NATIONAL HEALTH CARE for the HOMELESS COUNCIL

PRESSING ON WITH HEALTH REFORM IN TURBULENT TIMES

Medicaid, Homelessness, and Charting a Path Forward

June 21, 2017

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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

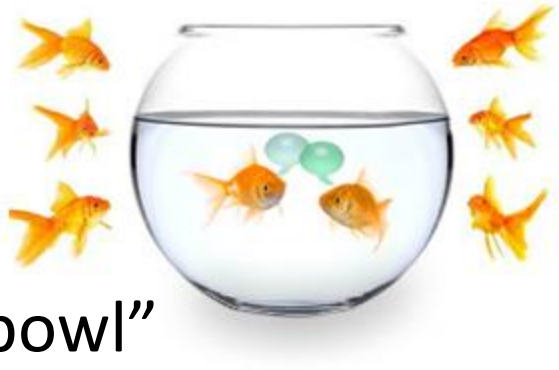
FRAMEWORK FOR TODAY

- **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

Center on Budget and Policy Priorities

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

Entitlement

Eligible Individuals are entitled to a defined set of benefits

States are entitled to federal matching funds

Federal

Sets core requirements on eligibility and benefits

PARTNERSHIP

State

Flexibility to administer within federal guidelines

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

MEDICAID

Support for Health Care System and Safety-Net

State Capacity for Health Coverage

THE HENRY J. KAISER FAMILY FOUNDATION

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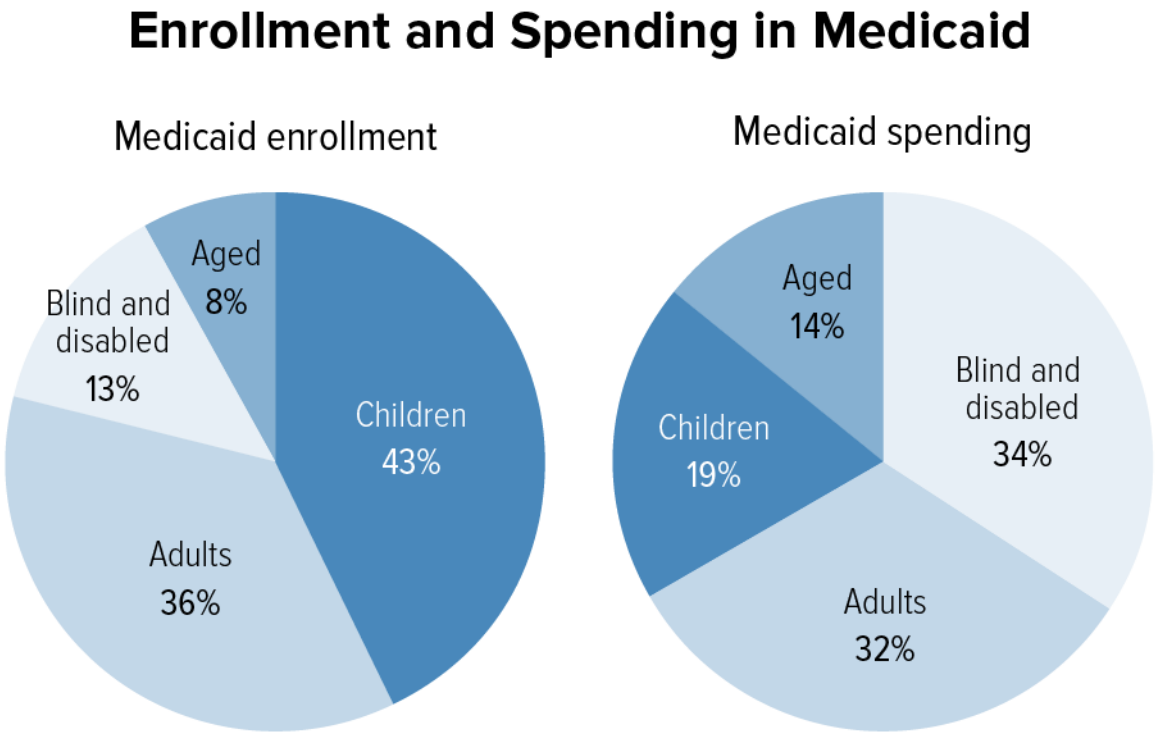
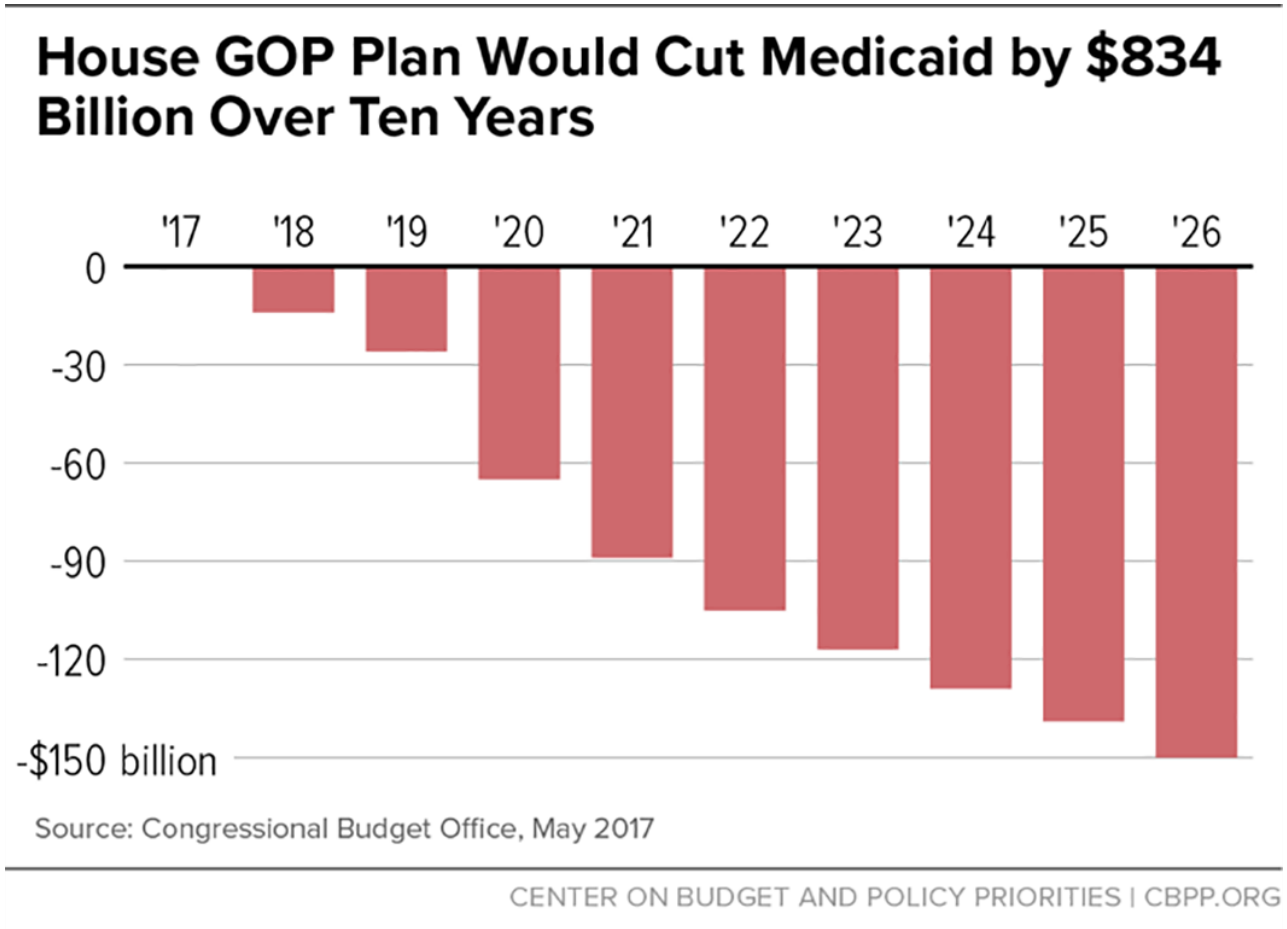
Source: *Kaiser Family Foundation, kff.org/slideshow/medicaid-moving-forward*

