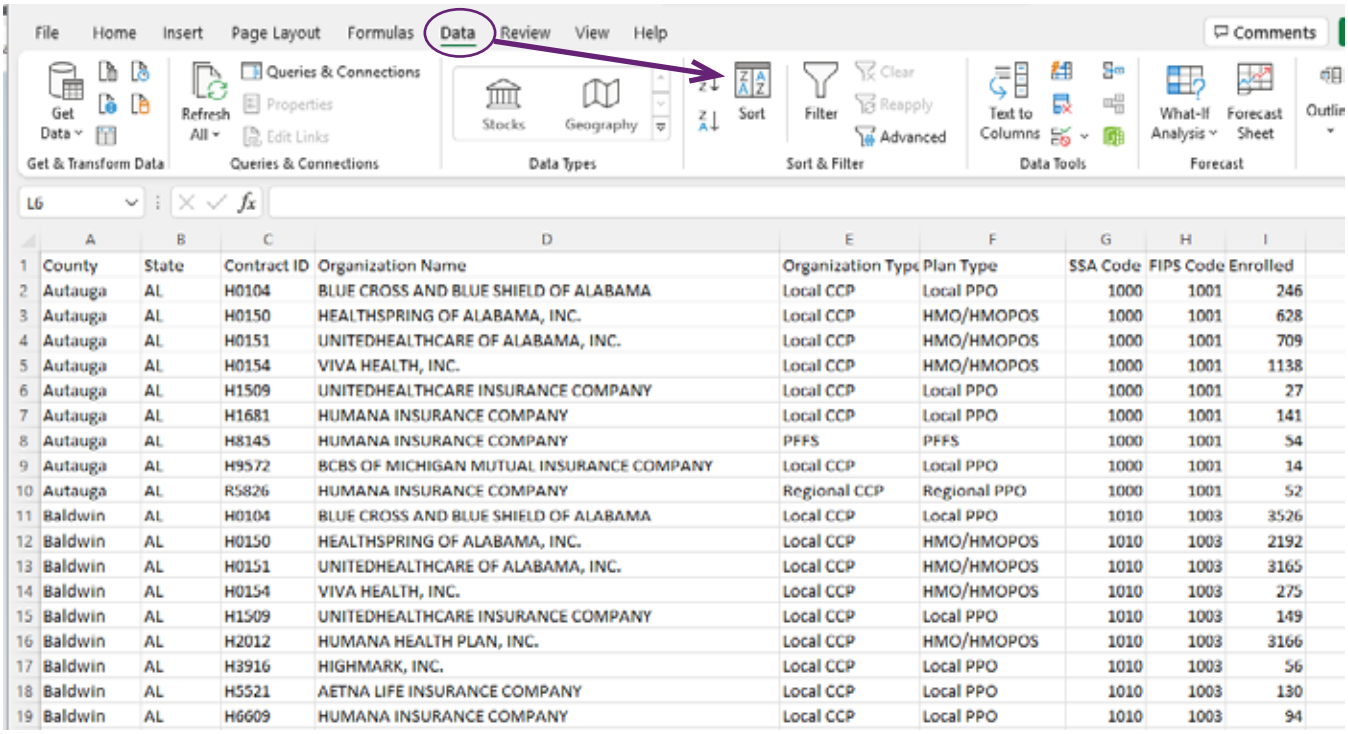


	A	B	C	D	E	F	G	H	I
1	County	State	Contract ID	Organization Name	Organization Type	Plan Type	SSA Code	FIPS Code	Enrolled
2	Autauga	AL	H0104	BLUE CROSS AND BLUE SHIELD OF ALABAMA	Local CCP	Local PPO	1000	1001	246
3	Autauga	AL	H0150	HEALTHSPRING OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1000	1001	628
4	Autauga	AL	H0151	UNITEDHEALTHCARE OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1000	1001	709
5	Autauga	AL	H0154	VIVA HEALTH, INC.	Local CCP	HMO/HMOPOS	1000	1001	1138
6	Autauga	AL	H1509	UNITEDHEALTHCARE INSURANCE COMPANY	Local CCP	Local PPO	1000	1001	27
7	Autauga	AL	H1681	HUMANA INSURANCE COMPANY	Local CCP	Local PPO	1000	1001	141
8	Autauga	AL	H8145	HUMANA INSURANCE COMPANY	PFFS	PFFS	1000	1001	54
9	Autauga	AL	H9572	BCBS OF MICHIGAN MUTUAL INSURANCE COMPANY	Local CCP	Local PPO	1000	1001	14
10	Autauga	AL	R5826	HUMANA INSURANCE COMPANY	Regional CCP	Regional PPO	1000	1001	52
11	Baldwin	AL	H0104	BLUE CROSS AND BLUE SHIELD OF ALABAMA	Local CCP	Local PPO	1010	1003	3526
12	Baldwin	AL	H0150	HEALTHSPRING OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1010	1003	2192
13	Baldwin	AL	H0151	UNITEDHEALTHCARE OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1010	1003	3165
14	Baldwin	AL	H0154	VIVA HEALTH, INC.	Local CCP	HMO/HMOPOS	1010	1003	275
15	Baldwin	AL	H1509	UNITEDHEALTHCARE INSURANCE COMPANY	Local CCP	Local PPO	1010	1003	149
16	Baldwin	AL	H2012	HUMANA HEALTH PLAN, INC.	Local CCP	HMO/HMOPOS	1010	1003	3166
17	Baldwin	AL	H3916	HIGHMARK, INC.	Local CCP	Local PPO	1010	1003	56
18	Baldwin	AL	H5521	AETNA LIFE INSURANCE COMPANY	Local CCP	Local PPO	1010	1003	130
19	Baldwin	AL	H6609	HUMANA INSURANCE COMPANY	Local CCP	Local PPO	1010	1003	94
20	Baldwin	AL	H8145	HUMANA INSURANCE COMPANY	PFFS	PFFS	1010	1003	131

9. Scroll across the table to determine the key data elements for the market you are analyzing. When you identify the reference county, sort the list by the Enrolled column (the number of persons enrolled in each MA plan).

