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

Peer Learning Opportunity

February 6, 2025 | 2:00-3:30 p.m. ET

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A Few Reminders

- ✓ Please introduce yourself and your organization in the chat
- ✓ Recording and slides will be shared following this session of the Health Equity Learning Collaborative
- ✓ Please keep yourself muted unless you have a question. We will have time for questions, but feel free to raise your hand at any time.
- ✓ A live transcript of the meeting is available. To turn on closed captioning, click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

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Agenda

1. Welcome and Introductions
2. Addressing Heath Equity through Multi-Payer Solutions: A Recap
3. Health Equity Capstone Event
4. Next Steps

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Addressing Health Equity through Multi-Payer Solutions

A Recap

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Health Equity/HRSN Regulatory Requirement	Organizations Impacted	Implementation Date
NCQA Social Needs and Intervention (SNS-E) HEDIS Measure	All Health plans with NCQA Accreditation	CY2023
NCQA Health Equity Accreditation Requirement	Medicaid MCOs in twelve (12) States	CY2023 – CY2025
Joint Commission Health Disparities Accreditation Requirement	All hospitals with Joint Commission Accreditation	CY2023
CMS CY2023 IPPS Rule requiring Hospitals to conduct HRSN screening for hospital admissions	All hospitals that accept Medicare and Medicaid reimbursement	CY2023 (Voluntary)/CY2024 (Required)
Medicare Advantage Special Needs Plan mandate to complete HRSN screening in Health Risk Assessments for all plan members	All Medicare Advantage Special Needs Plans	CY2024
CMS/CMMI ACO REACH Health Equity Plan Implementation	All CMMI ACO REACH Participants	CY2023

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An Example: November 2024 AHC Third Evaluation Report

- https://www.cms.gov/priorities/innovation/data-and-reports/2024/ahc-3rd-eval-report

- A CMMI 5-year model (2017 – 2021) that tested whether identifying and addressing the HRSNs of Medicare and Medicaid beneficiaries impacts total health care costs and utilization.

Accountable Health Communities (AHC) Model Evaluation

Third Evaluation Report

November 2024

Submitted To:
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, MD 21244-1850
Contract # HHSM-500-2014-000371
TO # 75FCMC18F0002

Submitted By:
RTI International
P.O. Box 12194
Research Triangle Park, NC
27709-2194
https://www.rti.org

RTI Point of Contact:
William Parish
Project Director
Telephone: (919) 316-3989
Email: wparish@rti.org

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Accountable Health Communities Model (2017 – 2022)

Model Overview

- The Accountable Health Community (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by screening and addressing health-related social needs (HRSNs).
- **1+ Million Medicare/Medicaid Beneficiaries** successfully screened using an evidence-based HRSN screening tool.

Key Components

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Prevalence of HRSNs in the AHC Population (N=1+ Million)

67%	**Food Insecurity**: Sometimes or often worried that food would run out before money was available to buy more, or food bought did not last and money was unavailable to buy more
53%	**Housing**: Worried about losing housing or having no steady place to live or problems with pests, mold, lead, heat, ovens, smoke detectors, or water
44%	**Transportation**: Lack of reliable transportation for medical appointments, meetings, work, or getting things for daily living
36%	**Utilities**: Electric, gas, oil, or water company threatened to shut off services or already shut off services
5%	**Interpersonal Violence**: Regular occurrence of being physically hurt, insulted, threatened with harm, or screamed or cursed at by another person, including a family member