One-Fifth of Medicaid Enrollees Account for Nearly Half of Medicaid Spending



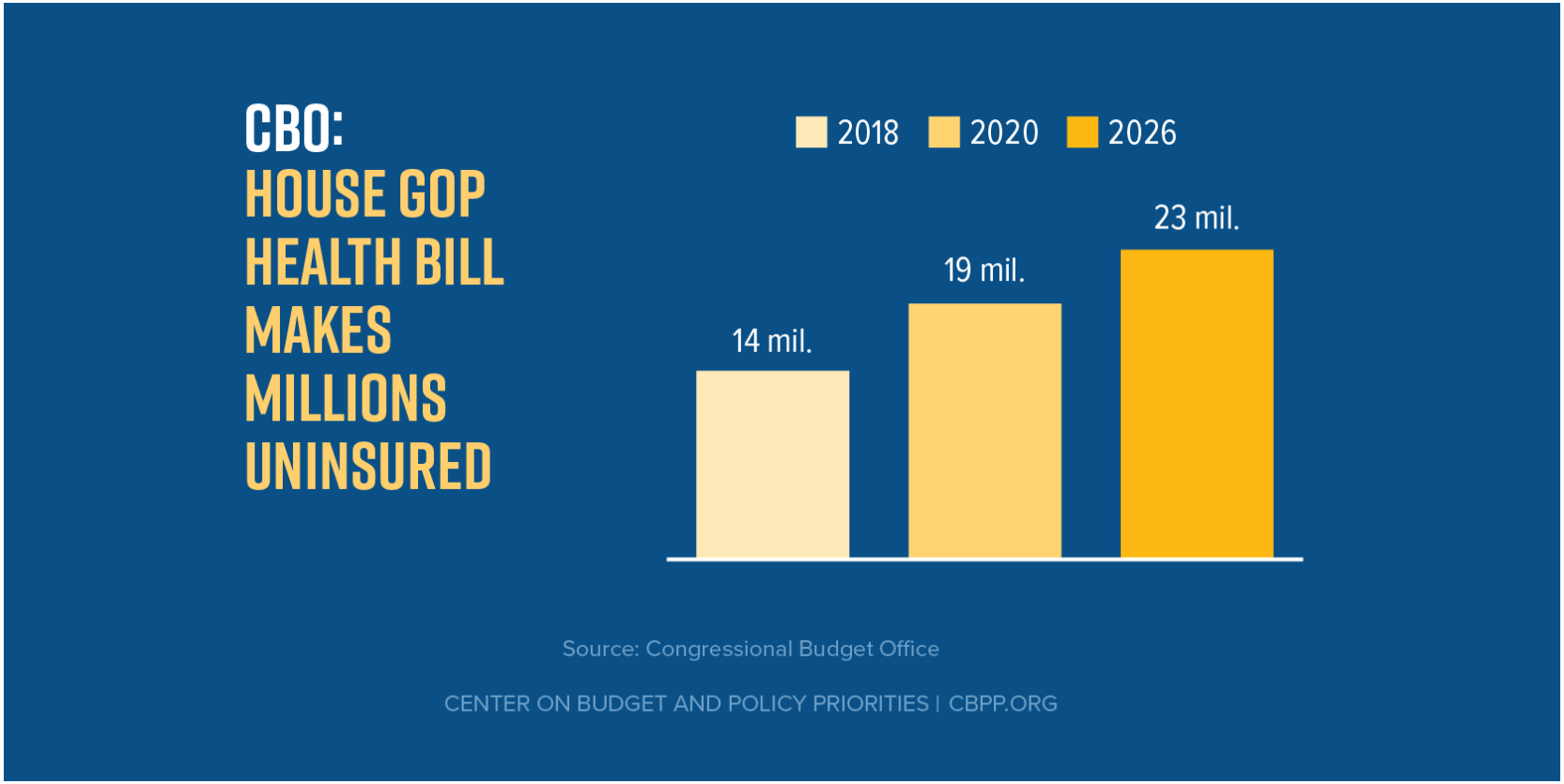
Source: Spending and enrollment estimates for FY2015 from the Congressional Budget Office's March 2016 Medicaid baseline. Figures may not sum to 100 percent due to rounding.

