Partnership
to Align Social Care

A National Learning
& Action Network

The Medicare Physician Fee Schedule Includes Codes to Address HRSNs...What Happens Next?

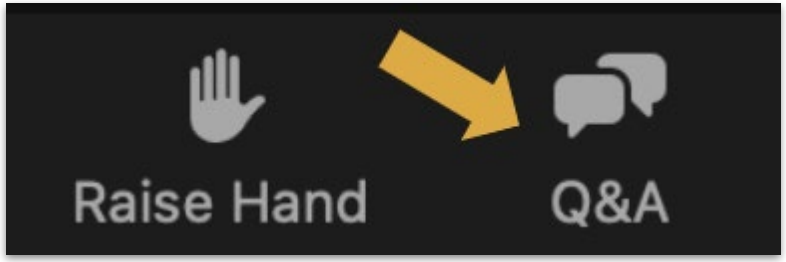
November 15, 2023 | 4:00-5:15 p.m. ET

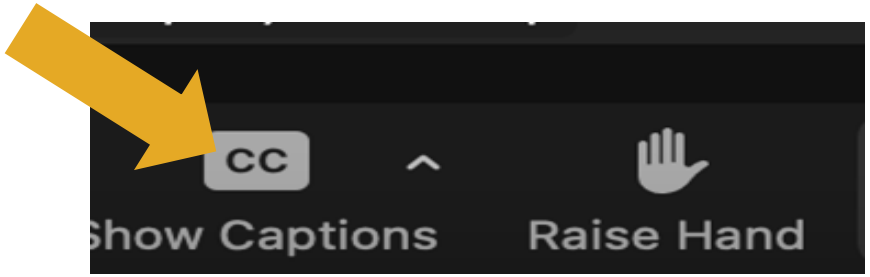
Partnership
to Align Social Care

A National Learning
& Action Network

Administrative Notes

- ✓ This webinar is being recorded. The recording, slides, and follow-up material will be shared with all registrants
- ✓ Please use the Q&A tab at the bottom of your screen and we'll try address as many questions as possible at the end of the presentation
- ✓ Closed captions are provided for this session, can also click "Show Captions" to display automated captions





Panelists

June Simmons, MSW, CEO, Partners in Care Foundation
Co-Chair, Partnership to Align Social Care

Douglas Jacobs, MD, MPH, Chief Transformation Officer, Center for Medicare, Center for Medicare and Medicaid Services (CMS)

Timothy McNeill, RN, MPH, CEO, Freedmen's Health Consulting
Co-Chair, Partnership to Align Social Care

Kelly Cronin, Deputy Administrator, Innovation and Partnership, HHS Administration for Community Living

Partnership
to Align Social Care

A National Learning
& Action Network

Partnership to Align Social Care

Mission:

To enable successful **partnerships** and contracts **between health care and community care networks** to **create** efficient and sustainable **ecosystems** needed to provide **individuals with holistic, person-centered social care** that demonstrates cultural humility.

Vision:

A **sustainably resourced, community-centered social care delivery system** that is **inclusive** of all populations and **empowered by shared governance** and financing, multistakeholder accountability, and federal/state/local policy levers.

Partnership
to Align Social Care

A National Learning
& Action Network

Implementing Co-Designed Social Care Delivery System Changes

Partnership
to Align Social Care

A National Learning
& Action Network

CY 2024 Medicare Physician Fee Schedule Final Rule

Final Rule Published: November 2, 2023
Takes Affect: January 1, 2024
Link to Final Rule: https://public-inspection.federalregister.gov/2023-24184.pdf

Highlights of CY 2024 Medicare PFS:

- New services to address health-related social need including CHI, SDOH Risk Assessment, and PIN Services
- Supports Medicare Providers that desire to contract with Community Care Hubs/CBOs to deliver reimbursable interventions to address health-related social needs for priority populations
- First clear benefit structure for orgs that employ CHWs to address health-related social needs, under a community-clinical integration strategy, as a reimbursable Medicare benefit.