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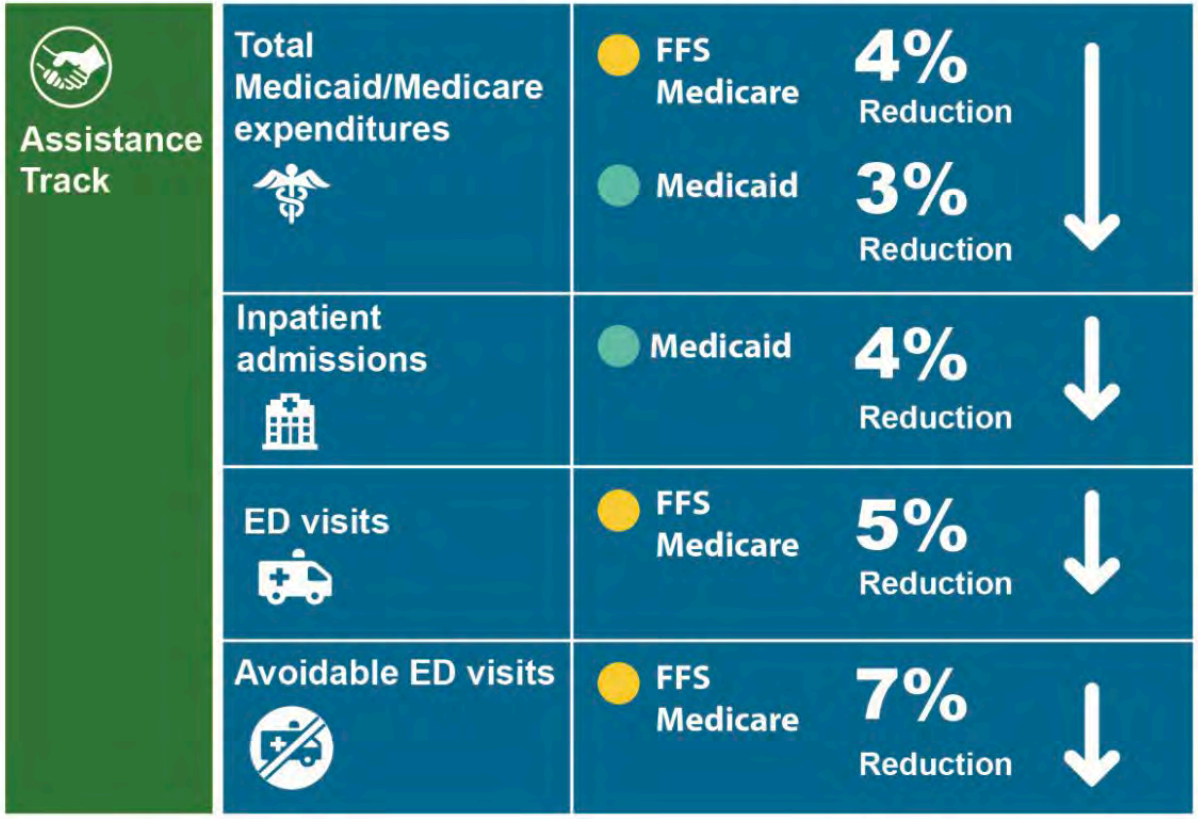
Impact on Hospital Utilization

Exhibit ES-2. Assistance Track Impacts on Expenditures and Hospital Use



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Some Populations Had Greater Reductions in Total Cost of Care

- Beneficiaries in the Assistance Track group had lower expenditures or fewer visits or stays in the first 3 years after screening for HRSNs

- Beneficiaries in the Assistance Track group had higher expenditures or more visits or stays in the first 3 years after screening for HRSNs

Exhibit ES-4. Assistance Track Impacts on Expenditures and Use for Selected FFS Medicare Subpopulations

Subpopulation		$ Total Expenditures	ED Visits	Avoidable ED Visits	Inpatient Admissions
Overall Impact for Assistance Track		↓	↓	↓	NS
	Non-White and/or Hispanic beneficiaries	↓	↓	↓	↓
	Non-Hispanic White beneficiaries	NS	↑	NS	NS
Is there a significant difference between subpopulations?		**Yes**	**Yes**	**Yes**	**Yes**
	Beneficiaries with pulmonary disease	↓	↓	↓	NS
	Beneficiaries without pulmonary disease	NS	↑	NS	NS
Is there a significant difference between subpopulations?		**Yes**	**Yes**	**Yes**	No
	Beneficiaries with diabetes	↓	↓	↓	↓
	Beneficiaries without diabetes	NS	↑	NS	↑
Is there a significant difference between subpopulations?		**Yes**	**Yes**	**Yes**	**Yes**