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

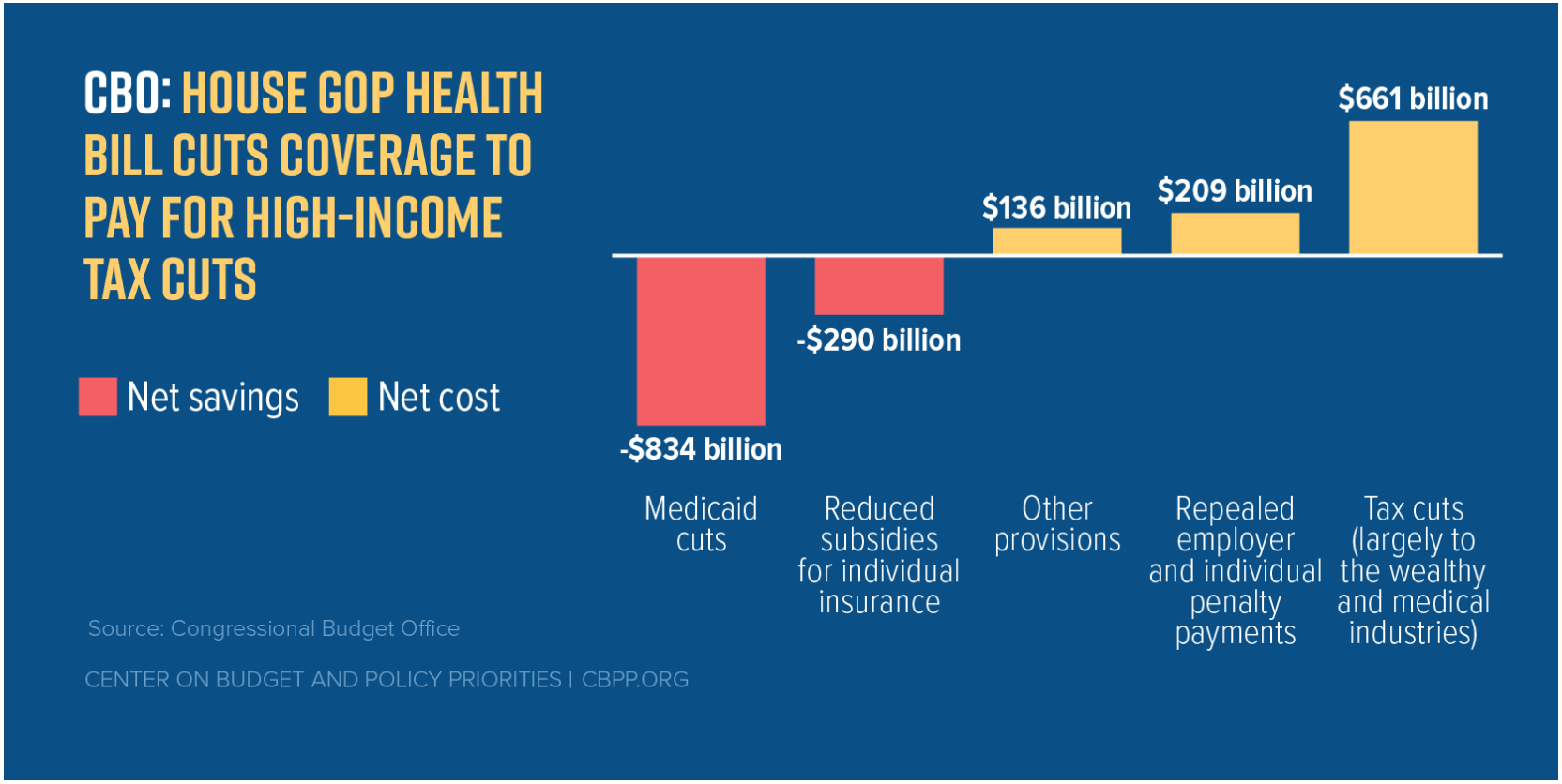



Republicans Divided Over Health Care Bill After Critical CBO Report
By SUSAN DAVIS • MAR 14, 2017
Republicans Have Absolutely No Idea How to Handle This Awful CBO Report
GOP's American Health Care Act: 'The end of Medicaid as we know it'
By Anjalee Khemlani, March 13, 2017 at 7:08 AM
Health Bill a Bitter Pill for Older Americans
Giveaway to insurers and drug companies
by Nancy LeaMond, AARP, March 10, 2017 | Comments: 40
MAR. 16, 2017 AT 6:37 AM
There May Be 22 House Republicans Ready to Sink the GOP Health Care Bill
Healthcare IT News
Government & Policy
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.

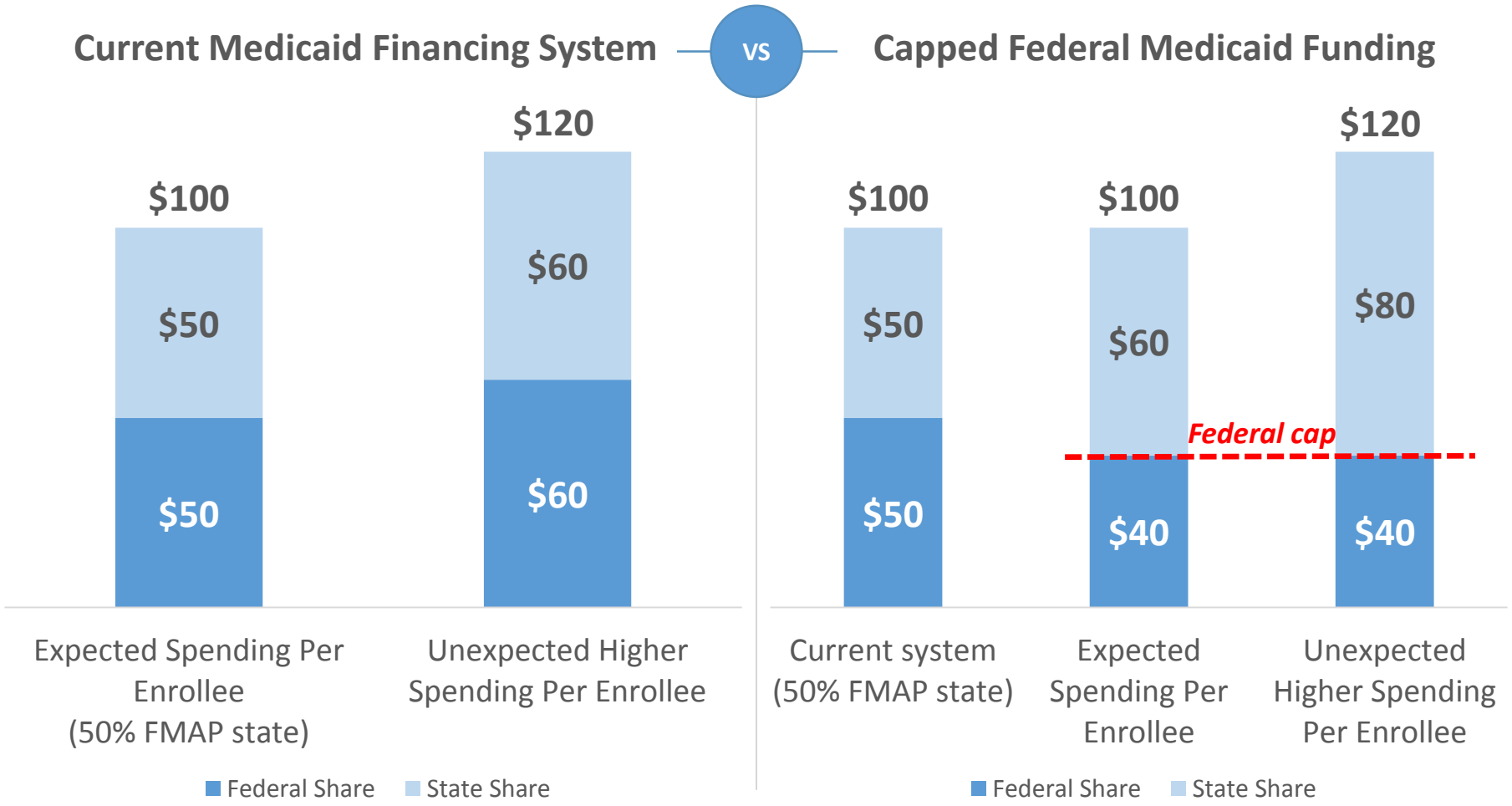
Updated CBO Cost Estimate of House GOP Plan