September 15 Partnership Letter on Proposed Rule: https://www.partnership2asc.org/wp-content/uploads/2023/09/Partnership-Sign-On-Letter-re-CMS-CY-2024-PFS-Proposed-Rule.pdf

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

CY2024 Physician Fee Schedule
Implications for Providers and CBOs addressing Health-Related Social Needs

Timothy P. McNeill, RN, MPH

CMS CY2024 Physician Fee Schedule

Title: CY 2024 Payment Policies under the Physician Fee Schedule & Other Changes to Part B Payment & Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare & Medicaid Provider & Supplier Enrollment Policies; and Basic Health Program

- Release Date: November 2, 2023
- CY2024 Medicare Physician Fee Schedule Final Rule Fact Sheet:
  - Available: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule
- Pre-publication Version of the final rule:
  - Available: https://public-inspection.federalregister.gov/2023-24184.pdf

SDOH Risk Assessment

SDOH Risk Assessment

- "After consideration of the public comments, we [CMS] are finalizing the title, "Social Determinants of Health" **(SDOH) risk assessment for HCPCS code G0136** as proposed."
- Frequency: Once every Six (6) Months
- Completed during a E/M Visit, with documentation in the EMR
- Valuation = We proposed a direct crosswalk to HCPCS code G0444 (Screening for depression in adults, 5-15 minutes), with a work RVU of 0.18, as we believe this service reflects the resource costs associated when the billing practitioner performs HCPCS code G0136.

SDOH Definition

- "We proposed to adopt CPT's examples of SDOH, with additional examples. Specifically, we proposed that SDOH(s) may include but are not limited to **food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities**, when they significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the CHI initiating visit."

Community Health Integration (CHI)

CHI Initiating Visit

- Requires an initiating visit
- Initiating visit must be performed by the billing practitioner who would also be furnishing the CHI services during the subsequent calendar months.
- Initiating visit is a pre-requisite to billing for CHI services.
  - Inpatient/observation visits, ED visits and SNF visits do not qualify as an initiating visit.
- During the initiating visit the billing practitioner would assess and identify SDOH needs that significantly limit the practitioners ability to diagnose or treat the patients medical condition and establish an appropriate plan.
- CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner that bills the initiating visit.

Initiating Visit Types

- Eligible Provider: Physician or Non-Physician Practitioner (NP or PA)

- Approved Visit Type: E/M Visit
- Approved Visit Type: Transitional Care Management

- Not Approved: Annual Wellness Visit (AWV) unless it is done with a E/M visit
- Not Approved: HBAI
- Not Approved: ED Visit, Inpatient. Visit, SNF Visit

Can CBOs or CHWs bill directly for CHI services

- CMS Response: There is no statutory benefit category that would allow CBOs to bill the PFS directly. Therefore, we are not finalizing such a policy.

Can Multiple Providers bill for CHI

- Only one (1) provider can bill for CHI services for the same beneficiary, during the same month.
- If more than one provider files a claim for CHI, during the same calendar month for the same beneficiary, the first claim is paid and all further claims are denied.

Focus of CHI

- "The focus of CHI services would need to be on addressing the particular SDOH need(s) that are interfering with, or presenting a barrier to, diagnosis or treatment of the patient's problem(s) addressed in the CHI initiating visit."
- Documentation in the medical record should support this goal.
  - Plan
  - Monthly CHI encounter notes
  - Clinical Integration meetings
  - Re-evaluation documentation

Consent and Cost-Sharing

- Verbal or Written consent is required.
- Consent must be documented in the medical record.
- Part B benefit
  - Deductible and co-insurance requirements apply
  - Medicaid or Medigap coverage may cover some or all deductible or co-insurance fees but the beneficiary is responsible for the cost.
  - Provider cannot elect to waive the deductible or cost sharing requirement.

Third Party Contract Arrangement with CBOs

- CHI and PIN services can be performed by staff provided by community-based organizations.
- Requires clinical integration between the eligible billing provider and the CBO.
- Documentation must be included in the EMR of the billing provider but to reduce administrative burden the provider can review documentation that is in a CBO system but the documentation responsibility ultimately rests with the billing provider.

