PRESSING ON WITH HEALTH REFORM IN TURBULENT TIMES

Medicaid, Homelessness, and Charting a Path Forward

June 21, 2017
FINDING COMMUNITY

• Acknowledging change in the midst of change
• Identifying common issues amid a wide range of experiences
• Finding support
• Continuing —and improving—our work
FRAMEWORK FOR TODAY

• **Lay of the Land:** Understand what federal legislation and other actions have been proposed or implemented to alter current policy

• **Implications:** Recognize how those proposals impact the HCH community broadly and health care practice transformation activities specifically

• **Path Forward:** Understand how to effectively respond in the current environment
DISCUSSION FORMATS

• Part 1: Panelist presentation, large group Q&A
• Part 2: Interview w/ leaders, “interactive fishbowl”

LUNCH

• Part 3: Presentation, “interactive fishbowl”
• Part 4: Opening comments, large group discussion
DISCLAIMER

The information or content and conclusions of this event should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Protect Our Care: Threats to Medicaid

Hannah Katch
June 2017
Protect Our Care: Threats to Medicaid

1. Who does Medicaid cover today?

2. How would the House-passed Republican health bill end Medicaid as we know it?
   - discussion of the House bill

3. What other threats does Medicaid face?
   - discussion, continued

4. What can we do?
1. Who Does Medicaid Cover Today?

- 33 million children
- 6 million seniors
- 10 million people with disabilities

*Number of Medicaid beneficiaries in any given month*
The Basic Foundations of Medicaid

• Enacted in 1965 as title XIX of the Social Security Act

<table>
<thead>
<tr>
<th>Entitlement</th>
<th>Eligible Individuals are entitled to a defined set of benefits</th>
<th>States are entitled to federal matching funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>Sets core requirements on eligibility and benefits</td>
<td>PARTNERSHIP</td>
</tr>
<tr>
<td>State</td>
<td>Flexibility to administer within federal guidelines</td>
<td></td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation, kff.org/slideshow/medicaid-moving-forward
Medicaid Plays a Central Role in Our Health Care System

Health Insurance Coverage

Assistance to Medicare Beneficiaries

Long-Term Care Assistance

Support for Health Care System and Safety-Net

State Capacity for Health Coverage

Source: Kaiser Family Foundation, kff.org/slideshow/medicaid-moving-forward
One-Fifth of Medicaid Enrollees Account for Nearly Half of Medicaid Spending

Enrollment and Spending in Medicaid

**Medicaid enrollment**
- Children: 43%
- Adults: 36%
- Blind and disabled: 13%
- Aged: 8%

**Medicaid spending**
- Blind and disabled: 34%
- Children: 19%
- Aged: 14%
- Adults: 32%

Source: Spending and enrollment estimates for FY2015 from the Congressional Budget Office’s March 2016 Medicaid baseline. Figures may not sum to 100 percent due to rounding.

**Center on Budget and Policy Priorities | CBPP.ORG**
2. How would the House-passed Republican health bill end Medicaid as we know it?

House GOP Plan Would Cut Medicaid by $834 Billion Over Ten Years

Source: Congressional Budget Office, May 2017
Republicans Have Absolutely No Idea How to Handle This Awful CBO Report

GOP’s American Health Care Act: ‘The end of Medicaid as we know it’

Health Bill a Bitter Pill for Older Americans

There May Be 22 House Republicans Ready to Sink the GOP Health Care Bill

AHA, America's Essential Hospitals oppose GOP's American Health Care Act

Safety net hospitals couldn't sustain Medicaid reductions without scaling back services or eliminating jobs,' AEH says.
Updated CBO Cost Estimate of House GOP Plan

CBO: HOUSE GOP HEALTH BILL MAKES MILLIONS UNINSURED

- 2020: 19 mil.
- 2026: 23 mil.