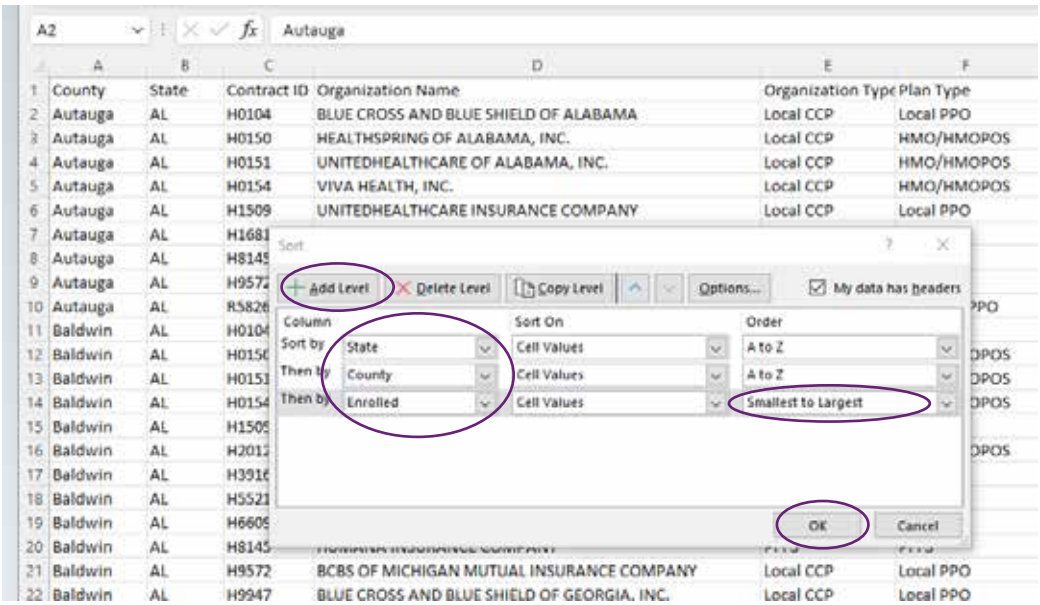
   Example:
   The process for sorting and analyzing MA Plan enrollment by county is as follows:

   1. Sort the data using the following commands.
      a. Select "Data" from the Menu bar.
      b. On the Data menu, select "Sort."



	A	B	C	D	E	F	G	H	I
1	County	State	Contract ID	Organization Name	Organization Type	Plan Type	SSA Code	FIPS Code	Enrolled
2	Autauga	AL	H0104	BLUE CROSS AND BLUE SHIELD OF ALABAMA	Local CCP	Local PPO	1000	1001	246
3	Autauga	AL	H0150	HEALTHSPRING OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1000	1001	628
4	Autauga	AL	H0151	UNITEDHEALTHCARE OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1000	1001	709
5	Autauga	AL	H0154	VIVA HEALTH, INC.	Local CCP	HMO/HMOPOS	1000	1001	1138
6	Autauga	AL	H1509	UNITEDHEALTHCARE INSURANCE COMPANY	Local CCP	Local PPO	1000	1001	27
7	Autauga	AL	H1681	HUMANA INSURANCE COMPANY	Local CCP	Local PPO	1000	1001	141
8	Autauga	AL	H8145	HUMANA INSURANCE COMPANY	PFFS	PFFS	1000	1001	54
9	Autauga	AL	H9572	BCBS OF MICHIGAN MUTUAL INSURANCE COMPANY	Local CCP	Local PPO	1000	1001	14
10	Autauga	AL	R5826	HUMANA INSURANCE COMPANY	Regional CCP	Regional PPO	1000	1001	52
11	Baldwin	AL	H0104	BLUE CROSS AND BLUE SHIELD OF ALABAMA	Local CCP	Local PPO	1010	1003	3526
12	Baldwin	AL	H0150	HEALTHSPRING OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1010	1003	2192
13	Baldwin	AL	H0151	UNITEDHEALTHCARE OF ALABAMA, INC.	Local CCP	HMO/HMOPOS	1010	1003	3165
14	Baldwin	AL	H0154	VIVA HEALTH, INC.	Local CCP	HMO/HMOPOS	1010	1003	275
15	Baldwin	AL	H1509	UNITEDHEALTHCARE INSURANCE COMPANY	Local CCP	Local PPO	1010	1003	149
16	Baldwin	AL	H2012	HUMANA HEALTH PLAN, INC.	Local CCP	HMO/HMOPOS	1010	1003	3166
17	Baldwin	AL	H3916	HIGHMARK, INC.	Local CCP	Local PPO	1010	1003	56
18	Baldwin	AL	H5521	AETNA LIFE INSURANCE COMPANY	Local CCP	Local PPO	1010	1003	130
19	Baldwin	AL	H6609	HUMANA INSURANCE COMPANY	Local CCP	Local PPO	1010	1003	94

2. Once you have selected the Sort command, you can customize your Sort.
3. Click "Add Level" then choose "State" from the drop down menu.
4. Click "Add Level" again, then choose "County" from the drop down menu.
5. Click "Add Level" again, then choose "Enrolled" from the drop down menu. Select "Smallest to Largest" in the "Order" drop down menu.
6. Click "OK."



7. Once the list is sorted by state, by county, and then by enrollment, scroll to the appropriate county and assess the plans by enrollment number rankings.

   Example:
   Dallas County, Texas, (August 2014): Top Five MA Plans by Enrollment
   1. United Healthcare Benefits of Texas, Inc. (HMO): 41,165
   2. Aetna Life Insurance Company (PPO): 7,091
   3. Wellcare of Texas, Inc. (HMO): 5,013
   4. Aetna Health, Inc. (HMO): 5,005
   5. Humana Health Plan of Texas, Inc. (HMO): 4,863

	A	B	C	D	E	F	G	H	I
1	County	State	Contract I	Organization Name	Organization Ty	Plan Type	SSA Code	FIPS Code	Enrolled
19694	Dallas	TX	H4510	HUMANA HEALTH PLAN OF TEXAS, INC.	Local CCP	HMO/HMOPOS	45390	48113	4863
19695	Dallas	TX	H4523	AETNA HEALTH, INC. (TX)	Local CCP	HMO/HMOPOS	45390	48113	5005
19696	Dallas	TX	H1264	WELLCARE OF TEXAS, INC.	Local CCP	HMO/HMOPOS	45390	48113	5013
19697	Dallas	TX	H4524	AETNA LIFE INSURANCE COMPANY	Local CCP	Local PPO	45390	48113	7091
19698	Dallas	TX	H4590	UNITEDHEALTHCARE BENEFITS OF TEXAS, INC.	Local CCP	HMO/HMOPOS	45390	48113	41165

Utility of the Data:
This enrollment data provides insight into which MA plan has the largest market share in a particular county. This data can help a CBO develop a contracting strategy for their particular market. In the Dallas, Texas, example, the local CBO could place their focus on working with United Healthcare MA plan because they have the overwhelming majority of the local market share.

Appendix C: Categories of Service for Multi-disciplinary Care Teams with CHW/Ps

Reference CMS Medicare Learning Network Guides that detail full service descriptions, regulatory requirements associated with each service, and associated billing codes.

Note: CMS periodically updates links and the learning guides. The links and guides listed below are current as of September 2022 and are also available at www.marc.org/aging-health/community-health-workers/chw-toolkit.