CBO Types

- Community Care Hub,
- Area Agencies on Aging (AAAs),
- Centers for Independent Living (CILs),
- Community Action Agencies,
- Housing Agencies,
- Aging and Disability Resource Centers (ADRCs), or
- other non-profits that perform social services.

Community Health Integration Services

CHI Services List		
Person-Centered Assessment	Facilitating patient-driven goal setting	Providing tailored support
Practitioner, HCBS Coordination	Coordinating receipt of needed services	Communication with practitioners, HCBS providers, hospitals, SNFs
Coordination of care transitions	Facilitating access to community-based social services	Health education
Building patient self-advocacy skills	Health care access / health system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leveraging lived experience when applicable	

CHI HCPCS Codes

- **G0019** Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner;
- 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) **that are significantly limiting ability to diagnose or treat problem(s)** addressed in an initiating E/M visit.

CHI HCPCS Codes

- **G0022** – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).

Community Health Integration Rate

HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0019	Community Health Integration Services SDOH 60 min	$79.24	$48.79
G0022	Community Health Integration Services; add 30 min	$49.44	$34.05

*The rates listed are the published National Rate. There will be some variation in the rate depending on the MAC and local market where services are being rendered.
**The facility rate is less because the facility receives a separate "facility fee" in addition to the services rendered.
***For CY2024, CMS is not establishing a cap on the number of G0022 add on units per calendar month. Each 30 minutes spent would be added to support additional reimbursement.

Frequency and coding limitations

- Therefore, we are finalizing 60 minutes for the base code [CHI] and 30 minutes for the add-on code **with no frequency limitation for the add-on code** as long as the time spent is **reasonable and necessary**.

FQHC/RHC HCPCS Codes for CHI/PIN

- CHI and PIN Services are billed under one code = G0511
- A FQHC/RHC is not limited to billing one G0511 per beneficiary per month.

CHI Documentation – Source File

- Documentation, in the end, is the responsibility of the billing practitioner. CBOs may enter data following our general policy, as long as the biller reviews and verifies the documentation.

Principal Illness Navigation (PIN) Services

Proposed Service Definition

- For CY 2024, we are proposing to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected **to last at least 3 months**, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.

Final Rule

- **G0023** Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities.
- **G0024** – Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023).

PIN Services

List of PIN Services		
Person-Centered assessment	Patient-driven goal setting	Providing tailored support
Coordinating Home and Community Based Care	Communicating with practitioners and HCBS services	Coordination of care transitions
Facilitating access to social services	Health education	Building self-advocacy skills
Health care access/health system navigation	Helping the patient access healthcare	Providing the patient with information/resources to consider participation in clinical trials
Facilitating behavioral change	Facilitating and providing social and emotional support	Leverage knowledge of the serious condition

Target Populations

- Examples of serious, high-risk diseases for which patient navigation services could be reasonable and necessary could include cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

Principal Illness Navigation Rate

HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0023	PIN Service, 60 minutes per month	$79.24	$48.79
G0024	PIN Service, add 30 min	$49.44	$34.05

*The rates listed are the published National Rate. There will be some variation in the rate depending on the MAC and local market where services are being rendered.
**For CY2024, CMS is not establishing a cap on the number of G0024 add on units per calendar month. Each 30 minutes spent would be added to support additional reimbursement.

Auxiliary Personnel operating Incident To the Physician

- The subsequent PIN services would be performed by auxiliary personnel incident to the professional services of the practitioner who bills the PIN initiating visit. The same practitioner would furnish and bill for both the PIN initiating visit and the PIN services, and PIN services must be furnished in accordance with the "incident to" regulation at § 410.26.
- We would not require an initiating E/M visit every month that PIN services are billed, but only prior to commencing PIN services, to establish the treatment plan, specify how PIN services would help accomplish that plan, and establish the PIN services as incident to the billing practitioner's service.

Contracting with CBOs to Perform PIN

- "…we [CMS] are finalizing as proposed that a billing practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the "incident to" and other requirements and conditions for payment of CHI services are met, and that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided.