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Persons with Multiple HRSNs Had Greater Reductions in Total Cost of Care

- Beneficiaries in the Assistance Track group had lower expenditures or fewer visits or stays in the first 3 years after screening for HRSNs

- Beneficiaries in the Assistance Track group had higher expenditures or more visits or stays in the first 3 years after screening for HRSNs

Exhibit ES-5. Assistance Track Impacts on Expenditures and Use for Selected Medicaid Subpopulations

Subpopulation		$ Total Expenditures	ED Visits	Avoidable ED Visits	Inpatient Admissions
Overall Impact for Assistance Track		↓	NS	NS	↓
	Beneficiaries with multiple HRSNs	↓	↓	↓	↓
	Beneficiaries with one HRSN	↓	↑	↑	↑
Is there a significant difference between subpopulations?		No p = .72	**Yes p < .01**	**Yes p < .01**	**Yes p < .01**

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Purpose of Health Equity Learning Collaborative

- Each of the key regulatory requirements apply to health plans, health systems, and healthcare providers.
- These regulatory requirements each have different:
  - implementation requirements
  - data reporting elements
  - reporting timelines
  - evaluation markers for successful implementation
- Many of the health plan requirements are delegated to healthcare providers; but the health system requirements do not align with the health plan requirements or reporting elements. As a result, many healthcare providers benefit from best practices for sustainable deployment of interventions to address needs uncovered by the national effort to screen for health-related social needs.
- Forming a Community-Clinical Team can ensure long-term sustainability of a Health Equity strategy and quality standards.

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Steps to Sustainable Health Equity Solutions

What does the health and social care environment look like where we work and live?

- Who are the hospitals and health care practitioners in our area?
- Do we have any managed care plans such as Medicaid Long Term Services and Supports or Medicare Advantage Plans?
- Do we have any Accountable Care Organizations?

Landscape Analysis

What health care programs and providers exist in our area of interest?

- What are the assets, needs and gaps in addressing social determinants of health across health care programs and providers?
- How do these gaps vary by dimensions of inequality (e.g., sex, gender, ethnicity, disability)?

Market Analysis

What value can we bring?

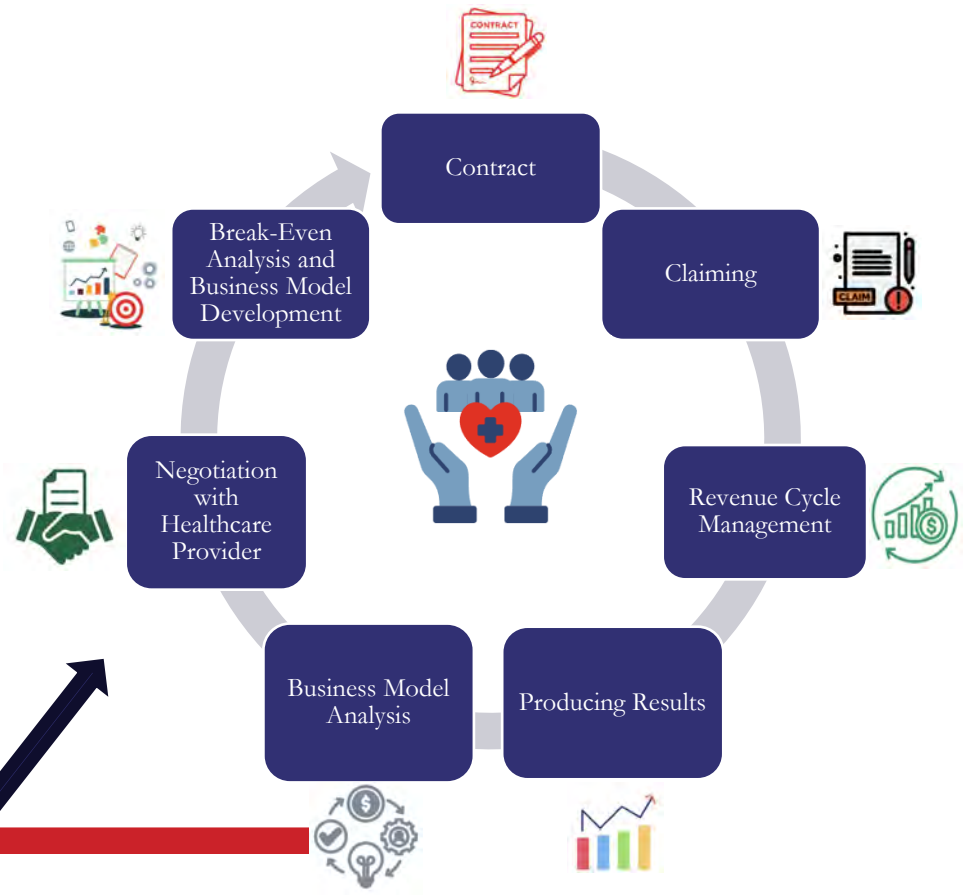
- What programs and services can we offer?
- Do we have specific expertise that can address a community need?
- How can we contribute to positive health outcomes?