House GOP Plan Cuts Coverage to Pay for High-Income Tax Cuts



Medicaid Per Capita Cap Would Shift Costs to States



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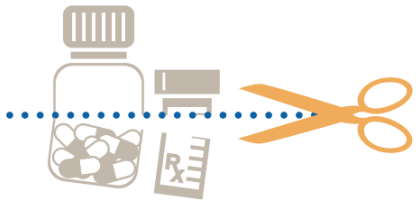
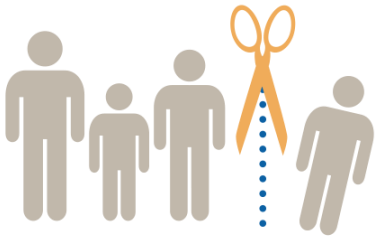
How Capping Federal Medicaid Funds Would Affect State Budgets

- 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



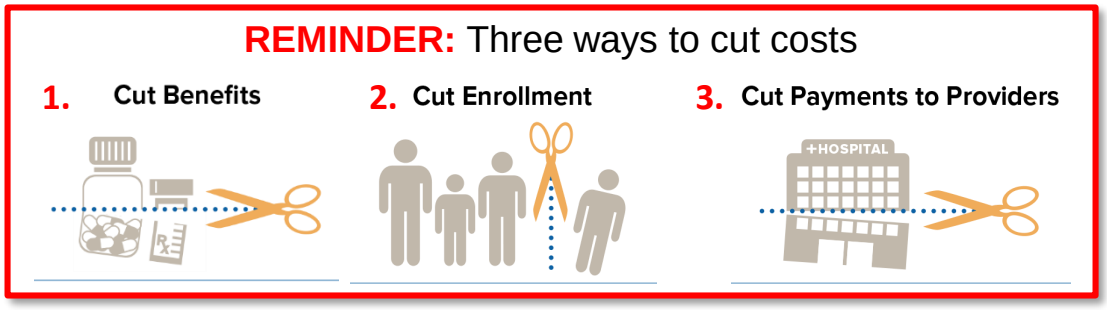
2. Cut Enrollment



3. Cut Payments to Providers

Cuts Will Fall Primarily on Beneficiaries

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



- 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

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QUESTIONS?

CHANGING
Maryland
for the Better

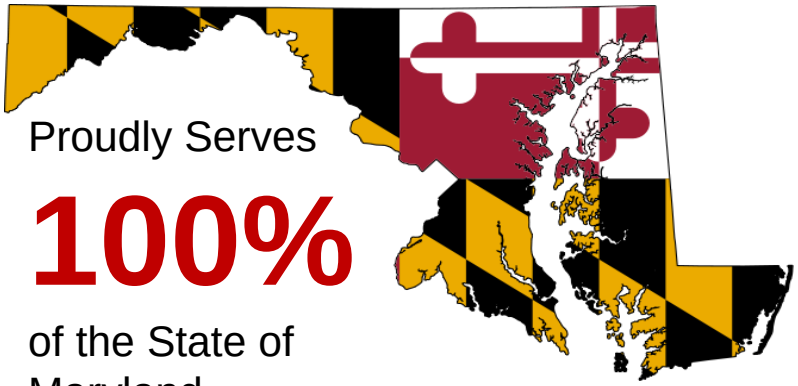
Pressing on with Health Reform in Turbulent Times: Medicaid, Homelessness and Charting a Path Forward

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

Oversees

24 Local Health Departments, including the Baltimore City Health Department

24 Boards and Commissions

Partners with

47

Hospitals

Operates

11

Facilities

Manages a budget of

$12.4 billion

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 SUPORT 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!
CHANGING
Maryland
for the Better