Peer Support Specialists

Nursing Home Transitions

- We [CMS] attempted to recognize this work with our proposed PIN code, but given the public comments we received, we are also finalizing two new codes, **HCPCS code G0140 and HCPCS code G0146 for Principal Illness Navigation – Peer Support (PIN-PS).**
- Given the nature of work typically performed by peer support specialists, **we are limiting these codes to the treatment of behavioral health conditions** that otherwise satisfy our definition of a high-risk condition(s).

Principal Illness Navigation – Peer Support

HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0140	Navigation Services, Peer Support, 60 minute	$79.24	$48.79
G0146	Navigation Services, Peer Support, add 30 min	$49.44	$34.05

*The rates listed are the published National Rate. There will be some variation in the rate depending on the MAC and local market where services are being rendered.
**For CY2024, CMS is not establishing a cap on the number of G0146 add on units per calendar month. Each 30 minutes spent would be added to support additional reimbursement.
***PIN and PIN-PS services cannot be billed concurrently for the same condition for the same beneficiary.

Implementation Examples

Sample CHI Intervention Model

Beneficiary with a medical condition impacted by HRSNs.

Coding: G0136 + E/M Code

SDOH Risk Assessment performed during E/M visit. HRSNs identified.

Provider updates problem list defining the intersection of the SDOH need and the problem identified in the E/M visit. **Provider refers to CBO/CCH.**

G0019 (60 min)

Person-centered assessment, performed to better understand the individualized context of the **intersection between the SDOH need(s) and the problem(s)** addressed in the initiating E/M visit.

CHI Services
G0019 (60 min)
G0022 (addt'l 30 min)

Facilitating patient-driven goal-setting and establishing an action plan.

Facilitating access to community-based social services

CBOs Blend & Braid Resources
Public + Private + Philanthropy

G0019 (60 min)
G0022 (addt'l 30 min)

Monthly Aggregate:
G0019 (60 min)
G0022 (addt'l 30 min)

Closed-Loop Reporting:
HRSN interventions deployed and documentation of intervention impact, with aggregate of time spent per calendar month.

Reassessment by the provider to determine if the CHI services addressed the problem identified in the E/M visit

Financial Analysis

- One Community Health Worker supporting a caseload of 50 patients
- Each person receives 1hour of CHI per calendar month.
- Reimbursement
  - G0019 = $79.24
  - 50 patients x $79.24 = $3,962.00

Anonymized Case Study w/ Community Health Worker

- John Doe. 59 y/o African American male residing in a Public Housing Unit.
  - Dual Eligible, receiving SSI.
- MSSP ACO Attributed Patient
- Health Factors
  - Congestive Heart Failure, HTN, Insulin Dependent Diabetes, Bipolar disease
  - Multiple Readmissions and Frequent ED Visits for CHF exacerbation and recent admission for DKA with blood glucose reading 650 on presentation in ED.
- SDOH Assessment in the hospital is positive for housing insecurity and food insecurity.

Transitional Care Management Visit

- Post discharge Transitional Care Management visit for DKA admission with blood glucose 650 on admission.
  - New diagnosis: Stage 3B Chronic Kidney Disease (CKD)
- PHQ-9 Score 15: Moderately severe. Self-Report of worsening feelings of loneliness and depression, with suicidal ideations in the past 2 weeks, but denies suicidal ideations at the time of visit.
- SDOH risk assessment performed:
  - Housing Insecurity
    - Failed three (3) unit inspections and is now at-risk of eviction due to poor maintenance of his public housing unit
    - Lives alone and has difficulty completing ADLs and performing light housekeeping
  - Food Insecurity
    - Reports eating Top Ramen noodles daily and goes to the local shelter for breakfast to receive pastry and juice, due to his inability to prepare meals

Sample Coding

- Post-Discharge Medical Encounter Coding
  - Transitional Care Management: 99496. High medical complexity, seen within 7 days of discharge.
  - Depression Screening: G0444
  - SDOH Risk Assessment: G0136
- Action:
  - Refer to CCH/CBO to deploy a CHW to the home for CHI Services (G0019, G0022)
  - Initiate concurrent Chronic Care Management Services to coordinate with nephrology and cardiology for medical management. (G0506, 99490, 99349)
  - Initiate Collaborative Care for Bipolar disease management (99492, 99493)