Business Model Analysis

One to two services

One population

One Healthcare Provider



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Alignment with Healthcare Requirements

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Homelessness as MS-DRG

- Part of CMS 2024 Inpatient Prospective Payment System rule
- There are SDOH-related Z codes that are used to document SDOH data such as homelessness, food insecurity, housing
- Emphasis and changes due to focus on health disparities and desire to improve health equity in care delivery
- Changes three ICD-10-CM diagnosis codes for homelessness severity level designations from non-complication or comorbidity to a complication or comorbidity, recognizing the higher average cost of care for these individuals

- SDOH data captured during health risk assessment and health screening tools
- Data capture helps measure impacts on resource consumption including comprehensive discharge planning

Code	Detail
Z59.00	Homelessness, unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness

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CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule and Mandatory Reporting

Adoption of three health equity-focused measures:

1. Facility Commitment to Health Equity measure data capture
2. Screening for Social Drivers of Health measure data capture
3. Screen for Positive Rate for Social Drivers of Health measure data capture

Hospitals and other health care entities

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CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule

Hospitals and other health care entities

Facility Commitment to Health Equity measure	
Domain	**Elements**
Health Equity is a strategic priority	- identifies priority populations experiencing disparities - identifies health equity goals and action steps - outlines specific resources dedicated to achieve equity goals - includes stakeholder engagement, including CBOs
Data collection	- collects demographic information and/or SDOH information - staff trained in culturally sensitive collection of information - information collected input into structured, interoperable data elements
Data analysis	- stratifies key performance indicators by demographic and/or SDOH variables to identify gaps used on performance dashboards
Quality improvement	- participation in national, local, or regional QIO activities focused on reducing health disparities
Leadership engagement	- senior leadership, executives, and boards of trustees review plans and performance indicators stratified annually

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CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule

Screening for Social Drivers of Health measure

- Development of five evidence-based HRSN domains to collect data for the measure:
  - Food insecurity
  - Housing instability
  - Transportation needs
  - Utility difficulties
  - Interpersonal safety
- Intent of measure: promote adoption of HRSN screening and identification of patients with HRSNs

* Federal Register Vol. 88, No. 83, Proposed Rules (govinfo.gov)

Desired Actions*

- Use screening as basis of individual action plans that could include navigation services and subsequent referrals
- Initiate and/or improve partnerships with CBOs to close equity gaps

Goals*

- Allow for identification of HRSNs that can be acted upon as part of discharge planning and contribute to long-term improvements in patient outcomes
- Strengthen linkages between hospitals and CBOs to promptly connect patients and families to the support they need

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CMS FY2023 Inpatient Prospective Payment System (IPPS) Rule (cont.)