PERSPECTIVES: MEDICAID DIRECTORS

Barbara DiPietro

Senior Director of Policy,

National HCH Council

&

HCH, Baltimore MD

HEALTH CARE LANDSCAPE

↑ Coverage rates

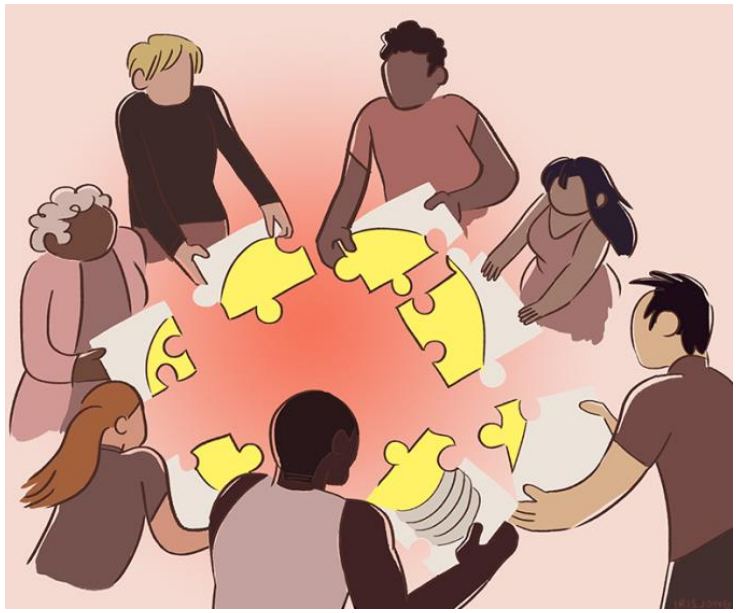
↑ Recognizing SDOH

↑ Integrating health and housing

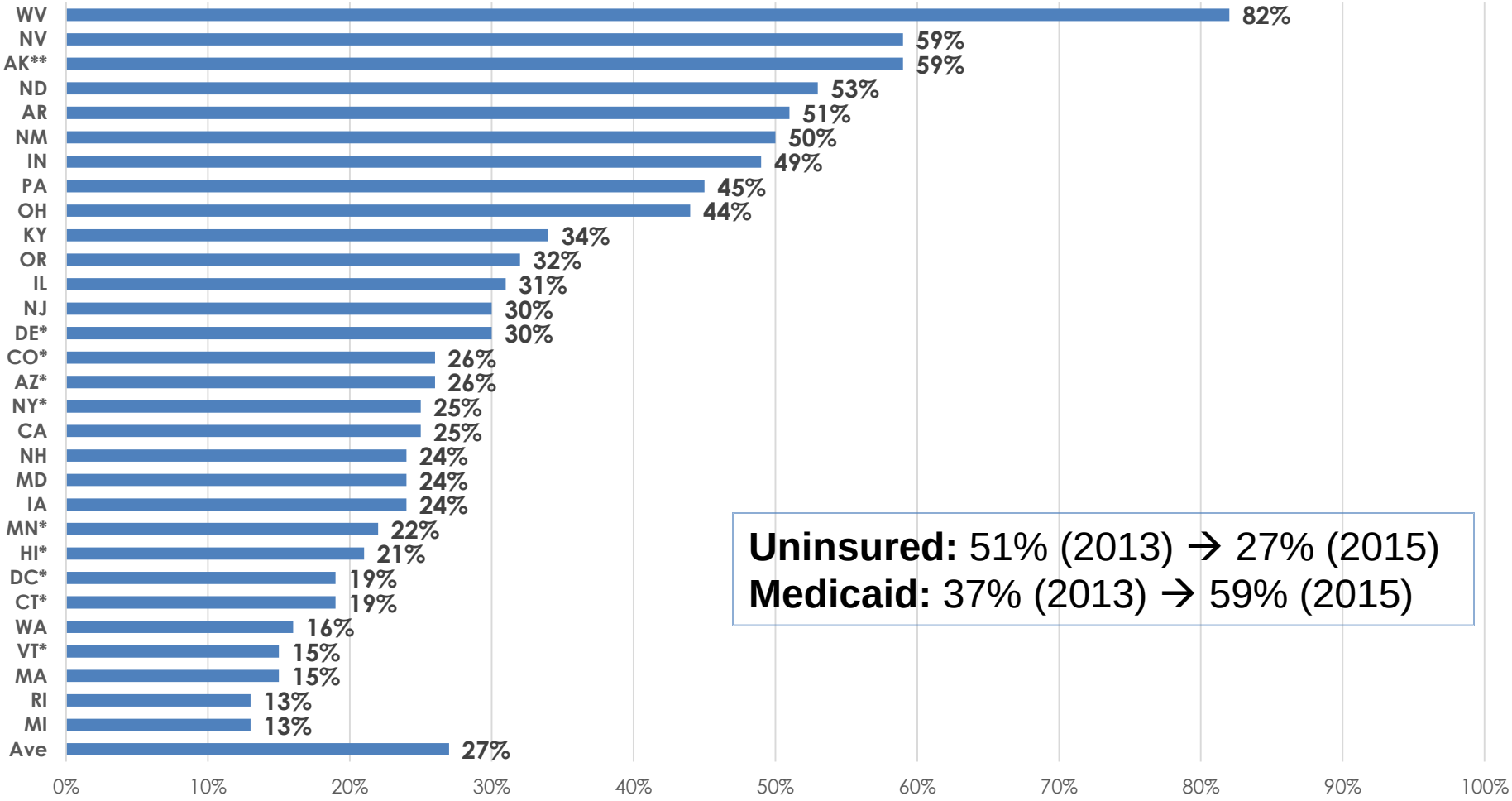
↑ Using data (collection, sharing, reporting)

↑ 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)
Medicaid: 37% (2013) → 59% (2015)

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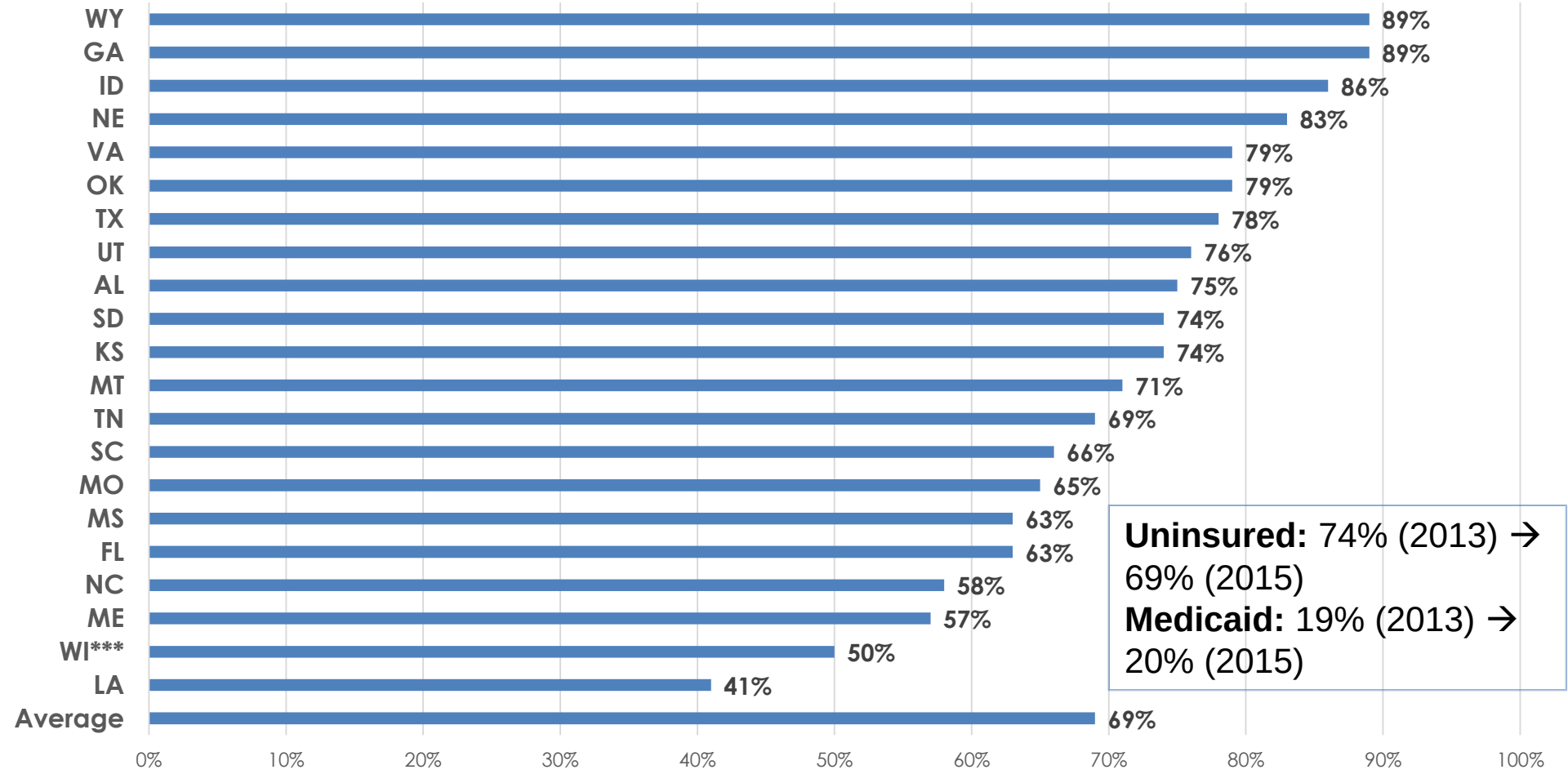
Policy brief on coverage at HCH projects: https://www.nhchc.org/wp-content/uploads/2011/10/issue-brief-insurance-coverage-hchs-march-2017.pdf

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

Percent of Uninsured Patients at HCH Projects in Non-Expansion States, 2015



Uninsured: 74% (2013) → 69% (2015)
Medicaid: 19% (2013) → 20% (2015)

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Policy brief on coverage at HCH projects: https://www.nhchc.org/wp-content/uploads/2011/10/issue-brief-insurance-coverage-hchs-march-2017.pdf

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?