Source: Congressional Budget Office

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG
House GOP Plan Cuts Coverage to Pay for High-Income Tax Cuts

CBO: HOUSE GOP HEALTH BILL CUTS COVERAGE TO PAY FOR HIGH-INCOME TAX CUTS

Net savings  Net cost

-$834 billion  -$290 billion  $136 billion  $209 billion  $661 billion

Medicaid cuts  Reduced subsidies for individual insurance  Other provisions  Repealed employer and individual penalty payments  Tax cuts (largely to the wealthy and medical industries)

Source: Congressional Budget Office

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG
### Medicaid Per Capita Cap Would Shift Costs to States

#### Current Medicaid Financing System vs Capped Federal Medicaid Funding

<table>
<thead>
<tr>
<th>Expected Spending Per Enrollee (50% FMAP state)</th>
<th>Unexpected Higher Spending Per Enrollee</th>
<th>Current system (50% FMAP state)</th>
<th>Expected Spending Per Enrollee</th>
<th>Unexpected Higher Spending Per Enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td>$120</td>
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<td>$60</td>
<td>$60</td>
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<td>$50</td>
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</tbody>
</table>

- **Federal Share**
- **State Share**

*Federal cap*
How Capping Federal Medicaid Funds Would Affect State Budgets

• Limited ways for states to spend less in Medicaid

• States will need to figure out how to “do more with less”

• To meet the caps, states really only have three ways to cut costs:

1. Cut Benefits
2. Cut Enrollment
3. Cut Payments to Providers
Cuts Will Fall Primarily on Beneficiaries

Magnitude of Federal Medicaid Cuts is Large and Medicaid is Already Very Efficient

REMINDER: Three ways to cut costs

1. Cut Benefits
2. Cut Enrollment
3. Cut Payments to Providers

• Payments to providers are already very low in Medicaid

• That leaves cuts to beneficiaries:
  → Either cut benefits or limit enrollment
QUESTIONS ABOUT THE HOUSE-PASSED BILL?
3. What other threats does Medicaid face?

• Medicaid waiver proposals
  → time limits
  → work requirements
  → scaling down Medicaid expansion
  → financing changes

• New authority for states to cut Medicaid
  → “flexibility”
4. What can we do?

✓ Talk to members of Congress

✓ Talk to Governors, state agencies

✓ Activate state partners and stakeholders

✓ Write editorials, talk to press
Pressing on with Health Reform in Turbulent Times: Medicaid, Homelessness and Charting a Path Forward

June 21, 2017
Shannon M. McMahon, MPA, Deputy Secretary

Shannon.McMahon@Maryland.gov
DHMH AT A GLANCE aka “THE WORLD WE LIVE IN”

- Proudly Serves 100% of the State of Maryland
- Manages a budget of $12.4 billion
- Operates 11 Facilities
- Partners with 47 Hospitals
- Oversees 24 Local Health Departments, including the Baltimore City Health Department
- Oversees 24 Boards and Commissions
- Composed of 9187 employees
MEDICAID DIRECTORS FACE SIMILAR ORGANIZATIONAL PRESSURES

Federal regulatory requirements dominating implementation activities into FY2018

- IT modernization
- Legislative reports
- Managed care ‘mega reg’
- Parity
- Home health
- Access
- Part 2
- Community rule

State requirements dominating implementation activities into FY 2018

- State level litigation
- Senior Rx Program
- Procurements
- Personnel/parking/administrivia
- Political uncertainty
- Program uncertainty
- Short tenure
MARYLAND MEDICAID PRIORITIES

• §1115 HealthChoice Waiver Renewal=Stakeholder driven process
  – Creating new funding pathways for community based pilot programs:
    – Home visiting services
    – Assistance in Community Integrated Services (ACIS)
  – Addressing the opioid epidemic
    • Command center
    • Coverage for Rx drugs and residential SUD treatment
  – Presumptive Eligibility for Transitions for Criminal Justice Involved Individuals
  – Addressing obesity
    • Pilot programs funded by philanthropy
PATHWAYS TO ADDRESS SOCIAL DETERMINANTS

• National Diabetes Prevention Program reimbursement model in MCOs
  – An evidence-based model using lay health workers
• Leveraging grant funds
  • Kids to Coverage Campaign
  • Chronic disease grants to MCOs (Diabetes, Hypertension)
• Strengthening partnerships – public health, community partners
  • Raising colorectal cancer screening rates in MCOs
  • Toolkit and adding screening to MCO Evaluation
• Participating in national and regional policy discussions on SDOH
• Supporting data needs of community leaders applying for federal Accountable Health Communities funding
• Tobacco cessation
HOW YOU CAN SUPPORT AND ADVOCATE

What works?