Hospitals and other health care entities

Screening for Positive Rate for Social Drivers of Health

- Requires reporting of resulting screen positive rates for each of the five domains
- Intent of measure: *capture the magnitude of HRSNs and estimate the impact of individual-level HRSNs on healthcare utilization when evaluating quality of care

* Federal Register Vol. 88, No. 83, Proposed Rules 2023-07389.pdf (govinfo.gov)

Desired Actions*

- Use screen positive rates over time to stratify risk as part of quality improvement efforts

Goals*

- As a result of clinical-community collaborations coupled with increases in system capacity and community investments, we see a net reduction in costly healthcare utilization by promoting more appropriate healthcare service consumption

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Joint Commission Health Care Disparities Requirements

- Effective January 1, 2023
  - Designate individual to lead activities to reduce health care disparities
  - Assess for health-related social needs (HRSN)
  - Identify healthcare disparity trends by stratifying quality and safety measures using sociodemographic characteristics of patient population (e.g., gender, age, language, disabilities, race, ethnicity)
  - Identify community resources and support services
  - Develop a written action plan to address at least one of the health care disparities prevalent in the population inclusive of plans for community resources

Desired Outcome

- Match identified trends with resources in the community.
- This is accomplished by connecting to CBOs that can support identified HRSNs

Challenge

- Knowing what resources are available in the community
- How to start the conversation with CBOs

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Hospital Case Study

- Tim's CBO is working with a DC Hospital.
- How can Tim's CBO bring value to the hospital?
- What HSRN screening requirements impact hospitals?
- How can a CBO support the hospital while leveraging the CHI/PIN Codes
- Can CHI/PIN support hospital transitions?

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Anonymized Case Study: John Doe

- **Background**
- 55 y/o male patient admitted from an area nursing home. History of paraplegia, suprapubic catheter, blind, schizophrenia, & homelessness.
- Patient refuses to return to nursing facility and **requests services in the community**. Cannot return to nursing facilities due to behavioral health history.
- Insurance: Dual (Medicare + DC Medicaid)
- Length of stay: 90 days
- **HRSNs/Clinical Issues Impacting Discharge**
  - Homelessness
  - Requires assistance with ADLs
  - Food insecurity: Inability to prepare meals of obtain food.
  - Requires skilled nursing for suprapubic catheter maintenance.
  - Behavioral Health condition limits community placement options

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PY2025 ACO REACH Information Links

- PY2025ACO REACH Participants
  - https://www.cms.gov/files/document/aco-reach-participants-2025.pdf
- ACO REACH Quality Measures
  - https://www.cms.gov/files/document/aco-reach-quality-msr-meth-py25.pdf

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PY2025 ACO REACH Quality Measures

- Risk-Standardized All-Condition Readmission (ACR)
  - Readmissions within 30 days after patient discharge
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)
  - Unplanned hospital admissions among Medicare FFS 66 or older with multiple chronic conditions.
- Days at Home for Patients with Complex, Chronic Conditions (DAH)
  - Number of days that Adults with complex chronic conditions spend in community settings – not acute or long-term care settings (applies to High Needs Population ACOs)

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PY2025 ACO REACH Quality Measures (cont.)

- https://www.cms.gov/files/document/aco-reach-quality-msr-meth-py25.pdf
- Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)
  - Percentage of acute events related to one of chronic conditions where follow-up care was received within the time frame recommended.
- CAHPS Survey
  - Independent survey of a representative sample of ACO patients related to their satisfaction with care.

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ACO REACH Case Study

- Tim's CBO is negotiating with the DC ACO REACH.
  - List of PY2025 ACO REACH Participants
  - https://www.cms.gov/files/document/aco-reach-participants-2025.pdf
- How can Tim's CBO provide value to the ACO REACH Organization / Individual Provider in the ACO REACH Model.
  - Total Cost of Care
  - Clinical Quality Measures
- How can the work be sustained?
- How does the ACO REACH payment model impact service delivery
- How do we start?
- What is required to start?