CHW Home Assessment Report

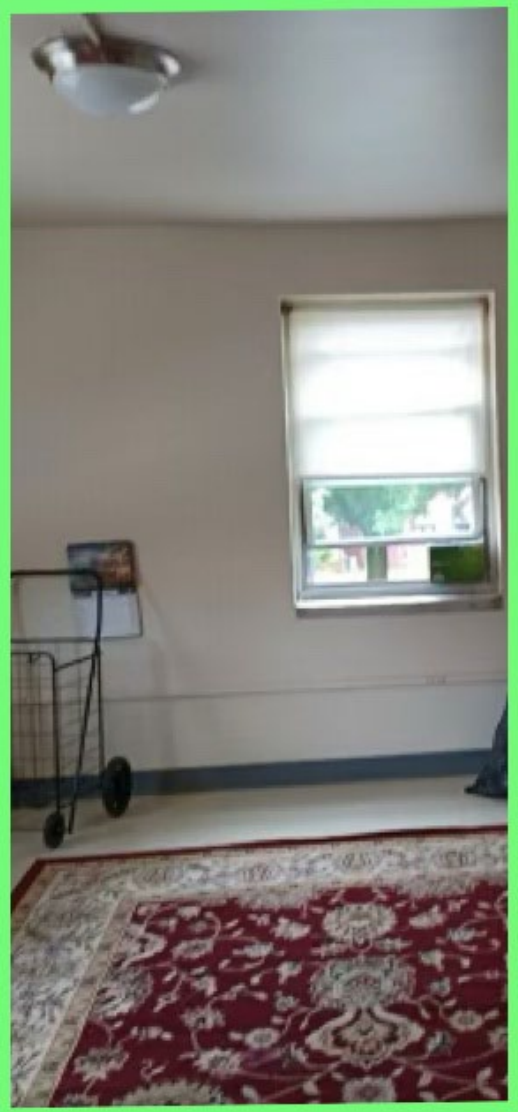
CHW Documents Findings

- PHA Housing Service Coordinator meeting
  - High risk of eviction due to inability to maintain unit.
  - Multiple interventions attempted to address unit maintenance.
  - History of homelessness prior to placement in Public Housing Unit
- Hoarding
- Fall Risk
- Lack of food
  - Only Top Ramen Noodles in the home
- Inability to complete ADLs
- Mice and Roach infestation

CHI Interventions

- Access to social services:
  - SNAP enrollment
  - Referral to Emergency Food Assistance Program
  - Home-Delivered Meals (Older Americans Act)
  - Referral to the ADRC to request assistance with enrollment in Medicaid Waiver/State Plan
    - Personal Care Aide services to assist with ADLs
    - Homemaker services
    - Nursing services for medication adherence support (insulin, CHF medication, etc.)
    - Consider transfer to Medicaid enrolled Assisted Living Facility
  - Coordinate with Housing Service Coordinator for pest abatement services
  - Provide social care navigation services to ensure all available social services are activated.

Before and After Images from Anonymized Case



Sample Coding

- Post-Discharge Medical Encounter Coding
  - Transitional Care Management: 99496. High medical complexity, seen within 7 days of discharge.
  - Depression Screening: G0444
  - SDOH Risk Assessment: G0136
- Action:
  - Refer to CCH/CBO to deploy a CHW to the home for CHI Services (G0019, G0022)
  - Initiate concurrent Chronic Care Management Services to coordinate with nephrology and cardiology for medical management. (G0506, 99490, 99349)
  - Initiate Collaborative Care for Bipolar disease management (99492, 99493)

Expected Outcomes

- Reduction in Ambulatory Sensitive Admissions
- Reduction in ED Utilization
- Improved medication adherence
- Improved diabetes management (current HgbA1c > 9)
- Delay progression of CKD to ESRD
  - Add ACE/ARB
  - Add SGLT2 Inhibitor
- Remission for depression symptoms, by PHQ-9, within 12 months