– Build relationships with political folks... but don’t always go straight to the top
– Build relationships with bureaucrats... the political folks don’t stay long
  • Help them help you
    – Bring best practices – our 1115 waiver is full of national best practices and some things we cooked up ourselves – we could not have gone this alone
    – Coordinate with colleagues – other FQHCs, advocates
    – Learn what makes them tick outside of meetings – coffee, lunch, etc.
  – Understand the political priorities & support the vision
  – Make the Medicaid Advisory Committee **Matter**
  – Be an honest broker – especially about other states – we state people talk to each other A LOT!
Thank you!
Barbara DiPietro

Senior Director of Policy,
National HCH Council
&
HCH, Baltimore MD
HEALTH CARE LANDSCAPE

↑ Coverage rates
↑ Recognizing SDOH
↑ Integrating health and housing
↑ Using data (collection, sharing, reporting)
↑ Establishing “value” & adopting EBPs
↑ Connecting with hospitals, managed care & other partners
Percentage of **Uninsured** Patients at HCH Projects in Medicaid Expansion States, 2015

Uninsured: 51% (2013) → 27% (2015)


Note: This data based on UDS-defined visits; does not include all encounters

Note: This data based on UDS-defined visits; does not include all encounters
NEW CHALLENGES

• Provisions of federal health reform proposals
• Budget proposals at HHS and HUD
• New authority from CMS for states to make changes to Medicaid
  → State activities need to be a focus!
• Possible slowing down of progress amid uncertainty
• Leading through uncertainty
• Finding Joy in the struggle
QUESTIONS?
PART 2: IMPLICATIONS FOR THE HCH COMMUNITY

Frances Isbell
President & CEO, HCH Houston

&

Kevin Lindamood
President & CEO, HCH Baltimore
PART 2: IMPLICATIONS FOR THE HCH COMMUNITY

Discussion
PART 3: PRACTICE TRANSFORMATION

Karen Batia
Principal, Health Management Associates

&

Barry Bock
CEO, Boston HCH
Health Care for the Homeless Council PCI
Value-Based Payment and Practice Transformation
NATIONAL TRENDS – The Triple Aim

- Improve individual experience
- Improve population health
- Control inflation of per capita costs
- The best care
- For the whole population
- At the lowest cost

D. Berwick, Institute of Healthcare Improvement, 2007
National Trends - The Evolution of the Triple Aim

Bodenheimer & Sinsky, Ann Fam Med 2014
The Shift to Value-Based Care Will Continue to Drive Health Care Delivery Business and Practice Transformation

**States Will Have More Flexibility**
- 1115 Waivers
- State Plan Amendments

**Medicaid**
- Block grant?
  - Will result in less Medicaid funding and we expect changes to what and who is covered

**Repeal and Replace the ACA**
- Harder than it appears
  - Senate Bill

**Future of HRSA, SAMHSA, and CMS (CMMI)**
- ???????
  - New HRSA expectations
Payments based on size of the population served and characteristics (diagnosis, complexity – level of risk)

Payment is not limited to a “billable encounter” but is intended to cover services that drive outcomes

Rewards achievement of performance (quality)

- Cost of care
- Health Outcomes
- Client satisfaction (experience of care)
VALUE-BASED CARE

Requires risk stratification of the population served and interventions appropriate to identified risks

*Deliver the right service to the right person in the right setting by the right person*

+ Reduce potentially avoidable utilization of urgent and acute care (inpatient and emergency department)
+ Improve access to primary care and use of medical homes
+ Team-based care where staff work at the top of their license, competence and skill set
Value Based Care Driving Development of Integrated Delivery Systems and Consolidation