Service Description		Comments
Transitional Care Management 7-days, High Complexity	Reference: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf	Care Transitions Intervention including a face-to-face visit, within 7 days of discharge, with a medical provider, medication review, and assessment of SDOH with a plan to address identified needs. Approved for Telehealth.
Transitional Care Management 14-days, Moderate Complexity		Care Transitions Intervention including a face-to-face visit, within 14 days of discharge, with a medical provider, medication review, and assessment of SDOH with a plan to address identified needs. Approved for Telehealth.
Diabetes Self-Management Training (DSMT Individual)	Reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DSMT-Fact-Sheet-909381.pdf	Diabetes Self-Management Training individual. Billed in 30-minute increments.
Diabetes Self-Management Training (DSMT Individual)		Diabetes Self-Management Training group. Billed in 30-minute increments.
Medical Nutrition Therapy (MNT Individual)	CDC DSMT Toolkit Available online at https://www.cdc.gov/diabetes/dsmes-Toolkit/index.html	Nutrition counseling. Individual. Billed in 15-minute increments.
Medical Nutrition Therapy (MNT Individual)		Nutrition counseling. Group. Billed in 30-minute increments.
Diabetes Prevention Program (DPP)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MDPP-MLN34893002.pdf	Risk based payment model based on weight loss.
Chronic Care Management		
CCM - Initial Plan of Care	Reference: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf	Person-centered planning based on an assessment of the medical, behavioral and social needs.
CCM - First 20 minutes per calendar month		Non-Complex (Initial 20 minutes) Care coordination and case management services based on a person-centered plan to address medical, behavioral and social needs.
CCM, Non-complex, each additional 20 minutes		Non-Complex (Additional 20 minutes each) Care coordination and case management services based on a person-centered plan to address medical, behavioral and social needs.
Complex CCM		Complex (Initial 60 minutes) Care coordination and case management services based on a person-centered plan to address medical, behavioral and social needs.
Complex CCM additional 30 minutes		Complex (Additional 30 minutes) Care coordination and case management services based on a person-centered plan to address medical, behavioral and social needs.

Behavioral Health Integration		
General Behavioral Health Care Management	Reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf	Evidence-based behavioral health intervention that is integrated with primary care. Billed for 20 minutes of an intervention delivered during a calendar month.
Collaborative Care Management - Initial (70 minutes)		Team-based care coordination services to address a behavioral health condition. Team includes behavioral health coach, consulting psychiatrist and medical provider.
Collaborative Care Management - Ongoing (60 minutes)		Team-based care coordination services to address a behavioral health condition. Team includes behavioral health coach, consulting psychiatrist and medical provider.
Disease Self-Management Supports		
Health Behavior Assessment or Reassessment (Untimed Code)	Reference: https://www.ncoa.org/article/information-resource-health-and-behavior-assessment-and-intervention-hbai-services	Assessment or reassessment of disease self-management support needs. Not used for mental health services. Services are meant to help patients cope with or manage physical health conditions.
Health Behavior Assessment/Intervention (HBAI) - Individual. First 30 minutes		Individual disease-self management training and supports. Not used for mental health services. Services are meant to help patients cope with or manage physical health conditions.
Health Behavior Assessment/Intervention (HBAI) - Individual. Each additional 15 minutes		Individual disease-self management training and supports. Not used for mental health services. Services are meant to help patients cope with or manage physical health conditions.
Health Behavior Assessment/Intervention (HBAI) - Group. First 30 minutes		Group (2+ participants) disease self-management training and supports. Not used for mental health services. Services are meant to help patients cope with or manage physical health conditions.
Health Behavior Assessment/Intervention (HBAI) - Group. Each additional 15 minutes		Group (2+ participants) disease self-management training and supports. Not used for mental health services. Services are meant to help patients cope with or manage physical health conditions.
MIscellaneous		
Depression Screen	G0444	Annual Depression screening
Alcohol / SUD Misuse Screen	G0442	Alcohol / SUD screen
Cognitive Functioning Assessment for Cognitive Decline	Reference: https://www.cms.gov/files/document/cognitive-assessment-care-plan-services-cpt-code-99483.pdf https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf	Comprehensive cognitive assessment and person-centered plan for a beneficiary with any level of cognitive decline.
Advanced Care Planning. First 30 Minutes		Face-to-face meeting to discuss the patient's health care wishes, medical treatment preferences and establish an end-of-life plan.
Advanced Care Planning. Each additional 30 Minutes		Face-to-face meeting to discuss the patient's health care wishes, medical treatment preferences and establish an end-of-life plan.

Annual Wellness Visit (Initial)	G0438 G0439 Reference https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html	Visit to develop a personalized prevention plan and perform a health risk assessment.
Annual Wellness Visit (Subsequent)		Visit to update a personalized prevention plan and perform a health risk assessment.
Preventive Medicine, Individual Counseling	References: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html	Preventive Health Services, rendered by a qualified provider. Services are incorporated into the Evaluation/Management service set.
Preventive Medicine, Individual Counseling		Preventive Health Services, rendered by a qualified provider. Services are incorporated into the Evaluation/Management service set.
Preventive Medicine, Individual Counseling		Preventive Health Services, rendered by a qualified provider. Services are incorporated into the Evaluation/Management service set.
Preventive Medicine, Individual Counseling		Preventive Health Services, rendered by a qualified provider. Services are incorporated into the Evaluation/Management service set.
Preventive Medicine, Individual Counseling		Preventive Health Services, rendered by a qualified provider. Services are incorporated into the Evaluation/Management service set.
*Rates reflected here are the Medicare National Rates. Actual rates are subject to local market variation.		

Service Description	HCPCS	Comments
Special Supplemental Benefits for the Chronically Ill (SSBCI)		
Home delivered prepared meal: In-person delivery		Disease-specific or Mechanically Altered meal program for persons with one or more chronic conditions, recent surgery, or impaired ability to eat due to stroke — delivered in-person.
Home delivered prepared meal: Drop ship frozen		Disease-specific or Mechanically Altered meal program for persons with one or more chronic conditions, recent surgery or impaired ability to eat due to stroke — delivered by UPS or other drop-ship method.
Nutritional Engagement		Nutrition classes, non-physician provider, per session.
Health Promotion Course delivered by a non-physician		Patient Education, not otherwise classified, non-physician provider, individual, per session (CDSME, Falls Prevention, etc.).
Grocery Incentive-upon completion of Health Promotion Course		CDSME, falls, health coaching, etc.
Supplemental Nutritional Shake or other meal supplement	T5999	Code definition: Supply, not otherwise specified
Home Care Training, All-inclusive Care Transitions/Post-Discharge social service care coordination.		Post discharge assessment and care plan to address SDOH, and disease self-management support needs.
Home Care Training, All-inclusive Care Transitions/Post-Discharge Service (care management, medication review, and health promotion course).		All-inclusive interventions based on person-centered plan (care management, medication review and health promotion course) to provide social service care coordination and disease self-management supports.
Social Isolation Intervention: Evidence-based or Evidence-Informed Intervention to address social isolation or loneliness impacting health outcomes.		CPT definition: Not medically necessary service.
*Rates are determined at the time of contract negotiation.		

