Speakers

Moderator: Sabrina Edgington, MSSW
Director of Special Projects, National Health Care for the Homeless Council

• Henry C. Fader, Esquire
  Pepper Hamilton LLP

• Rebecca Ramsay, BSN, MPH
  Executive Director – Population Health Partnerships, CareOregon

• Carrie Harnish, LMSW
  Clinical Director Community Benefit, Trinity Health

• Brandon Clark, MBA
  Chief Executive Officer, Circle the City
Medical Respite Funding and Return on Investment Panel Discussion
May 31, 2016

Henry C. Fader, Esquire
Pepper Hamilton LLP
Background

39 states contract with comprehensive Medicaid MCOs –

19 provide MCO enrollment data on their websites
In most states that report their Medicaid MCO enrollment, at least 50% of beneficiaries are in MCOs.
Payments to comprehensive MCOs account for more than one-quarter of total national Medicaid spending.
Local and national MCOs both play a large role in the Medicaid managed care market.
Medicaid Program Structure

Federal

Medicaid Program

Fee for Service

Providers

Beneficiaries

Respite Care Programs

State

Managed Care Organization

Providers

Beneficiaries

Respite Care Programs
Certain Characteristics of MCO Medicaid Plans

- Due to Waivers from Federal Government, Not All State Programs Are the Same
- Providers Taking Financial Risk/Capitation
- Limited Networks – Consists of Providers Offering Services at Discounted Rates
- Beneficiary Initial Choice of Plans and Ability to Change Plans
- Limited Cost Sharing by Beneficiaries
- Gatekeeper Requirement for Referrals
Medicaid Managed Care Organizations

Managed Care Organization

Benefit Plan
Design A

Benefit Plan
Design B

Benefit Plan
Design C
Types of MCO Benefit Design

- Comprehensive Risk-Based Plans
- Primary Care Case Management
- Limited Benefit Plans
Contractual Legal Issues for Providers

- Use of Standard Provider Agreement
- Licensing of Medical Respite Providers
- Variations among Plan Designs, MCO and Benefits – Provider agrees to accept all
- Sharing of Pricing Information Generally Prohibited
- Credentialing Is Important to MCO for Medical Staff and Other Personnel
- “Medical necessity”
- Development of required encounter data
- Be clear on what constitutes “covered services”
- Claims submissions process – final claims usually required in 120 days
Contractual Legal Issues for Providers

- Federal/State/Plan Compliance Issues
- Excluded/Suspended Providers
- Confidentiality
- Privacy/Security
Medical Respite Funding and Return on Investment Panel Discussion

May 31, 2016

Rebecca Ramsay, BSN, MPH
Executive Director – Population Health Partnerships, CareOregon

Curtis Peterson, Health Resilience Specialist and Gordon Rasmussen, Care Oregon Member
CareOregon

- Publically financed healthcare insurer for low-income citizens
- 234,000 Members; Medicaid and Medicare beneficiaries
  - 85% live in the Portland Metro region; rest are spread statewide
- Not for Profit
- Contracted network
  - Contracts with primary care providers, specialists, hospitals, medical equipment vendors, home health agencies, pharmacies
  - About 50% of our primary care providers practice in clinics that disproportionately care for the poor
- Participating in 4 regional Medicaid Coordinated Care Organizations

Our Mission: Cultivating individual wellbeing and community health through shared learning and innovation.

Our Vision: Healthy communities for all individuals regardless of income or social circumstances.
Central City Concern is a critically important delivery system partner for CareOregon

- Old Town Clinic – FQHC that provides trauma-informed primary care to 2600 CareOregon members
  - 600 of these members (24%) are considered high risk, high cost members
  - Old Town Clinic was one of the five original primary care practices that partnered with CareOregon on a safety-net medical home transformation model (2006)
- Central City Recovery Center – safety-net community mental health and CD treatment provider that serves hundreds of CareOregon members
- Hooper Detox Center – medically supervised detox
- Recuperative Care Program – medical respite for homeless population
- Numerous housing and vocational programs that serve our members
Recuperative Care Program

- CareOregon initiated a contract with the Recuperative Care Program (RCP) in 2005; hospitals also initiated contracts for their uninsured populations
- CareOregon approves approximately 15 RCP admits per month; 180 per year
- Does not operate like a typical medical benefit
- Referrals generally come from hospital discharge planners/hospitalists/case managers
- Health Plan care coordinators process referrals; care coordination RNs assess eligibility along with CCC staff, and present each referral to a medical director for approval or denial
- Initial approvals are for 30 days – we can extend for longer on a case-by-case basis
The MCO Business Case for Medical Respite

- Average cost of hospitalization for complex CO member is $10,000
- For homeless members, even higher
- Previous studies published demonstrate avg 30-day readmit rate for homeless populations is around 50%
Methodological issues:

- Regression to the Mean
- Need a longer time horizon to “prove” effect
- Comparison groups are difficult
Health outcomes affecting homeless in Portland

- 3% Age Over 60
- 3% HIV/AIDS
- 4% Tuberculosis
- 6% Cancer
- 7% Emphysema
- 9% Cirrhosis/End Stage Liver Disease
- 11% Diabetes
- 12% Heart Conditions
- 14% Asthma
- 21% Hep C
- 24% Tri-Morbid*
- 36% Other indicator

* Tri-Morbid definition: Co-occurring psychiatric, substance abuse, and chronic medical condition.