Shared governance, resources, processes and workflows

Clinical and financial integration

Economy of scale
Evidence of clinical integration includes:

- Use of shared HIT that allows exchange of patient information
- Development and adoption of shared clinical protocols
- Review of clinical care based on established clinical protocols
- Formal mechanisms to monitor adherence to protocols

Evidence of financial integration that demonstrates the required “significant risk” includes:

- Agreement to provide services at capitated rates
- Use of specific financial incentives to achieve cost-containment goals
- Withholds of a substantial amount of compensation due, with distribution based on group achievement of shared goals
- Financial rewards/penalties based on IDS performance
- Agreement to provide coordinated care for fixed, predetermined payment
HRSA has set goal that 100% Community Health Centers will be PCMH recognized

- Practice transformation is not achieved by becoming PCMH recognized
  - Requires continued effort, discipline and resource investment

HRSA and other payers are beginning to shift toward value based payment methodologies and away from FFS

- Revenue impacted by quality achieved

- HCH programs must demonstrate improved population health outcomes and ability to meet individual patient quality metrics
  - Outreach, engage and maintain continuity of care → re-engage
  - Risk Stratification and Care Management
  - Chronic care management
“But we have been successful with the current approach for many years”

Eastman Kodak Company

Source: The Economist, January 14, 2012
High-Value Elements of a System to Manage Attributed Populations

- Attributed Members/Not Yet Patients: ≤50%
- Well Populations: 15-50%
- Chronic Conditions: 5-15%
- Frequent Users of ED and IP: 5%
- Health Homes and Other High-Cost Patients: 5%
- Intensive Care Management
- Clinical Care Management
- Care Coordination and/or Disease Management
- Wellness, Prevention, and Monitoring
- Engagement and Outreach

Health Management Associates
ADAPTING A RISK PYRAMID TO HCH POPULATIONS

Uncontrolled multiple chronic conditions; living on the streets; history of chronic homelessness; high vulnerability score; not engaged in medical home; frequent ED utilization, inpatient stays and criminal justice involvement

Multiple chronic conditions; frequent ED, inpatient utilization; unstably housed or actively homeless; inconsistent use of medical home

Health conditions controlled; actively engaged in medical home; limited ED and inpatient utilization; support systems in place; housing subsidy in place, quickly re-housed

Health conditions unknown; not accessing care; homeless; frequent social services; criminal justice involvement potential

Intensive Community Care Management; consistent and assertive outreach and engagement; street clinical interventions

Clinical care management including care coordination and transition of care management; outreach and engagement, proactive re-engagement; ongoing peer supports

Care transition supports as needed, disease management; health literacy and crisis prevention focus

Outreach and engage; connect to care as relationship established
**ALTERNATIVE PAYMENT MODEL FRAMEWORK**

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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</thead>
<tbody>
<tr>
<td><strong>Fee for Service – No Link to Quality &amp; Value</strong></td>
<td><strong>Fee for Service – Link to Quality &amp; Value</strong></td>
<td><strong>APMs Built on Fee-for-Service Architecture</strong></td>
<td><strong>Population-Based Payment</strong></td>
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<tr>
<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>APMs with Upside Gainsharing</td>
<td>Condition-Specific Population-Based Payment</td>
<td>Comprehensive Population-Based Payment</td>
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<tr>
<td>Pay for Reporting</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
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<td>Rewards for Performance</td>
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<tr>
<td>Rewards and Penalties for Performance</td>
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</table>

Health Care Payment Learning for Action Network (CMS)
Continuum of Risk-Based Contracting

- High Accountability
- Moderate Accountability
- Low Accountability

Financial Risk

- Fee-for-service
- Care Coordination Fee
- Pay-for-performance
- Shared Savings up & down
- Partial Capitation
- Global Capitation
Value-Based Reimbursement Continuum

Accountability, financial opportunity, and Incentive alignment supported by clinical integration, infrastructure and data analytics