Benefit Enhancements Approved for Participant Providers in a CMMI Advanced Alternative Payment Models, and applicable to the *incident to* rules including regulatory requirements for the use of auxiliary personnel	
HCPCS Code	**Description**
G0076	Care management home visits, new patient, 20 minutes.
G0077	Care management home visits, new patient, 30 minutes.
G0078	Care management home visits, new patient, 45 minutes.
G0079	Care management home visits, new patient, 60 minutes.
G0080	Care management home visits, new patient, 75 minutes.
G0081	Care management home visits, existing patient, 20 minutes.
G0082	Care management home visits, existing patient, 30 minutes.
G0083	Care management home visits, existing patient, 45 minutes.
G0084	Care management home visits, existing patient, 60 minutes.
G0085	Care management home visits, existing patient, 75 minutes.
G0086	Care management home visits, care plan oversight, 60 minutes.
G0087	Care management home visits, care plan oversight, 30 minutes.
G2001	Post-discharge home visit new patient, 20 minutes.
G2002	Post-discharge home visit new patient, 30 minutes.
G2003	Post-discharge home visit new patient, 45 minutes.
G2004	Post-discharge home visit new patient, 60 minutes.
G2005	Post-discharge home visit new patient, 75 minutes.
G2006	Post-discharge home visit existing patient, 20 minutes.
G2007	Post-discharge home visit existing patient, 30 minutes.
G2008	Post-discharge home visit existing patient, 45 minutes.
G2009	Post-discharge home visit existing patient, 60 minutes.
G2013	Post-discharge home visit existing patient, 75 minutes.
G2014	Post-discharge care plan oversight, 30 minutes.
G2015	Post-discharge care plan oversight, 60 minutes.

Appendix D: Becoming a Medicare Enrolled Provider

In order to become a Medicare provider or supplier, an organization has to demonstrate that they have the ability to deliver at least one covered service. However, the one covered service cannot be Diabetes Self-Management Therapy, as a stand-alone service. The example in this section outlines one pathway to enroll as a Medicare provider. Once an organization is approved to become a Medicare provider or supplier, then the approved organization can add additional services that can be rendered by the types of individual providers that are affiliated with the organization that is enrolled as a Medicare provider or supplier. Providers and suppliers can provide any eligible service that is within the scope of practice of the individual clinician, as defined by the practice acts, in their respective state, territory or the District of Columbia.

(*See the Medicare Provider Enrollment Process, starting on the next page.*)

Medicare Provider Enrollment Process

The steps listed below are the responses provided by CMS contractor/fiscal intermediary Palmetto, regarding establishing a Medicare entity application for a non-profit AAA providing Medical Nutrition Therapy (MNT) and/or Diabetes Self-Management Training (DSMT). However, these instructions should apply to other parts of the country as well, not just those for which Palmetto serves as CMS Medicare Administrative Contractor (MAC) also known as the "fiscal intermediary".

> [NOTE: An organization that only provides DSMT cannot obtain a Medicare number. You must provide at least one other Medicare Part B service, in order to obtain a Medicare number and bill for DSMT. Medical Nutrition Therapy (MNT) is an eligible primary service that will enable a program to obtain a Medicare billing number with DSMT as a secondary service. Providing both MNT and DSMT also enables you to establish a viable cash flow to cover your costs in providing these services.]

The applicant (e.g., the AAA) will have to complete and submit the following four (4) application documents:

A. 855B
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf

B. 855i
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf

C. 855R
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855r.pdf

D. 588
http://www.cms.gov/apps/files/aco/cms588.pdf

Complete each of these forms simultaneously. The primary application is the 855B, which is required to establish which organization will bill Medicare to provide Medical Nutrition Therapy using employed or contracted Registered Dietitians. Whenever an organization is going to provide a covered Part B service using employed personnel in a non-facility setting, the "Clinics/Group Practice" application (that is, the 855B) is required.

Submit the completed application to the Provider Enrollment division of the CMS Medicare Administrative Contractor (MAC) for your specific state. You also have the option of submitting the application online using the following instructions which

are quoted from the 855B Provider enrollment guide produced by CMS MAC Contractor, Trailblazer Health Enterprises, copyright 2012. However, for FY2013, CMS awarded the MAC Contractor contract to Novitas Solutions.

When enrolling, providers have the option of using:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS).
- Standard 855 paper enrollment. Using Internet-based PECOS is easy! Internet-based PECOS allows physicians and non-physicians to enroll, make changes in their enrollment, or view their Medicare enrollment information. Internet- based PECOS has the following benefits:
- Faster than paper-based enrollment.
- Scenario-driven application process.
- Built-in help screens. Additional information about Internet-based PECOS can be located at: http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp

You can find the specific Part B Medicare Administrative Contractor (MAC) for your specific state using the following link:

http://www.cms.gov/medicare-coverage-database/indexes/contacts-part-b-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&

The applicant should pay attention to the following key provisions:

CMS Form 855B

SECTION 1: BASIC INFORMATION

A. Apply as a new enrollee to Medicare
B. Check all that apply

SECTION 2: IDENTIFYING INFORMATION

A. Type Of Supplier
   Under "Type of Supplier" select "Clinic/Group Practice". A group practice includes an organization that employs professionals that provide eligible Medicare Part B services. Your organization is going to provide Medical Nutrition Therapy and employ registered dietitian(s) to provide the service, so you are considered a Clinic/Group Practice by Medicare, even if that is not how you may view your AAA.
B. Supplier Identification Information
   1. BUSINESS INFORMATION
      Enter the information specific to your organization
   2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION
      Most States do not require a special State license to provide MNT. However, if your program is licensed to provide DSMT from either

AADE or ADA, you would list the license information for DSMT in this section.

3. CORRESPONDENCE ADDRESS
   The CMS contractor/intermediary will send correspondence about your application to a specific address. It is important that you enter this address accurately (mailing and email address) and check for mail frequently.

C. Hospitals Only
Do not complete this section

D. Comments/Special Circumstances
Include the following comments, as applicable:

"As an organization, we will provide medical nutrition therapy as our primary Medicare Part B services to Medicare Beneficiaries. We will have a primary location and multiple satellite locations where we will provide individual and group nutrition education throughout our community."

If your program is an accredited DSMT program, at the time of submitting this application, from the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA), then you should add an additional statement such as:

"Our organization will provide diabetes self-management training (DSMT) as a secondary service to eligible Medicare beneficiaries.