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MSSP ACO Model Overview

- MSSP: Medicare Shared Savings Program.
- Most Popular Alternative Payment Model – based on provider participation.
- PY2025: 15,192 MSSP ACOs.
- ACOs are operating in every State, Puerto Rico, and the District of Columbia.
- Tiered Risk model compared to ACO REACH which is full-risk.

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MSSP ACO Quality Measures

- https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/guidance-regulations#quality

Quality

Quality Reporting and Measurement

Participating ACOs must report quality data to CMS after the close of every performance year to be eligible to share in any earned shared savings and to avoid sharing losses at the maximum level. CMS measures every ACO's quality performance using standard methods.

Beginning with PY 2021, ACOs participating in the Shared Savings Program have been required to report through the Alternative Payment Model (APM) Performance Pathway (APP) for purposes of assessing their Shared Savings Program quality performance.

The APP is designed to:

- Reduce reporting burden
- Create new scoring opportunities for participants in Merit-based Incentive Payment System (MIPS) APMs
- Encourage participation in APMs

To learn more about the Shared Savings Program quality measurement and the APP, refer to the resources below:

- The APP Toolkit (ZIP) contains resources designed to help ACOs participating in the Shared Savings Program and their MIPS-eligible clinicians to successfully report quality data through the APP for PY 2024.
- 2024 APP Quality Requirements (Shared Savings Program ACOs only) (ZIP): Provides Quality Submission measure documentation for Shared Savings Program ACOs, including APP Quality Data Submission Options, APP Quality Measures Set details, and APP Quality Measure Specifications.
- APM Performance Pathway webpage
- Quality Payment Program (QPP) Resource Library
- Medicare Shared Savings Program: Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) (guidance document) (PDF): Describes electronic clinical quality measures (eCQM)/MIPS CQM reporting scenarios specific to APM Entity-level reporters. Specifically, this guidance is for Shared Savings Program ACOs and provides a framework that ACOs can use to

OPTION 1: APP Quality Measures Set

(Individual, Group, APM Entity – All Models/Programs, Excluding Shared Savings Program ACOs)

Quality ID: 001

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare Part B Claims

SUBMITTER TYPE
- MIPS Eligible Clinician
- Group (Representative of a Practice)
- APM Entity
- Third Party Intermediary

Quality ID: 134*

Preventive Care and Screening: Screening for Depression and Follow-up Plan

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare Part B Claims

SUBMITTER TYPE
- MIPS Eligible Clinician
- Group (Representat… Practice)
- APM Entity
- Third Party Intermediary