<table>
<thead>
<tr>
<th>FFS</th>
<th>Care Coordination Fee</th>
<th>P4P</th>
<th>Shared Savings (up only)</th>
<th>Shared Savings (up and down)</th>
<th>Partial Capitation</th>
<th>Global Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPS Service Unit Based</td>
<td>Delegation of specific Activities (data provided, shared HRA, Care Plans, risk stratification)</td>
<td>P4P Based on Outcomes - ED utilization - Admissions - Readmissions</td>
<td>Shared Savings earned</td>
<td>Shared Savings earned or lost</td>
<td>Partial Capitation</td>
<td>Full Risk for all services</td>
</tr>
<tr>
<td>FFS</td>
<td>FFS Plus Add On Payments</td>
<td>Outpatient Capitated Rate Inpatient and Outpatient Capitated Rate</td>
<td>Sub Capitated Rate</td>
<td>Capitated Rate with Guardrails</td>
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<tr>
<td><strong>How it works</strong></td>
<td><strong>Fee for Service</strong></td>
<td><strong>Care Coordination Fee</strong></td>
<td><strong>Pay for Performance</strong></td>
<td><strong>Shared Savings Upside Only</strong></td>
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<tr>
<td></td>
<td>Starting point is Medicaid or Medicare fee-for-service rates</td>
<td>PMPM payment for specific populations or activities</td>
<td>Usually tied to performance metrics required of MCOs, by CMS, or states, such as: HEDIS measures, State-specific quality measures, CAHPS, Cost/quality drivers such as readmission rates</td>
<td>Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved</td>
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<td></td>
<td>May be negotiated up or down by a few percentage points</td>
<td>May have no contingencies attached to payment</td>
<td></td>
<td>Allows much more flexibility in practice redesign, innovative care and financial incentives for overall appropriate cost management and premium management</td>
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</tr>
<tr>
<td><strong>Implications to Provider</strong></td>
<td>Encourages volume-based vs. value-based medicine</td>
<td>Helps to fund people, processes and technology for upgraded care</td>
<td>Helps to fund upgraded care</td>
<td>Perfect way to gain understanding and control of holistic financial performance without taking any financial risk</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Sometimes can only be used for care and cannot be used for reserves</td>
<td>Helps to focus on specific areas of improvement</td>
<td>Allows provider to get ready to take financial risk, if desired</td>
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<tr>
<td></td>
<td></td>
<td>May be used to build reserves</td>
<td>May be used to build reserves</td>
<td>Gain-share money can be distributed in ways that incent desired behavior changes</td>
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</table>

*Health Management Associates*
<table>
<thead>
<tr>
<th>How it works</th>
<th>Partial Risk (Up and down)</th>
<th>Partial Capitation</th>
<th>Global Capitation</th>
</tr>
</thead>
</table>
| **Implications to Provider** | • A good method to take on limited financial risk with opportunity for more financial gain  
  • Shared savings money can be distributed in ways that incent desired behavior changes  
  • May be used to build reserves | • Allows provider significant flexibility and financial responsibility in an area of strength without having financial responsibility for total care  
  • Excess money beyond the cost of care can be used for anything the provider deems important; reserves, incentives, people, processes, technology | • Provider gains significant leverage with payers, total control or practice design, incentives and investments in people, processes, technology |
MANAGED CARE ORGANIZATIONS

Need assistance with high cost and difficult to engage members

Contract and reward high value care and incentivize further improvement

Move beneficiaries to higher value providers where possible
discontinue contracts with low value providers where no improvement is deemed feasible

Plans are beginning to recognize homeless populations cycle in and out of being covered and across plans
IMPLICATIONS FOR PROVIDER ORGANIZATIONS

Quality and Performance Matters

Population Health Strategy
- Risk stratification
- Integrated care
- Care management

Market Share Matters
- Geographical spread
- Volume or members

Marketing Clout
- Negotiating power
- Sharing of best practices
- Sharing of risk
- Efficient infrastructure
Performance is not a naturally occurring phenomenon and a contract is not a plan

VBP will require organizations to develop or enhance your skills, capacity, and systems for managing clinical, financial, and operational performance and risk