[Insert your organization's name] was accredited by
[specify which organization accredited your program – ADA or AADE].

Certification information: [insert from your certificate]

Certification number____[insert from your certificate]_

State issued___[insert from your certificate]

Effective Date___[insert from your certificate];

Expiration Date__[insert from your certificate]_.

(Make sure that you also include a copy of the certificate along with the CMS Form 855B.)

E. Not Applicable

F. Not Applicable

G. Not Applicable

H. Not Applicable

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

Complete as necessary.

SECTION 4: PRACTICE LOCATION INFORMATION

A. Practice Location Information
    1. List all of the information for your primary site. Under the practice location description section, select "Group practice office/clinic"
    2. For each satellite location, i.e., Senior center, etc., complete a separate page 16.
       List the address.
       For "Is this practice location a:", check "Other health care facility".
       Next to "(Specify)", list the type of facility. For example, based on the earlier example, you would fill in "Senior Center"
B. Where do you want remittance notices or special payments sent?
    1. Check "ADD" and fill in the effective date for the address you input in Section 4A above.
    2. Check whether your "Special Payments" address is the same or different from the address in Section 4A and if it is different, fill out the address.
C. Where do you keep patients' medical records?
    1. Check "ADD" and fill in the effective date.
    2. List your primary location for medical record storage. If using electronic medical records (EMR), list the primary location of your facility.
    3. If you have a second location, list it.
D. Rendering Services in Patients' Homes
    Not Applicable
E. Base of Operations Address for Mobile or Portable Suppliers
    Not Applicable
F. Vehicle Information
    Not Applicable
G. Geographic Location for Mobile or Portable Suppliers …

    Not Applicable

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION

A. Organization with Ownership Interest and/or Managing Control
    1. You must complete this section . If the organization maintains managing control of itself, then list the organization information in this section.
    2. The effective date will be the date of incorporation.
B. Final Adverse Legal Action History
    Complete this section if applicable

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

A. Individuals with Ownership Interest and/or Managing Control
    a. Complete with at least one managing control individual.
    b. Select their relationship with the supplier (your organization) as applicable.
B. Final Adverse Legal Action History
    Self-explanatory

SECTION 7: FOR FUTURE USE

Not Applicable

SECTION 8: BILLING AGENCY INFORMATION

Check the box if this section does not apply.
If you have a current contract with a Medicare billing company, complete the rest of this section.

SECTIONS 9 – 12

Not Applicable

SECTION 13: CONTACT PERSON

List the primary contact person and contact information for any questions regarding this application.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

Read this very carefully. There is nothing to fill out.

SECTION 15: CERTIFICATION STATEMENT

A. Additional Requirements for MedicarE Enrollment
    Read the certification statements carefully
B. 1st Authorized Official Signature
    Person must be authorized to sign on behalf of the organization.
C. 2nd Authorized Official Signature

CMS Form 588:

CMS Form 588 is to establish authorization for electronic funds transfer (EFT) services. EFT is the method that CMS routes payments to the organization. Fill it out carefully. You will not receive payment if you do not supply accurate information.

CMS Forms 855i & 855R

CMS Forms 855i and 855R are required for the registered dietitian that will be working with the organization. The 855i registers the dietitian with Medicare and the 855R authorizes CMS to pay the organization for professional services rendered to Medicare beneficiaries by the registered dietician, as an employee of your organization.

CMS Form 855i
Complete Sections 1 – 4b, with the exception of 4a (do not complete section 4a)

CMS Form 855R
Complete all sections.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: April 24, 2019

TO: Medicare Advantage Organizations

FROM: Kathryn Coleman
Director

SUBJECT: Implementing Supplemental Benefits for Chronically Ill Enrollees

The Bipartisan Budget Act of 2018 (Public Law No. 115-123) amended section 1852(a) of the Social Security Act to expand the types of supplemental benefits that may be offered by Medicare Advantage (MA) plans to chronically ill enrollees. We refer to these as Special Supplemental Benefits for the Chronically Ill (SSBCI). SSBCI include supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees, as discussed below. We believe the intended purpose of the new category of supplemental benefits is to enable MA plans to better tailor benefit offerings, address gaps in care, and improve health outcomes for the chronically ill population.

Section 1852(a)(3)(D)(ii), as amended, defines a chronically ill enrollee as an individual who:

1) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee;
2) has a high risk of hospitalization or other adverse health outcomes; and
3) requires intensive care coordination.

As discussed in the CY 2020 Final Call Letter, for CY 2020, CMS will consider any enrollee with a condition identified as a chronic condition in section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual to meet the statutory criterion of having one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee. MA plans will not submit to CMS the processes used to identify chronically ill enrollees that meet the three pronged definition of chronically ill enrollee. However, all three criteria must be met for an enrollee to be eligible for the SSBCI authorized under section 1852(a)(3)(D) beginning CY 2020. CMS expects MA plans to document their determinations about an enrollee's eligibility for SSBCI based on the statutory definition noted above.

In general, MA organizations have broad discretion in developing items and services they may offer as SSBCI provided that the item or service has a *reasonable* expectation of improving or maintaining the health or overall function of the chronically ill enrollee. MA organizations also have broad discretion in determining what may be considered 'a reasonable expectation' when choosing to offer specific items and services as SSBCI. CMS will provide supporting evidence

or data to an MA organization if CMS determines that an MA plan may not offer a specific item or service as a SSCBI because it does not have a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee. These benefits can be in the form of:

- Reduced cost sharing for Medicare covered benefits (such as to improve utilization),
- Reduced cost sharing for primarily health related supplemental benefits,
- Additional primarily health related supplemental benefits, and/or
- Non-primarily health related supplemental benefits.

The special supplemental benefits available to chronically ill enrollees must be entered as a single SSBCI package in Section B19a and/or B19b of the Plan Benefit Package (PBP). CMS-HCC or ICD-10 codes should not be included in the notes. The MA plan may require enrollees to participate in a care management program or use high value providers as a condition of reduced cost sharing or additional benefits. Plans may process the reduced cost sharing or additional benefits for chronically ill enrollees through retroactive reimbursement.

Examples of Non-Primarily Health Related Special Supplemental Benefits for the Chronically Ill

As noted above, beginning CY 2020, MA plans will have the ability to offer a "non-primarily health related" item or service to chronically ill enrollees if the SSBCI has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee. This expectation must be met for each item or service; the examples provided below assume that the reasonable expectation has been established that the item or service will improve or maintain the chronically ill enrollee's health or overall function.