Quality ID: 236*

Controlling High Blood Pressure

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare Part B Claims

SUBMITTER TYPE
- MIPS Eligible Clinician

Quality ID: 321

CAHPS for MIPS

COLLECTION TYPE
- CAHPS for MIPS Survey

SUBMITTER TYPE
- Third Party Intermediary

Quality ID: 479

Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

COLLECTION TYPE
- Administrative Claims

SUBMITTER TYPE

Quality ID: 484

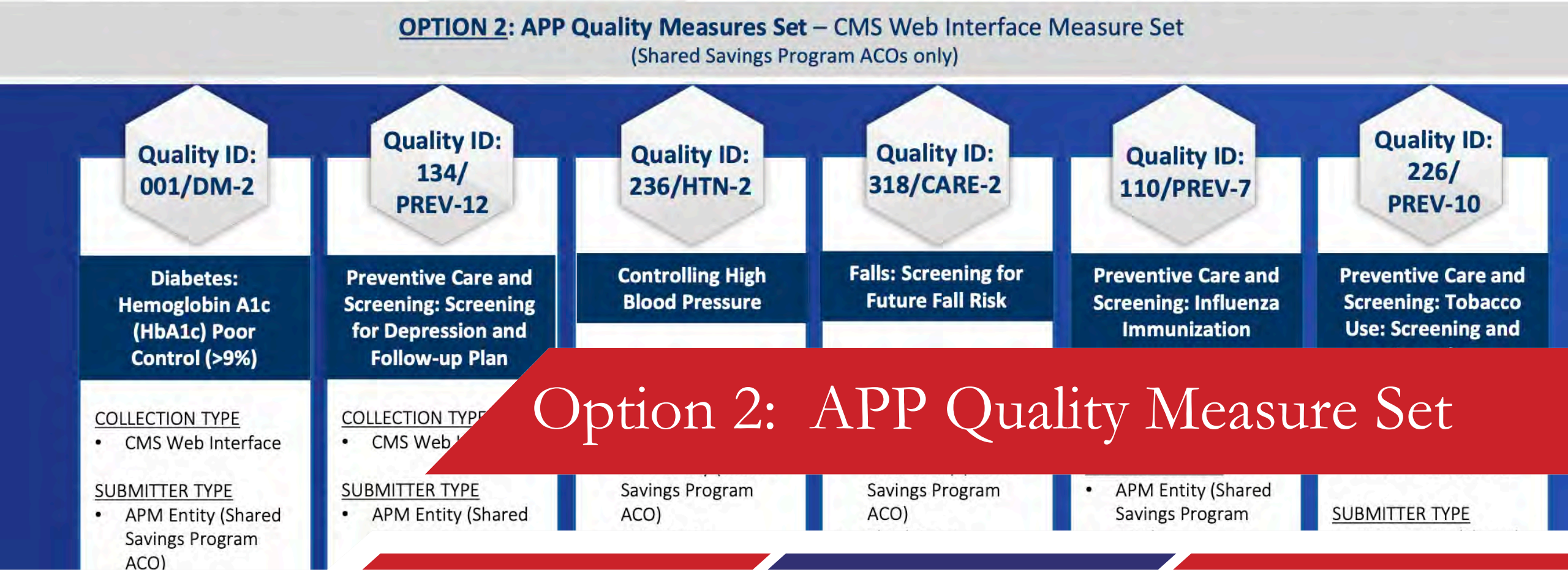
Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

COLLECTION TYPE
- Administrative Claims

Option 1: APP Quality Measure Set

Shared Savings Program ACOs have the option to report the 10 CMS Web Interface measures. Shared Savings Program ACOs that choose to report the CMS Web Interface measures must also administer the CAHPS for MIPS Survey and will be evaluated on 2 administrative claims measures. This alternative measure set is available only to Shared Savings Program ACOs.

Note: The 2024 performance period will be the final year for Shared Savings Program ACOs to report through the CMS Web Interface.



Option 2: APP Quality Measure Set

OPTION 2: APP Quality Measures Set – CMS Web Interface Measure Set (Continued)

(Shared Savings Program ACOs only)

Quality ID: 113/PREV-6	Quality ID: 112/PREV-5	Quality ID: 438/PREV-13	Quality ID: 370/MH-1	Quality ID: 321	Quality ID: 479	Quality ID: 484
Colorectal Cancer Screening	**Breast Cancer Screening**	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	**Depression Remission at Twelve Months**	**CAHPS for MIPS**	**Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups**	**Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions**
COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity (Shared Savings Program ACO) • Third Party Intermediary	COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Intermediary	COLLECTION TYPE • CMS Web Interface SUBMITTER TYPE • APM Entity	COLLECTION TYPE • CAHPS for MIPS Survey SUBMITTER TYPE • Third Party Intermediary	COLLECTION TYPE • Administrative Claims	COLLECTION TYPE • Administrative

Option 2: APP Quality Measure Set (Cont.)