Need to:
- Know what your clinical, operational, and financial performance is *all the time* and what is driving performance issues
- *Reliably* achieve performance for care, outcomes, and costs across many dimensions
- Employ advanced methods for managing the health and costs of your populations
- Have a financial model and operational and financial systems that support performance and manage expenses
## COMMON GAPS FOR VBP CORE ELEMENTS

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board, Leadership and Strategic Readiness</td>
<td>Staff readiness&lt;br&gt;Performance management dashboard</td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Technology to support retrieving, storing, calculating and reporting on clinical quality metrics&lt;br&gt;Real-time communication and alerts, including proactive alerts for ER and hospital use&lt;br&gt;Quality reports/data inform patient outreach&lt;br&gt;Have and use an actionable patient registry</td>
</tr>
<tr>
<td>Patient-Centeredness</td>
<td>Assess and address patients’ linguistic and cultural needs</td>
</tr>
<tr>
<td>BH/PC Integration</td>
<td>Primary care and behavioral health staff on site and integrated into clinical care teams&lt;br&gt;Primary care and behavioral health staff document in a shared medical record</td>
</tr>
<tr>
<td>Cost Efficiency of Current Operations</td>
<td>Evaluate productivity based on Relative Value Units</td>
</tr>
<tr>
<td>Financial Analysis of Patient-Centered Care</td>
<td>Employ professional coders to ensure the accuracy of provider coding practices and documentation&lt;br&gt;Analyze client utilization of specific services&lt;br&gt;Analyze total, annual cost per client</td>
</tr>
<tr>
<td>Financial Health</td>
<td>Revenue model developed to project impact on future cash flow and upfront costs of participation</td>
</tr>
</tbody>
</table>
BHCHP’s Approach to Payment Reform in the Care of People Experiencing Homelessness

Barry Bock, Denise De Las Nueces and Jessie Gaeta
Boston Health Care for the Homeless Program
Reflection Points

- What is missing in the system for our patients?
- How can we improve health outcomes and utilization?
- How should we be thinking about reducing Total Cost of Care (TCOC)?
### Expenditures for the Most Expensive Tenth of the Patients

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>N</th>
<th>Expenditures</th>
<th>Share of $</th>
<th>Average $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Expensive 10%</td>
<td>650</td>
<td>$71,409,801</td>
<td>48%</td>
<td>$109,861</td>
</tr>
<tr>
<td>Least Expensive 90%</td>
<td>5,843</td>
<td>$77,503,066</td>
<td>52%</td>
<td>$13,264</td>
</tr>
<tr>
<td>All Patients</td>
<td>6,493</td>
<td>$148,912,866</td>
<td>100%</td>
<td>$22,934</td>
</tr>
</tbody>
</table>

Of the patients in the most expensive tenth, 400 or 62% were Medicaid-only patients. And 250 or 38% were dual eligibles – out of proportion with their 27% share of the total patient group.
Compared with the overall MassHealth membership, BHCHP patients are much sicker, much more expensive and have far more hospital stays.

<table>
<thead>
<tr>
<th>Medicaid-Only Individuals Not Enrolled in MCOs</th>
<th>Number of Patients or Members</th>
<th>Average DxCG score</th>
<th>Average annual cost</th>
<th>Hospital discharges per 1,000</th>
<th>ED visits per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHCHP Patients</td>
<td>4,168</td>
<td>3.4</td>
<td>$20,093</td>
<td>852</td>
<td>4,060</td>
</tr>
<tr>
<td>PCC Plan Members</td>
<td>447,912</td>
<td>1.5</td>
<td>$6,679</td>
<td>129</td>
<td>1,095</td>
</tr>
<tr>
<td>Ratio BHCHP:PCC</td>
<td>2.3</td>
<td>3.0</td>
<td>6.6</td>
<td>3.7</td>
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</tbody>
</table>

The BHCHP patients have DxCG scores twice as high, average costs three times higher, hospital discharges over six times higher and emergency department visits almost four times higher than MassHealth members under age 65.
The average expenditures for patients with selected physical diagnoses are far above the average for all patients of $23,000.