Eligibility for SSBCI must be determined based on identifying the enrollee as a chronically ill enrollee, using the statutory definition, and if the item or service has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. MA plans can provide non-primarily health related supplemental benefits that address chronically ill enrollees' social determinants of health so long as the benefits maintain or improve the health or function of that chronically ill enrollee. MA plans may consider social determinants of health as a factor to help identify chronically ill enrollees whose health could be improved or maintained with SSBCI and they may use social determinants to further limit SSBCI eligibility. However, they may not use social determinants of health as the sole basis for determining eligibility for SSBCI.

The list below provides examples of non-primarily health related supplemental benefits for the chronically ill. All non-primarily health related supplemental benefits must be entered and briefly described as part of a SSBCI package in PBP Section B19b/13i. This list is not exhaustive:

- **Meals (beyond limited basis):** Existing guidance in Chapter 4 of the Medicare Managed Care Manual provides that meals are a primarily health related benefit (PBP category B13c) in

limited situations: when provided to enrollees for a limited period immediately following surgery, or an inpatient hospitalization, or for a limited period due to a chronic illness. In those situations, a meals supplemental benefit is permissible if the meals are: 1) needed due to an illness; 2) consistent with established medical treatment of the illness; and 3) offered for a short duration. Meals may be offered beyond a limited basis as a non-primarily health related benefit (PBP category B19b/13i) to chronically ill enrollees. Meals may be home-delivered and/or offered in a congregate setting.

- **Food and Produce:** Food and produce to assist chronically ill enrollees in meeting nutritional needs may be covered as SSBCI. Plans may include items such as (but not limited to) produce, frozen foods, and canned goods. Tobacco and alcohol are not permitted.

- **Transportation for Non-Medical Needs:** Transportation to obtain non-medical items and services, such as for grocery shopping, banking, and transportation related to any other SSBCI, is a non-primarily health related benefit. Such transportation may be reimbursed, arranged, or directly provided by an MA plan as a SSBCI.

- **Pest Control:** Pest eradication services that are necessary to ensure the health, welfare, and safety of the chronically ill enrollee. Services may include pest control treatment(s) or products that may assist the enrollee in the pest eradication (e.g., traps, pest control sprays, cleaning supplies).

- **Indoor Air Quality Equipment and Services:** Equipment and services to improve indoor air quality, such as temporary or portable air conditioning units, humidifiers, dehumidifiers, High Efficiency Particulate Air filters, and carpet cleaning may be covered as SSBCI. Plans may also include installation and servicing of equipment as part of the benefit.

- **Social Needs Benefits:** Access to community or plan-sponsored programs and events to address enrollee social needs, such as non-fitness club memberships, community or social clubs, park passes, and access to companion care, marital counseling, family counseling, classes for enrollees with primary caregiving responsibilities for a child, or programs or events to address enrollee isolation and improve emotional and/or cognitive function, are non-primarily health related benefits that may be covered as SSBCI.

- **Complementary Therapies:** Complementary therapies offered alongside traditional medical treatment may be offered as non-primarily health related SSBCI. Complementary therapies must be provided by practitioners who are licensed or certified, as applicable, in the state in which they practice and are furnishing services within the scope of practice defined by their licensing or certifying state. Alternative therapies that are considered primarily health related may be offered by an MA plan as a supplemental benefit in PBP category B14c.

- **Services Supporting Self-Direction**: Services supporting self-direction allow enrollees to have the responsibility for managing all aspects of healthcare delivery in a person-centered planning process; while such services are a non-primarily health related benefit, they may have a reasonable expectation of improving or maintaining the health or overall function of

the chronically ill enrollee. Plans may provide services to assist in the establishment of decision-making authority for healthcare needs (e.g., power of attorney for health services) and/or may provide education such as financial literacy classes, technology education, and language classes. Interpreter services may also be provided to enrollees to facilitate encounters with healthcare providers. Plans may not include expenses for funerals as a covered benefit. Primarily health related education (e.g., Health Education, Medical Nutrition Therapy) that is consistent with existing guidance (see Chapter 4, section 30.3) for primarily health related supplemental benefits may be offered by an MA Plan as a supplemental benefit in PBP category B14c.

- **Structural Home Modifications:** Structural modifications to the home that may assist in the chronically ill enrollee's overall function, health, or mobility are permitted if those items and services have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee (e.g., widening of hallways or doorways, permanent mobility ramps, easy use doorknobs and faucets).

- **General Supports for Living:** General supports for living such as housing may be provided to chronically ill enrollees if the benefit has a reasonable expectation of improving or maintaining the health or overall function of the enrollee. General supports for living may be provided for a limited or extended duration as determined by the plan. The benefit may include plan-sponsored housing consultations and/or subsidies for rent or assisted living communities. Plans may also include subsidies for utilities such as gas, electric, and water as part of the benefit. These benefits should be entered in Section B19b/13i of the PBP under "Transitional Supports."

Maximum Plan Benefit Coverage Amount for Supplemental Benefits

Consistent with other supplemental benefits, plans have the flexibility to establish a maximum plan benefit coverage amount for each SSBCI or a combined amount that includes multiple SSBCIs. For example, a plan could establish a combined maximum plan benefit coverage amount that applies to transportation for non-medical needs and social needs benefits; a chronically ill enrollee for whom both of these types of benefits have a reasonable expectation of improvement or maintenance of the health or overall function could use both benefits during the coverage period up to the combined maximum amount. To establish coverage of multiple supplemental benefits (i.e., benefits in different categories) subject to a combined maximum plan benefit coverage amount, the MA organization should enter the appropriate data in PBP Section B and include a note in each applicable section that it is a combined maximum plan benefit amount. With the exception of supplemental benefit offerings in PBP Section B19, plans providing a combined maximum plan benefit coverage amount for multiple benefit categories also enter the combined amount in PBP Section D. As noted above, plans may offer SSBCI to chronically ill enrollees through retroactive reimbursement.

Waiver of Uniformity Requirements for SSBCI

The Act also allows CMS to waive the uniformity requirements with respect to SSBCI, effective in CY 2020. As discussed in the CY 2019 Final Rule (83 FR 16440, 16481-82), the waiver authorized under section 1852(a)(3)(D)(ii) of the Act gives CMS the authority to allow MA plans to offer chronically ill enrollees supplemental benefits that are not uniform. Thus, beginning CY 2020, CMS will use this waiver authority to allow MA plans to vary, or target, SSBCI as they relate to the individual enrollee's specific medical condition and needs. In other words, SSBCI under this waiver may not be provided to a chronically ill enrollee if that benefit does not have a reasonable likelihood of improving or maintaining that specific enrollee's health or overall function. We expect MA plans to develop objective criteria (e.g., health risk assessments, review of claims data, etc.) in determining SSBCI eligibility. The objective criteria may be helpful to address potential beneficiary appeals, complaints, and/or general oversight activities performed by CMS.