OPTION 3: APP Quality Measures Set – eCQM/MIPS CQM/Medicare CQM Measure Set

(Shared Savings Program ACOs Only)

Quality ID: 001/ 001SSP *

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare CQM

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 134/ 134SSP *

Preventive Care and Screening: Screening for Depression and Follow-up Plan

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare CQM

SUBMITTER TYPE
- APM Entity (Shared Savings Program ACO)
- Third Party Intermediary

Quality ID: 236/ 236SSP *

Controlling High Blood Pressure

COLLECTION TYPE
- eCQM
- MIPS CQM
- Medicare CQM

SUBMITTER TYPE
- APM Entity (Shared

Quality ID: 321

CAHPS for MIPS

COLLECTION TYPE
- CAHPS for MIPS Survey

SUBMITTER TYPE
- Third Party Intermediary

Quality ID: 479

Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

COLLECTION TYPE
- Administrative Claims

Quality ID: 484

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

COLLECTION TYPE
- Administrative

Option 3: APP Quality Measure Set

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MSSP ACO Case Study Implementation

- Tim's CBO is going to contract with the FQHC that is participating in a MSSP ACO.
- How can Tim's CBO provide value to the FQHC?
  - Total Cost of Care
  - Clinical Quality Measures
- How will the work be sustained?
- How do we get started?
- Process Flow requirements.

Special Needs Plans (SNPs) Overview

- Special Needs Plans
  - Dual Eligible Special Needs Plans (D-SNPs)
  - Chronic Disease Special Needs Plans (C-SNPs)
  - HIDE-SNP
  - FIDE-SNP
- HRSN Screening is required as part of the Health Risk Assessment (HRA).
- Final Rule: https://public-inspection.federalregister.gov/2022-09375.pdf
- NCQA HEDIS Measure

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SNP Negotiation

- Tim's CBO is going to contract with a D-SNP.
- How can Tim's CBO provide value to the D-SNP?
  - Total Cost of Care
  - Clinical Quality Measures
- How will the work be sustained?
- How do we get started?
- Process Flow requirements.

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Health Equity Capstone Event

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Purpose

- Highlight accomplishments, lessons learned and next steps
- Celebrate progress made since the inception of the Health Equity Learning Collaborative
- Provide content for marketing those accomplishments beyond the conclusion of the Health Equity Learning Collaborative

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Benefits to Your Organization

- Placement on the Health Equity map which will support overall marketing of your health equity efforts

[HELC Participants | Partnership to Align Social Care]

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Instructions

- Step 1. Prepare your Capstone using one of the templates located here ->HELC Resources | Partnership to Align Social Care
- Step 2. Send your Capstone to HealthEquity@partnership2asc.org **by the end of February**
  - If you choose not to present a Capstone, your organization will be removed from the Health Equity map
- Step 3. Choose a preferred presentation date.
  - March 6 from 2 to 3:30 ET
  - March 20 from 2 to 3:30 ET
- Step 4. Be ready to share a 5-minute presentation of your Capstone during selected date
  - If the date assigned does not work for you, please reach out to HealthEquity@partnership2asc.org

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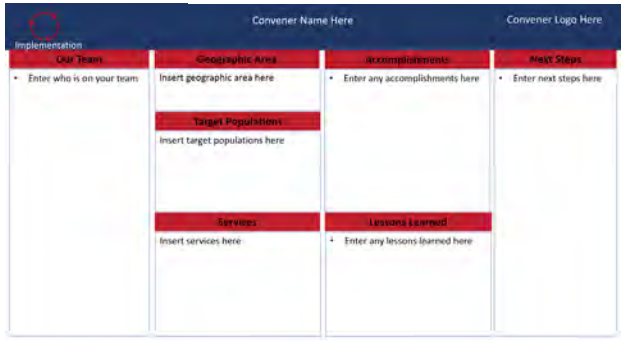
Preparation

Status	Definition
In Development	Building Partnerships Readiness to file a claim is greater than 6 months
In Progress	Readiness to claim is less than 6 months
In Implementation	Have filed at least one claim



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Questions?

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Next Steps

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Reminder

- **February HELC Sessions**
  - **February 20** @ 2:00-3:30 p.m. ET, ECHO Session Office Hours

- **March HELC Capstone**
  - **March 6**@ 2:00-3:30 p.m. ET,
  - **March 20** @ 2:00-3:30 p.m. ET

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Learning Collaborative Resources

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

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More Information About the HELC

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

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Thank you!

Tim McNeill, RN, MPH

tmcneill@freedmenshealth.com