For example, costs for patients with Hepatitis C were $41,000, for patients with ischemic heart disease $59,000, and for those with congestive heart failure $79,000.
Patients with a substance use diagnosis have average costs twice those of patients with no behavioral diagnosis. Patients with mental illness have average costs five times larger.
THE WORLD IS CHANGING: REALITIES AND OPPORTUNITIES
Realities and Opportunities

• We will be part of larger care delivery networks
  – ACOs
  – Community Partners (CPs)
• We need to be experts in coordinating and managing the clinical care for people who are homeless
• The quality of our work will be monitored and expected to improve
• Value will be important and compared to alternative providers of care
Realities and Opportunities

• We will be expected to function as a *PCMH on steroids*, emphasizing patient involvement and use of data to manage populations

• Highly functioning teams are a prerequisite for success in the near future

• Reasonable access and strong integration between behavioral health and primary care will be expected

• We will need to broaden our ability to perform care coordination for all our patients, and complex care management for highest-risk patients, especially at times of transition
Realities and Opportunities

• At least part of our reimbursement will be per patient, not per visit
• We will have more flexibility to use reimbursement money the way we feel is most likely to improve the health of our patients
• Uncertainty about level of reimbursement that we will receive and the exact methodology to be used to determine rates
  – Although MassHealth will “risk adjust” payments based on certain social determinants of health including homelessness
IMPLICATIONS FOR OUR CARE MODEL
Key Responsibilities

• Coordinate and integrate both medical and behavioral health care
• Develop and maintain individualized care plans
• Manage transitions in and out of inpatient settings aggressively
• Provide 24 hour call with elastic response / diversionary capabilities: offer alternatives to ER
• Impact social determinants of health
Progression of Massachusetts Reform Initiatives

• Patient Centered Medical Home (PCMH)
• One Care
• Primary Care Payment Reform (PCPR)
• Accountable Care Organizations (ACOs)
Progression Towards Accountable Care

- Payment Methodology
  - Global Payment
  - FFS

- Degree of Integration
  - Limited Integration
  - Full Care Integration

- Payment Innovation
  - “Business as Usual”
  - Old Market

- True Accountable Care
  - Delivery System Transformation
  - PCPR
  - PCMHI
  - Duals
  - ACOs

- True Accountable Care
  - “Business as Usual”
  - Old Market
CMS Investment and Targets: Concept Overview

More aggressive targets → larger savings off trend → larger potential net investment

Projected trend

Performance

Total savings over 10 years = $2B

$2B upfront investment over 5 years

Net investment

Year 1: $0.6B
Year 2: $0.6B
Year 3: $0.3B
Year 4: $0.3B
Year 5: $0.2B

Investment is explicitly temporary, goes away after Year 5
In subsequent years, reform is self-sustaining and supported by savings

MassHealth savings

Year 6
Year 7
Year 8
Year 9
Year 10
Goals of MassHealth Restructuring

• Improve population health and care coordination through payment reform and value-based payment models

• Improve integration of physical and behavioral health care

• Scale innovative approaches for populations receiving long-term services and supports

• Ensure financial sustainability of MassHealth
BHCHP’s Approach to ACOs

- What are the ways ACOs are an awkward fit for us?
- What were the considerations for us regarding whether to join BACO?
- Exactly which patients are we talking about, again?
- How will things look different for BHCHP when BACO starts in December?
BEHAVIORAL HEALTH COMMUNITY PARTNERS (HEALTH HOMES)
BH CP Claims-Based Eligibility Criteria

- ACO and MCO members > 21* with SMI and/or SUD and high service utilization
- Example claims-based eligibility criteria, final still in development by MassHealth:

<table>
<thead>
<tr>
<th>Members must have a diagnosis from the below list, e.g.,</th>
<th>...AND meet at least one additional criterion, e.g.,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any SUD diagnosis, excluding caffeine and nicotine</td>
<td>ESP interaction</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Detoxification</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Methadone treatment</td>
</tr>
<tr>
<td>Personality / other mood disorders</td>
<td>IP visits (e.g., 3+)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>ED visits (e.g., 5+)</td>
</tr>
<tr>
<td>Trauma</td>
<td>Select medical comorbidities (e.g., 3+)</td>
</tr>
<tr>
<td>Attempted suicide or self-injury</td>
<td>High LTSS utilization</td>
</tr>
<tr>
<td>Homicidal ideation</td>
<td>Current DMH enrollment</td>
</tr>
<tr>
<td>Major depression</td>
<td></td>
</tr>
<tr>
<td>Other depression</td>
<td></td>
</tr>
<tr>
<td>Adjustment reaction</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Psychosomatic disorders</td>
<td></td>
</tr>
<tr>
<td>Conduct disorder</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
</tr>
</tbody>
</table>

Note: EOHHS estimates that ~50k-60k MassHealth members will be eligible for BH CP services at any given time based on these criteria, but will only pay the DSRIP PMPM for up to 35k members at any given time. No specifics have been provided yet on how ACOs / CPs should address this gap.

* Members < 21 will continue to use CBHI CSAs as today. As with BH CPs, ACOs will be required to contract with all CSAs in their service areas, and CSAs will be eligible to receive CP Infrastructure DSRIP funding (not care coordination PMPM).
BHCHP’S APPROACH TO:
BH COMMUNITY PARTNERS
Targeted Cost Challenge Investment Awardee Highlight: Boston Health Care for the Homeless Program

BOSTON HEALTH CARE for the HOMELESS PROGRAM

**Challenge Area** | **Proposed Award**
--- | ---
Social Determinants of Health | $750,000

**Primary Aim**
Reduce ED visits and admissions by 20% for high cost and high need homeless patients

**Innovative Model**
Coordinated care hub for primary care, behavioral health care, housing agencies and shelters, and social services providers
BHCHP will serve as a hub for a team of primary, acute, and specialty medical providers along with shelters, and advocacy organizations to identify patients, track utilization, and provide intensive case coordination for patients whose needs and day-to-day paths span many types of services and providers.

**Partners**
- Bay Cove Human Services
- Boston Public Health Commission
- Boston Rescue Mission
- Casa Esperanza
- Massachusetts Housing and Shelter Alliance
- The New England Center and Home for Veterans
- Pine Street Inn
- St. Francis House
- Victory Programs

**Total Initiative Cost**
$919,085

**Estimated Savings**
$1,496,000

Source: Health Policy Commission Board Meeting, July 27, 2016
Social Determinants of Health
Coordinated Care Hub
for people experiencing homelessness

Supports for You
as You Support Your Highest-Risk Clients

1. DEDICATED RESOURCES
   15:1 client-to-staff ratio
   • Recognizes challenge of engaging high-risk clients
   • Ensures that engagement can be focused and consistent over time
   • Special program requiring client consent for participation

2. SHARED INFORMATION TECHNOLOGY
   so you can contact & communicate with other agencies more easily
   shared care management platform (ECHO)

3. SHARED CARE PLANS
   so your client’s goals are created by him or her – and being supported by all of us

4. CONNECTION TO PRIMARY CARE
   You’ll know your client’s health care team, and they’ll know you
   • Regular communication with doctors/nurses
   • Joint training and care conferencing

5. DATA TO HELP YOU UNDERSTAND YOUR CLIENT’S NEEDS & SERVICE USE
   Information from Medicaid claims, health record & other social service agencies
   • Data about how to improve client’s connection to care (e.g., when due for cancer screenings)
   • Data about recent hospitalization/ED visits
   • Data about care management & housing from HMIS

6. SUPPORT FROM HUB LEADERSHIP TEAM
   Meets regularly to troubleshoot and strategize about progress and “pain points”
   • Dashboard reviewed monthly so we’ve got all eyes on goal
   • May be able to prioritize housing, services, or other resources
PART 3: PRACTICE TRANSFORMATION

Discussion
PART 4:
THE PATH FORWARD

Bobby Watts
CEO, National HCH Council