We remind MA plans that coverage requests from enrollees or providers, including requests for any supplemental benefits, should be treated similar to requests for other benefits furnished by an MA plan. If a request concerning coverage of a discrete item or service submitted to a plan fits within one of the actions defined as an organization determination under 42 C.F.R. § 422.566(b), then the coverage decision is subject to the Subpart M appeals process. Furthermore, MA plans are responsible for clearly identifying in the plan's Evidence of Coverage (EOC) what will and will not be covered. Any limitations on coverage should be clearly noted in the EOC, including the process and/or criteria for determining eligibility to receive a SSBCI under the new authority beginning CY 2020. Plans may also inform beneficiaries of SSBCI, including through marketing and communication materials. When marketing SSBCI, MA plans must not mislead or misrepresent these benefits to enrollees and must not state that they are guaranteed.

Policy questions related to the information in this memorandum, may be submitted at: https://dpap.lmi.org/dpapmailbox/. If you have any operational and/or PBP related questions about the information outlined in this memorandum, please submit your question to https://mabenefitsmailbox.lmi.org/.

Appendix F: Steps to Completing a Market Analysis

1. Learn your health care market:
   - Identify the number of Medicare beneficiaries in your target market. Document the results in your market analysis document.
   - Assess the penetration of Medicare Advantage in your target market.
   - Determine the individual Medicare Advantage Plan enrollment in your target market. Document the results in your market analysis document.
   - Assess if there are Medicaid Managed Care Plans operating in your state and the population that they serve.
   - Assess the penetration of commercial insurers in your market area.
2. Determine the Payer mix of beneficiaries that are served by a health care organization that you are working with or the distribution of health plan members across the defined market.
   - Payer mix includes the types of insurance and, for example, the number of beneficiaries that are admitted to the hospital on average, over a year.
   - For example, the percentage of beneficiaries admitted to the hospital, by payer type is commonly referred to the "Payer Mix" at the facility.
3. Stratify the list of Payers in your market based on their current penetration and the utilization of their beneficiaries at the hospitals you serve.
4. Assess how the health care organization has fared in addressing Health Effectives Data and Information Set (HEDIS) measures, health equity, HRSN or unnecessary health care utilization for the target population.
5. Assess if there are currently operating Advanced Alternative Payment Models in your target market. Document the results in your market analysis document.
   - List the types of Advanced Alternative Payment Models in your market and assess if there are any publicly reported outcome results for the ACO.
6. Review your market analysis document to determine each of the key Payers in your market.
7. Determine how your program can assist each potential Payer in achieving their requirements to improve quality and reduce costs for a target population.
8. Develop a strategy and timeline to meet with each Payer and present your program with a goal of obtaining a contract for services.

Appendix G: Steps to Determining Your Value Proposition

1. Identify the risk that your potential target population has (financial and quality).
2. Determine the penetration of the target population in the market.
3. Determine the types of beneficiaries served by the Payer and list all of the challenges faced by this target population.
4. Assess how your service addresses the Payer's risk.
5. Determine the level of access that you have to the target population. (Can you effectively reach their target population)?
6. Determine if there is a subset of the population served by the customer that you could have the most impact in serving (e.g., pregnant women or dual eligible).
7. Document how your program will complete the following:
   - Reach the target population.
   - Provide services to the target population.
   - Document the effectiveness of your program for the individual and the population served, using program evaluation data or other publicly available data of similar interventions.
   - Track the ROI obtained by buying your services.
   - Provide continuous quality improvement.
   - Deliver regular data to the customer to show the impact of your program at the individual and aggregate level.

Appendix H: General Payer Contract Negotiation Checklist

Name Of Agency / Organization: _____

Customer: _____ **Target Population:** _____ **Date:** _____

Item	Yes	No	Comments
1. Do we know what our break-even projection is, as it relates to volume (i.e., minimum number of beneficiary referrals to meet required revenue projections)?			
2. Are we prepared to meet any increased volume requirements placed upon us by the Payer? If so, what is the maximum volume that we can produce and when will we be prepared to operate at this capacity?			
3. Have we developed a quality assurance plan?			
4. Do we have a uniform data collection method?			
5. Do we have a method of providing individual and aggregate outcome data?			
6. Have we included relevant HEDIS measures in our quality assurance and individual outcome reporting requirements?			
7. Is our data collection process HIPAA compliant?			
8. Can we share clinical data according to the current Office of the National Coordinator (ONC) Meaningful Use Standards?			
9. Have we incorporated the data reporting and quality assurance requirements into our cost estimate?			
10. Will our services/program be considered as part of the mandatory Medical Loss Ratio (MLR) spending requirements?			
11. Do we have adequate insurance coverage for the services we are providing?			
12. Will cyber insurance be required? If so, do we have a current policy or a current quote for a policy?			
13. Do we need to include subcontractors or partnering organizations as “additionally insured entities” under our primary insurance policy?			

Reviewer Name: _____ **Title:** _____ **Date:** _____

Appendix I: Managed Care Organization Contract Negotiation Checklist

Name Of Agency / Organization: _____

Customer: _____ **Target Population:** _____ **Date:**_____

Item	Yes	No	Comments
1. Do you know how the MCO plan fared on the Medical Loss Ratio requirement for the prior year?			
2. Do you know what the MCO plan spent on hospital readmission activities last year?			
3. Do you know what the competitor MCO plan spent on hospital readmission activities last year?			
4. Do you know how the MCO plan performed on their HEDIS performance card?			
5. Does the MCO have current health equity or Advanced Alternative Payment models that incorporate SDOH for vulnerable populations?			
6. Is our data collection process HIPAA compliant?			
7. Can we share clinical data according to the current Office of the National Coordinator (ONC) Meaningful Use Standards?			
8. Have we incorporated the data reporting and quality assurance requirements into our cost estimate?			
9. Will our services/program be considered as part of the mandatory Medical Loss Ratio spending requirements?			
10. Do we have adequate insurance coverage for the services we are providing?			
11. Will cyber insurance be required? If so, do we have a current policy or a current quote for a policy?			
12. Do we need to include subcontractors or partnering organizations as “additionally insured entities” under our primary in-surance policy?			