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for the
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COUNCIL

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

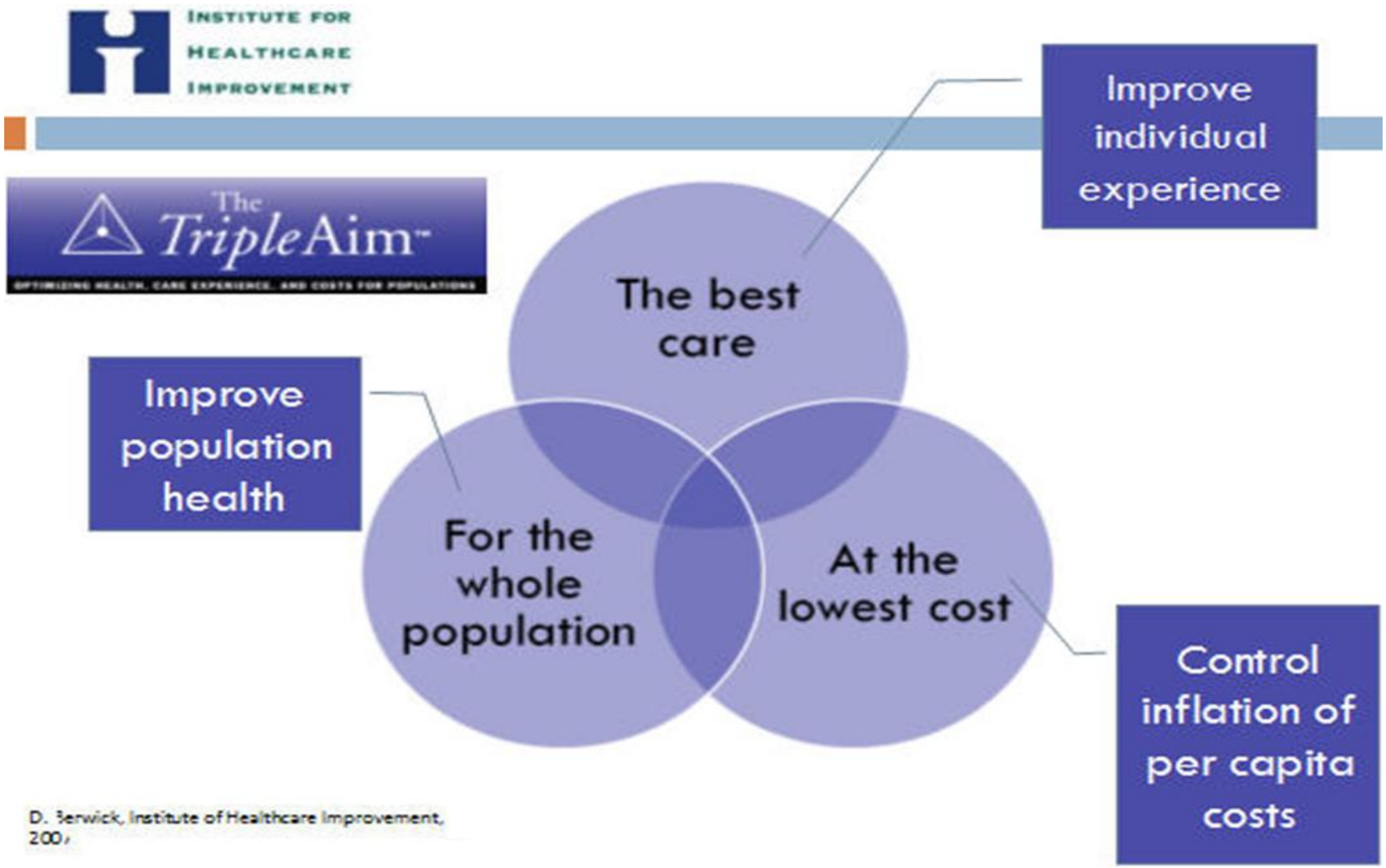
CEO, Boston HCH

HEALTH MANAGEMENT ASSOCIATES

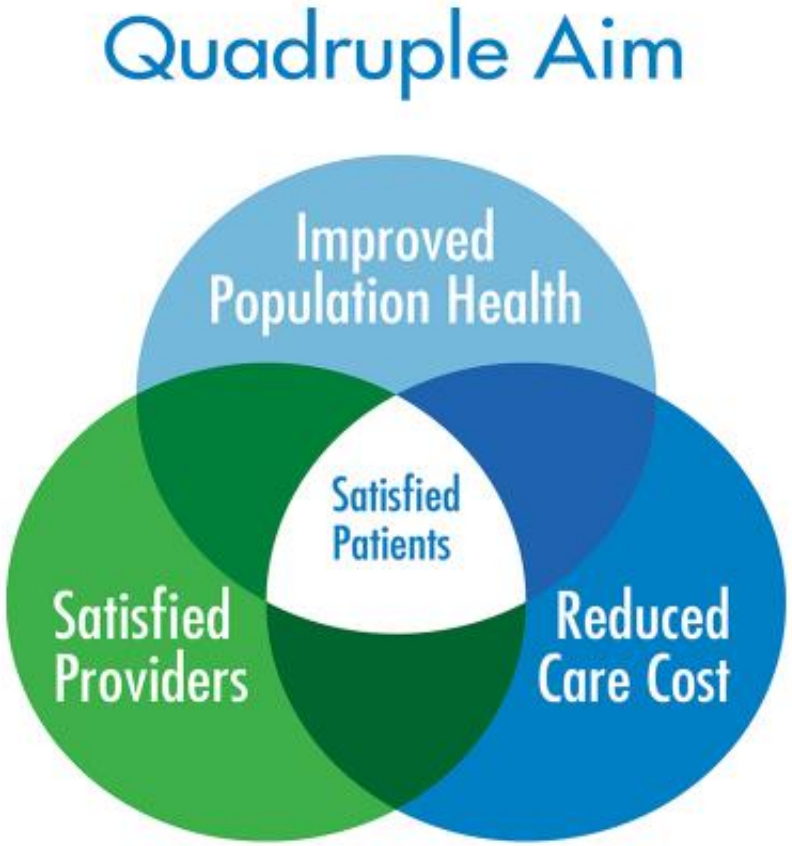
Health Care for the Homeless Council PCI