PIN Example

Case #2: Anonymized Case Study w/ Lewy Body Dementia

- John Doe. 82 y/o White Male
- Federal Government retiree, lives with frail 79-year-old spouse. Daughter lives with her husband and children, out of state.
- MSSP ACO Attributed Patient
- Health Factors
  - Congestive Heart Failure, Lewy Body dementia
- Need:
  - Caregiver support
  - Advanced dementia care services required
  - Inability to complete ADLs
  - Demonstrating aggressive behavior with elderly spouse

Initiating Visit Sample Coding

- E/M Medical Encounter Services
  - E/M Visit high complexity
  - Cognitive Functioning Assessment: 99483
  - Advance Care Planning: 99497
  - Caregiver Training: 97550
  - Principal Illness Navigation: G0140
  - SDOH Risk Assessment: G0136

Caregiver Training

- CPT codes 97550 (Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (without the patient present), face-to-face; **initial 30 minutes**), and add-on code,
- CPT code 97551 (**each additional 15 minutes** (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550)), and
- 97552 (**Group caregiver training** in strategies and techniques to facilitate the patient's functional performance in the home or community

PIN Services Initiated

- Principal Illness Navigation issues for consideration
  - Requires PIN services to determine the best plan of action and support the patient and caregiver in implementing the plan.
  - Barriers to Care:
    - Federal Government retiree status disqualifies the patient for Medicaid despite being low income.
    - Unable to receive Medicaid PCA services
    - Does not have long-term care insurance
    - Cannot afford private pay for aide services

Comparison Utilization Data

ASPE Analysis of CCM/TCM Utilization

- ASPE Report on the 2019 utilization of CCM and TCM by eligible Medicare beneficiaries:

Exhibit 2: Medicare FFS Beneficiaries Receiving CCM or TCM Services in 2019

Category	CCM	TCM
Total Medicare FFS beneficiaries with Part B coverage	35,598,051	35,598,051
Number of FFS beneficiaries potentially eligible for CCM or TCM	22,570,404	6,282,242
Percent of FFS beneficiaries potentially eligible for CCM or TCM	63.4%	17.7%
Beneficiaries with one or more CCM or TCM claims	882,728	1,078,580
Percent of potentially eligible beneficiaries with CCM or TCM claims	4.0%	17.9%

https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

Thank You

811 L Street, SE
Washington, DC 20003

202-344-5465

tmcneill@freedmenshealth.com

Learning System to Align Health and Social Care

- Multi-pronged approach to learning a collaborative and holistic model of care that builds upon existing community capacity to address HRSNs
- Intended to meet CBOs, hubs, and their health care partners where they are in journey to screen, refer, coordinate, deliver, and finance services
- Coordinate across various organizations providing relevant TA to implement a comprehensive approach that reaches a broad group of CBOs, hubs, and health care organizations

Technical Assistance Opportunities in 2024

- **Community Care Hub 101 Learning Series**
  - All CBOs interested in or early in their hub development
- **Community Care Hub National Learning Community**
  - For CBOs- existing and emerging hubs with existing health care contracting capacity
- **Center of Excellence to Align Health and Social Care**
  - Funding opportunity for community care hubs to support and enhance hub infrastructure
- **Health Equity Learning Collaborative (Partnership to Align Social Care)**
  - For more advanced hubs and their health care partners to collaborate on team based learning and multi-payer alignment
- **ECHO learning series on care transitions with CBOs and hospital partners**
  - All CBOs serving older adults/people with disabilities with hospital partners learn how to collaborate on HRSN screening, referral, transition support, and service activation/coordination
- **Housing and Services Partnership Accelerator** https://acl.gov/HousingAndServices/Accelerator
  - Support state teams coordinating across organizations that provide services and resources that help people find – and keep – stable housing in the community
- **Multi-state IT learning collaborative on interoperable referral systems**

Care Transitions ECHO Series for Hospitals and CBOs

- Monthly, interactive, virtual meetings from January – August 2024 that will support collaborative approaches to HRSN screening, connection to community-based social services and transition support pre and post discharge.
- The series uses the Extension for Community Healthcare Outcomes (ECHO) Model, an “all teach, all learn” approach for peer-based learning
- Who is it for?
  - Hospitals who have a CBO partner – formal or informal
  - Hospitals seeking a CBO partner – we can support matchmaking
  - Community based organizations (CBOs) that serve older adults and people with disabilities