Reviewer Name: _____ **Title:** _____ **Date:**_____

Appendix J: Steps to Accountable Care Organization Negotiations

1. Document the Return on Investment for your program, based on your past performance providing care transitions services.
2. Incorporate the ROI investment outcome and calculation method in your presentation materials. ROI investment outcome should be targeted to Payer's population and goals.
3. Assess to determine if the organization is participating in an Advanced Alternative Payment Model or a MCO entering into value-based contracts with health care providers.
4. Assess the publicly reported success or lack of success obtained over the course of their participation thus far.
5. Determine how your program can assist in helping the ACO to meet their quality improvement and cost containment goals.
6. Be prepared to modify your current program delivery model if required to meet the needs of the hospital in achieving the goals of their ACO participation.
7. Assess the range of health care providers that are participants in the ACO model, including hospital representatives.
8. Determine if your program has existing relationships with any of the other ACO providers.
9. Develop an implementation strategy documenting how your CHW/P intervention will support the goals of ACO with a focus on health equity and HRSN needs of the target population.
10. Assess how your program provides value towards meeting the goals of the ACO program.
11. Determine who the decision maker is at the health care organization, as it relates to their participation in the ACO.
12. Know your break-even cost and volume rate prior to entering a negotiation.
13. Present the cost of your program and the ROI as it relates to the ACO goals of improving quality and reducing overall costs.
14. Prepare to negotiate on price and volume, while ensuring that you do not accept a price below your break-even amount.

Appendix K: Steps to BPCI-A (Bundled Payment) Negotiations

1. Document the Return on Investment for your CHW/P intervention, based on your past performance providing care transitions services.
2. Incorporate the ROI investment outcome from the perspective of the BPCI-A organization and calculation method in your presentation materials.
3. Assess to determine if the hospital is participating in one of the CMS Bundled Payments for Care Improvement (BPCI) program?
4. If the hospital is a CMS BPCI participant, assess to determine which model they are participating in, the length of the episode and the types of conditions selected.
5. Define the proposed intervention to address needs of the target population during the defined episode of care. The interventions can include — but are not limited to — HRSN interventions, interventions to achieve health equity and interventions to reduce total cost of care.
6. Be prepared to modify your current program delivery model if required to meet the needs of the Bundled Payment participant, in achieving the goals of their BPCI participation.
7. Identify if there are post-acute care providers also participating in the BPCI initiative.
8. Determine if your program has existing relationships with any of the post-acute care providers that are involved in the BPCI initiative.
9. Develop an implementation strategy documenting how the CHW/P intervention will support the goals of BPCI for the episode of care integrating with the hospital and other post-acute care providers.
10. Assess how your program provides value towards meeting the goals of the BPCI program.
11. Determine who the decision maker is for the BPCI participant.
12. Know your break-even cost and volume rate prior to entering a negotiation.
13. Present the cost of your program and the ROI as it relates to the BPCI target price goal attainment requirements.
14. Prepare to negotiate on price and volume, while ensuring that you do not accept a price below your break-even amount.

Appendix L: Examples of Incorporating CHW/Ps into Reimbursement

Example 1: CHW/P working in a Fee-for-Service model

XYZ Clinic is a Federally Qualified Health Center in the District of Columbia. XYZ Clinic serves a population that have multiple chronic conditions. The primary care team at XYZ clinic conducted depression screening on the target population and determined a high percentage of the population have a co-morbid depression. The clinical team determined that they need to deploy a behavioral health integration model to address the high levels of co-morbid depression affecting the target population.

The primary care team researched the interventions that have the most evidence for improving clinical outcomes for depression in the older adult population. One of the evidence-based interventions with demonstrated success is Collaborative Care Management (CoCM). CoCM uses a team-based approach to addressing the behavioral health needs of the target population. The intervention is led by a primary care provider (PCP). The team members include a consulting psychiatrist, behavioral health care manager and CHW. The members of the team work with each eligible beneficiary each month. The CoCM Medicare benefit pays for services rendered over a calendar month. The CHW can work as a member of the clinical team and operates under the general supervision of the PCP. The time of each member of the care team rendering services for the beneficiary is aggregated each month.

The combined aggregate of time spent working on behalf of the beneficiary, to address any behavioral health needs, is defined for each calendar month. The aggregated time includes the time spent by the CHW, working under general supervision of the PCP. The CoCM billing code incorporates the time spent by the CHW and other members of the care team. Reimbursement is secured for the Collaborative Care Management services rendered to the total population served each month. The reimbursement payment covers the cost of the time spent by each member of the care team providing CoCM services each calendar month.

Example 2: CHW/P working in an Alternative Payment Model

The ABC Clinic is located in Fayetteville, North Carolina. ABC Clinic is participating in the Medicare Shared Savings Program (MSSP) Accountable Care Organization Program. When ABC Clinic joined the ACO program, the ACO Director determined that success as an ACO requires ABC Clinic to improve clinical outcomes and reduce the total cost of care. Clinical outcome improvement is defined by reporting a range of ACO Quality Measures. One of the ACO Quality Measures that is most relevant to ABC Clinic is the At-Risk Population Diabetes measure. The description of this measure is the following:

Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)

The ACO executive pulled the listing of beneficiaries that have a report of a HbA1c >0 percent and alerted each physician that serves as the primary care provider for each respective beneficiary. Some of the primary care providers noted that SDOH negatively impacted the health outcomes for some of the patients on the list. SDOH are defined as conditions in the places where people live, learn, work and play that affect a wide range of health and quality-of-life risks and outcomes. When SDOH are a contributing factor to achieving positive health outcomes, the ACO will not achieve success in the alternative payment model, unless they develop a strategy to address the relevant social drivers of health.

The ACO hired a CHW to embed with the clinical team with a specific focus on completing a screening assessment for SDOH and implementing social care interventions to address identified needs. The CHW completed social needs screening for the target population. The social needs screening revealed that multiple beneficiaries could not afford the cost of their co-payments to obtain their insulin. Failure to fill their insulin prescriptions has a direct negative impact on the diabetes outcomes for the target population. The CHW/P was tasked with identifying resources to address the barrier to filling insulin prescriptions for the target population.

After conducting research on the programs to address the needs of persons that are not able to afford their prescriptions, the CHW identified that there is a program to provide a financial subsidy for persons that cannot afford their Medicare Part D prescription costs. The program is called *Extra Help*. The CHW/P found this information related to the program:

Medicare beneficiaries can qualify for *Extra Help* paying for their monthly premiums, annual deductibles and co-payments related to Medicare prescription drug coverage.

We estimate the *Extra Help* is worth about $5,100 per year. To qualify for *Extra Help*, you must be receiving Medicare and have limited resources and income. You must also reside in one of the 50 states or the District of Columbia.

The CHW contacted the State Health Insurance Program (SHIP), located at the local Area Agency on Aging. The CHW worked with each beneficiary and the SHIP counselor to complete an application for the *Extra Help* program for each low-income beneficiary that could not afford their prescriptions. Each person was approved and received the subsidy worth $5,100 per year. The subsidy covered the full cost of their Part D drug copayment. This allowed each person to obtain their monthly insulin. Once the beneficiaries obtained their insulin, there was a precipitous drop in their HbA1c levels. The drop of HbA1c level resulted in a significant improvement in the ACO Quality Measure score. The improved ACO Quality Measure score resulted in the ACO and the individual practice receiving an increased shared savings payment. The efforts of the CHW directly contributed to the clinical and financial success of the ACO.

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