Value-Based Payment and Practice Transformation

NATIONAL TRENDS – The Triple Aim

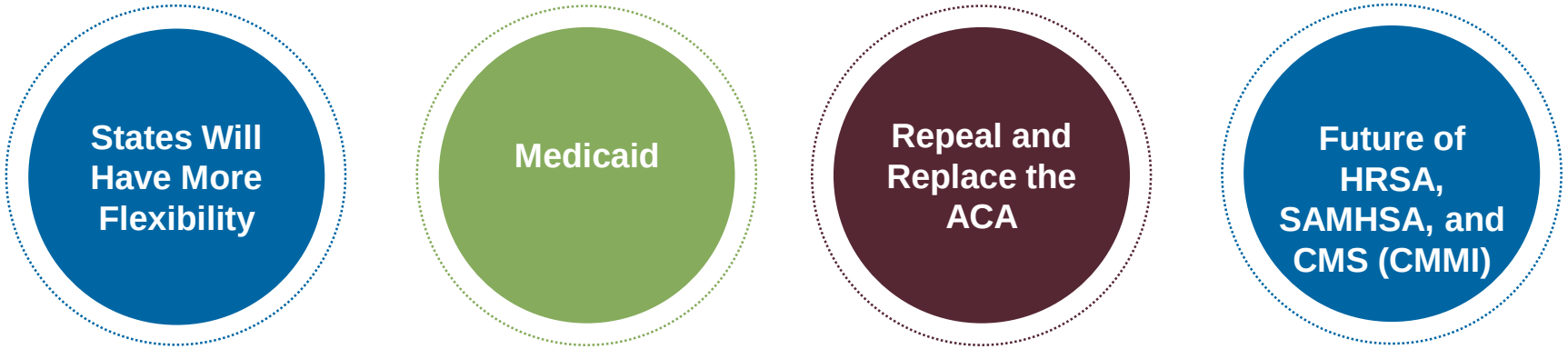


National Trends - The Evolution of the Triple Aim



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	Medicaid	Repeal and Replace the ACA	Future of HRSA, SAMHSA, and CMS (CMMI)
1115 Waivers State Plan Amendments	Block grant? Will result in less Medicaid funding and we expect changes to what and who is covered	Harder than it appears Senate Bill	??????? New HRSA expectations

VALUE BASED CARE

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

National Trends – Practice and Financial Transformation

- 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

NATIONAL TRENDS IMPACT ON HCH

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

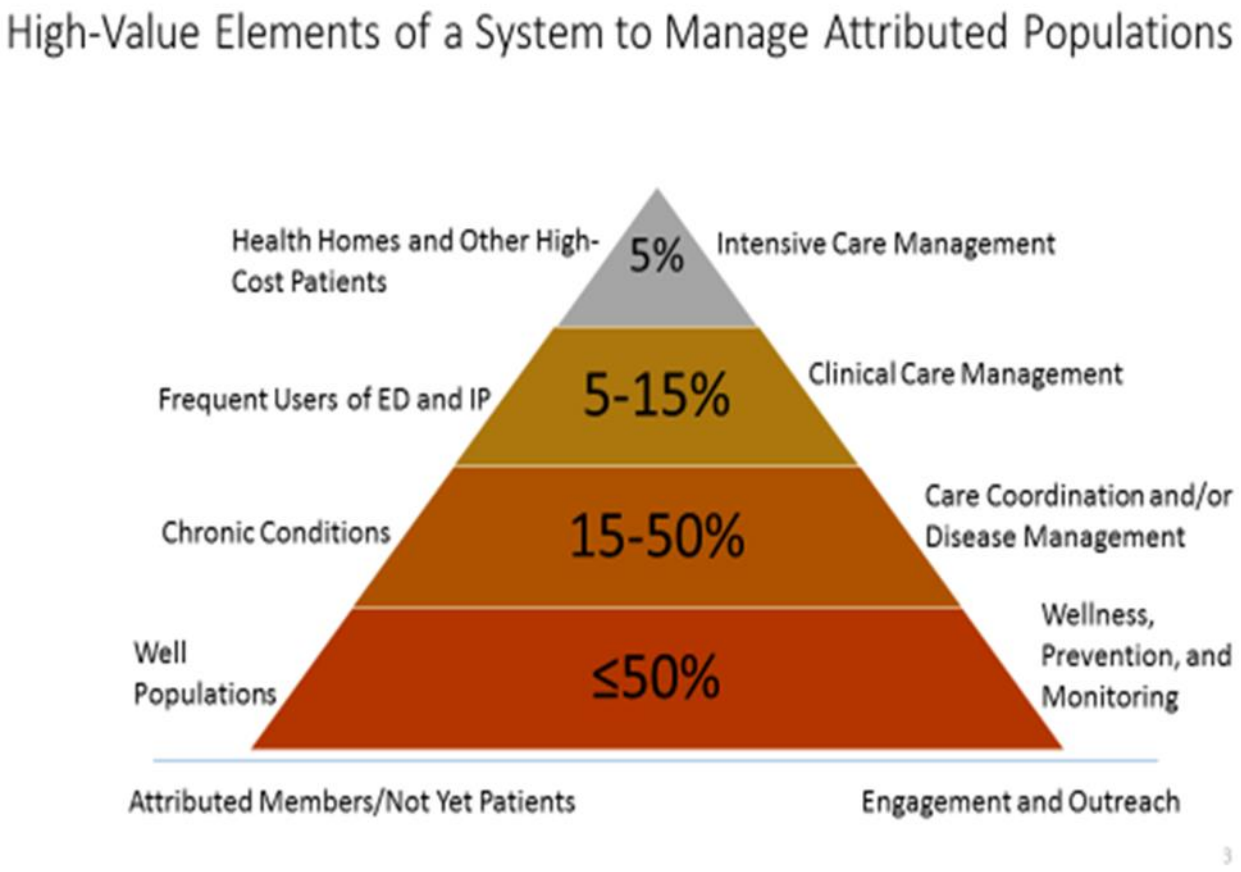
+ HCH programs must demonstrate improved population health outcomes and ability to meet individual patient quality metrics
  - Outreach, engage and maintain continuity of care → re-engage
  - Risk Stratification and Care Management
  - Chronic care management

"But we have been successful with the current approach for many years"