Care Transitions ECHO Series for Hospitals and CBOs

- What is the goal?
  - Help organizations leverage community partnerships to address their patient's unmet social needs using existing staffing and resources to ensure smooth community transitions
  - Offer hospitals and their CBO partners the opportunity to work together through guided ECHO sessions to develop and implement strategies for screening, referral and transition support that will:
    - Factor in the latest requirements for screening of social drivers of health, health equity initiatives and Medicare/Medicaid reimbursement opportunities
    - Use examples shared by hospital and CBOs and foster a teams based approach
- How do I sign up?
  - Complete this brief survey to indicate your interest: ACL Care Transitions ECHO (smartsheet.com)
- Questions?
  - Email caretransitions@lewin.com

Learning System Timeline

November 23'

- Accepting applications for ACL's 2023/2024 Community Care Hub (CCH) National Learning Community
- **CCH 101 Learning Series hosted by Center of Excellence to Align Health and Social Care**
  - **Timeline**: 2 months
  - **Audience**: New and emerging CCHs, and other organizations interested in the CCH model

December 23'

- Announce funding opportunity for CCHs through Center of Excellence
- **Launch of HHS-HUD Housing and Services Partnership Accelerator**
  - **Timeline**: 12 months
  - **Audience**: Up to 4 states with Medicaid 1115 demonstrations or section 1915(i) state plan benefit to address housing stability

January 24'

- **Launch of Community Driven, Multi-Payer Health Equity Solutions: An ECHO Collaborative**
  - **Timeline**: 12 months
  - **Audience**: Up to 20 community/ clinical teams
- **Launch of ACL's 2023/2024 CCH National Learning Community**
  - **Timeline**: 10 months
  - **Audience**: Up to 30 CCHs serving aging and/or disability populations
- **Launch of ACL's Care Transitions ECHO Series**
  - **Timeline**: 9 months
  - **Audience**: Aging and disability network organizations and their hospital partners

February 24'

- **Launch of Multi-State Learning IT Collaborative Series**
  - **Timeline**: 6 months
  - **Audience**: State agency leadership (e.g., SUAs, CIOs, Medicaid)

March 24'

- Award grants for up to 20 CCHs through Center of Excellence

- *Ongoing participant engagement in various Learning System activities*

Operationalizing contracts: Improving contracting implementation and collaboration

Contracting to Align Health and Social Care Ecosystems:
A Webinar Series Sharing Leading Practices
Hosted by the Partnership to Align Social Care

December 12, 2023 | 12-1 pm

Register now: www.partnership2asc.org/contractingwebinarseries2023

Hear from speakers

Natasha Dravid
Senior Director, Camden Coalition

Stephanie Orlando
COO, Western NY Independent Living Center, Inc.

Nikki Kmicinski
Executive Director, Western New York Integrated Care Collaborative, Inc.

Dawn Odrzywolski
VP Medicare Programs, Independent Health

Partnership
to Align Social Care

A National Learning
& Action Network

How to Get Involved in the Partnership…

- Sign up for our email list: https://www.partnership2asc.org/sign-up/

- Follow the Partnership on social media:

www.linkedin.com/company/partnership-to-align-social-care

@partnership2asc

- Reach out directly to:
  - ✓ *Support the Partnership*
  - ✓ *Ask about getting involved in leadership/workgroup activities*
  - ✓ *Share your expertise/experiences*

Partnership to Align Social Care

A National Learning & Action Network

Co-Chairs

June Simmons
Partners in Care Foundation
jsimmons@picf.org
818-837-3775 x101

Timothy P. McNeill
Freedmen's Health
tmcneill@freedmenshealth.com
202-344-5465

Director

Autumn Campbell
acampbell@Partnership2ASC.org
202-805-6202

Project Manager

Jeremiah Silguero
jsilguero@Partnership2ASC.org
818-408-5269

@Partners2ASC