2008 Vulnerability Index: Data from a 2008 survey of 646 homeless individuals in Portland to determine the fragility of their health and identify the most vulnerable according to risk factors and the duration of homelessness.46

Health Care Reform & Homelessness in Multnomah County – City Club or Portland Bulletin, Vol. 97, No. 10, January 6, 2015
Medicare STARS and CCO quality incentives – Quality Scores determine PMPM revenue

<table>
<thead>
<tr>
<th>Medicare Quality Measure</th>
<th>CCO (Medicaid) Quality Measure</th>
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<tbody>
<tr>
<td>Hypertension – is blood pressure in control?</td>
<td>Hypertension – is blood pressure in control?</td>
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<tr>
<td>Diabetes Care – is blood sugar level under control?</td>
<td>Diabetes Care – is blood sugar level under control?</td>
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<tr>
<td>Diabetes Care – are all appropriate tests being completed regularly?</td>
<td>Diabetes Care – are all appropriate tests being completed regularly?</td>
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<tr>
<td>Cancer – are breast cancer and colon cancer screenings occurring regularly?</td>
<td>Cancer – are colon cancer screenings occurring regularly?</td>
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<tr>
<td>Care for Older Adults – is a comprehensive medication review completed at least annually?</td>
<td>Pregnancy – are prenatal visits occurring regularly?</td>
</tr>
<tr>
<td>Care for Older Adults – is a functional assessment completed at least annually?</td>
<td>Mental Health – are regular outpatient mental health visits occurring after psych hospitalization?</td>
</tr>
<tr>
<td>Osteoporosis – is appropriate screening occurring regularly?</td>
<td>Dental – are dental sealants being applied?</td>
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Medical Respite

Opportunities for Hospital Partnerships

Carrie Harnish, LMSW
Clinical Director Community Benefit
May 31, 2016

Trinity Health
Livonia, MI
Agenda

• Brief description of the community benefit program and how medical respite programs can partner with local hospitals.
• Discussion of the wide range of partnerships possibilities and program models, including examples from the field
What is Community Benefit?

1. Programs or activities that provide treatment and/or promote health and healing
2. Responses to identified community needs
3. Increases access to health care and improves community health
4. Required by the IRS to maintain tax exemption
Get a Seat at the Table

- Community Health Needs Assessments (CHNAs) and Implementation Plans
- Community Coalitions
- Build Relationships
  - Speak Their Language
  - Share Knowledge
  - Share Your Research
- Connect the Dots
Medical Respite Partnership Opportunities

• Make the Case
• Have a Clear Ask
• Be Patient & Persistent
• Be Willing to Work Through the Issues
• Partnership with St. Luke’s Rest Home
• Room is available on a pre-arrangement basis
  o Prep
  o Recovery
• Appropriate for patients who do not need a lot of care
• HCH staff coordinate the stay
  o Phone Call
  o Face Sheet
• Cost is covered by donations
Recuperative Care Program
A floor of the Gateway Shelter
Funding from Mercy Care Foundation and small grants
Receive referrals from the local hospitals
Provide team-based support for healing and planning
Team includes a nurse manager, social worker and a personal support aide, M-F, 9-5pm
In 2015, admitted 133 clients and successfully discharged 106 of them to more stable situations
Average length of stay is 35 days
• Need is identified
• Funding is allocated
• Location is the challenge
  o Shelter is too small
  o NIMBY
  o Locations are too close to schools or parks
Our Mission…

To create and deliver innovative healthcare solutions that compassionately address the needs of men, women and children facing homelessness.
Medical Respite Program

• Overview
  o 50 bed, free-standing medical respite center in Central Phoenix, AZ;
  o Staffed 24/7 by nurses (RN’s/LPN’s), ‘respite assistants,’ and security;
  o Providers on-site 7 days/wk.
  o Serves ~350 patients/yr.
Medical Respite Program Funding

FY2013-FY2016

FY2013
FY2014
FY2015
FY2016

- Medicaid
- Hospital Community Benefit
- Government Grants
- Events / Donations
- Philanthropic Grants
Medical Respite Program Funding

Normalized to Growth; FY2013-FY2016

- Medicaid
- Hospital Community Benefit
- Events / Donations
- Philanthropic Grants
- Government Grants
Strategic Backdrop

FY2013 – Medical Respite is Launched

FY2014 – State Medicaid Expansion

FY2015 – Initial MCO Partnerships

FY2016 – FQHC Alignment
Funding Mechanisms for MCO Partnerships

• **Fee-for-service billing**
  - Professional fees for services provided by duly licensed medical providers via routine Medicaid benefit;

• **Bundled payments**
  - MCO’s may choose to bundle your services provided into a single CPT and pay an enhanced rate;
  - CTC partnered with 3x MCO’s in 2014/2015 – billed home visit CPT’s (99342-99345 / 99348-99350) via a bundled rate of $202-$272 per diem.

• **Value-based payments**
  - Special contractual agreements that let you share the value your program creates for MCO’s;
  - *Examples:* Administrative investments, Quality-based payments, Outcomes-based payments, Shared savings, Hybrids, etc.
  - Structures vary widely by MCO.
Tips for Engaging MCO’s

• On-site tours and conversations;
• Leverage your network, community and board to reach decision makers;
• Involve consumers – especially MCO members;
• Share as much data as you have;
• Don’t undervalue qualitative data and storytelling;
• Let them worry about the mechanics of billing and payment.

Other Considerations

• Billing systems – invoicing, claims or both?
• Revenue cycle and cash timing;
• Utilization management – both hospital and health plan;
• What data are you gathering, tracking and/or sharing with your payers?
Piecing Together the Safety Net

1. MCO/Medicaid revenue;
2. Hospital community benefit for uninsured/underinsured;
3. Government block grants (CDBG, etc.);
4. Private philanthropic grants for uninsured;
5. Private charitable funding via donations, special events, etc.
At the end of the day...
Questions?

Henry Fader
faderh@pepperlaw.com

Carrie Harnish
Carrie.Harnish@trinity-health.org

Rebecca Ramsay
ramsayr@careoregon.org

Brandon Clark
bclark@circlethecity.org