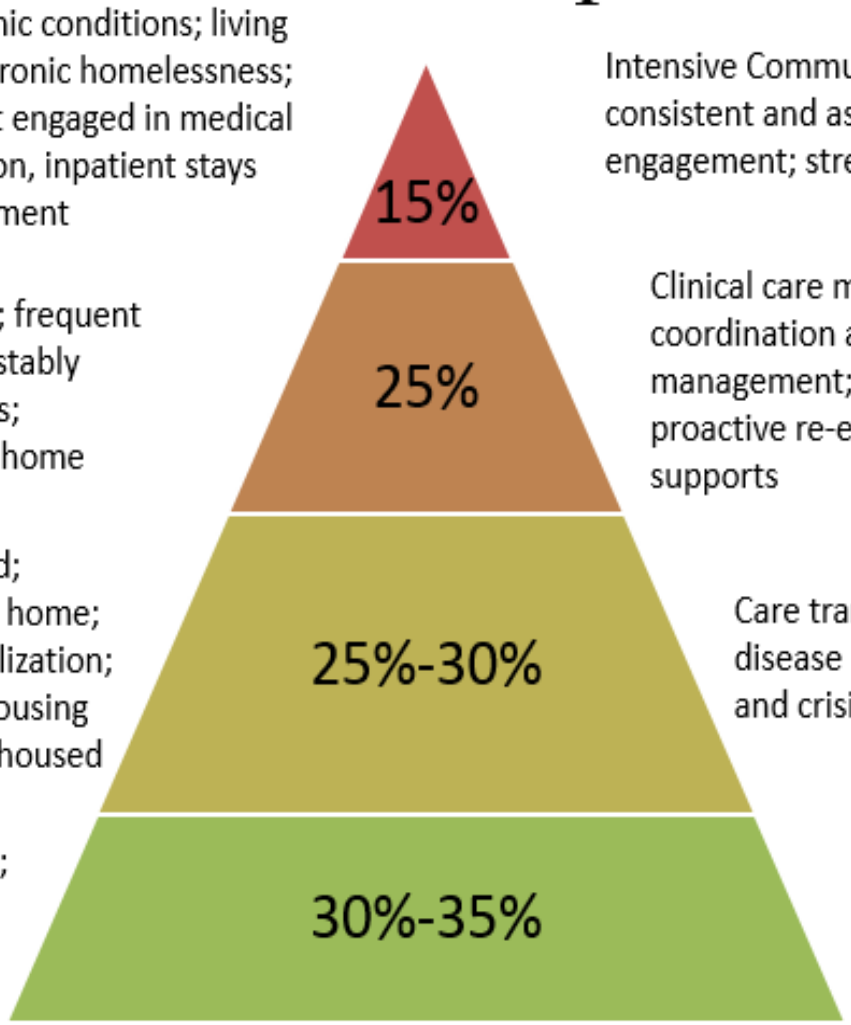
Eastman Kodak Company

Source: The Economist, January 14, 2012

TRADITONAL RISK PYRAMID



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

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

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

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

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

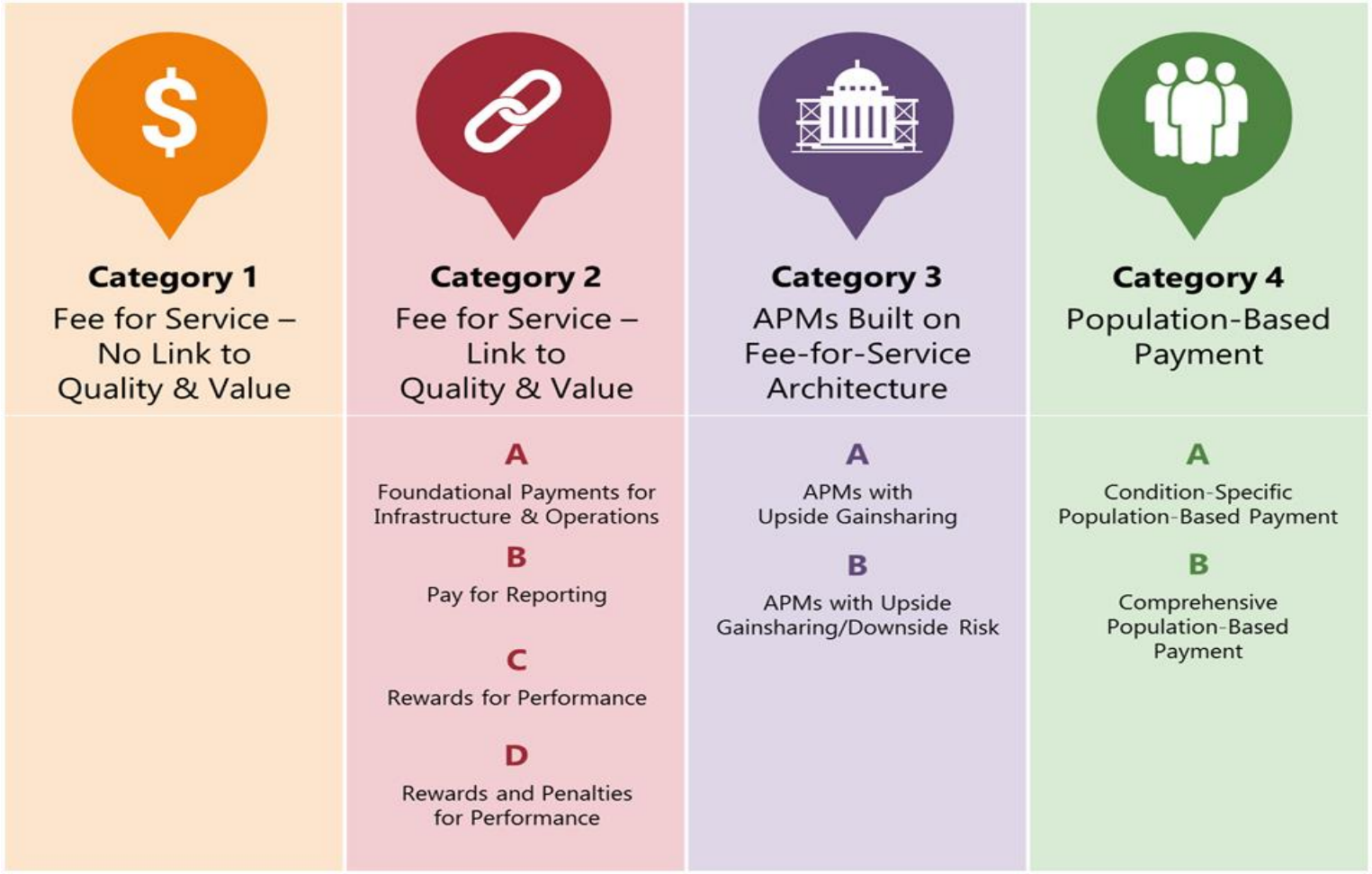
Care transition supports as needed, disease management; health literacy and crisis prevention focus

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

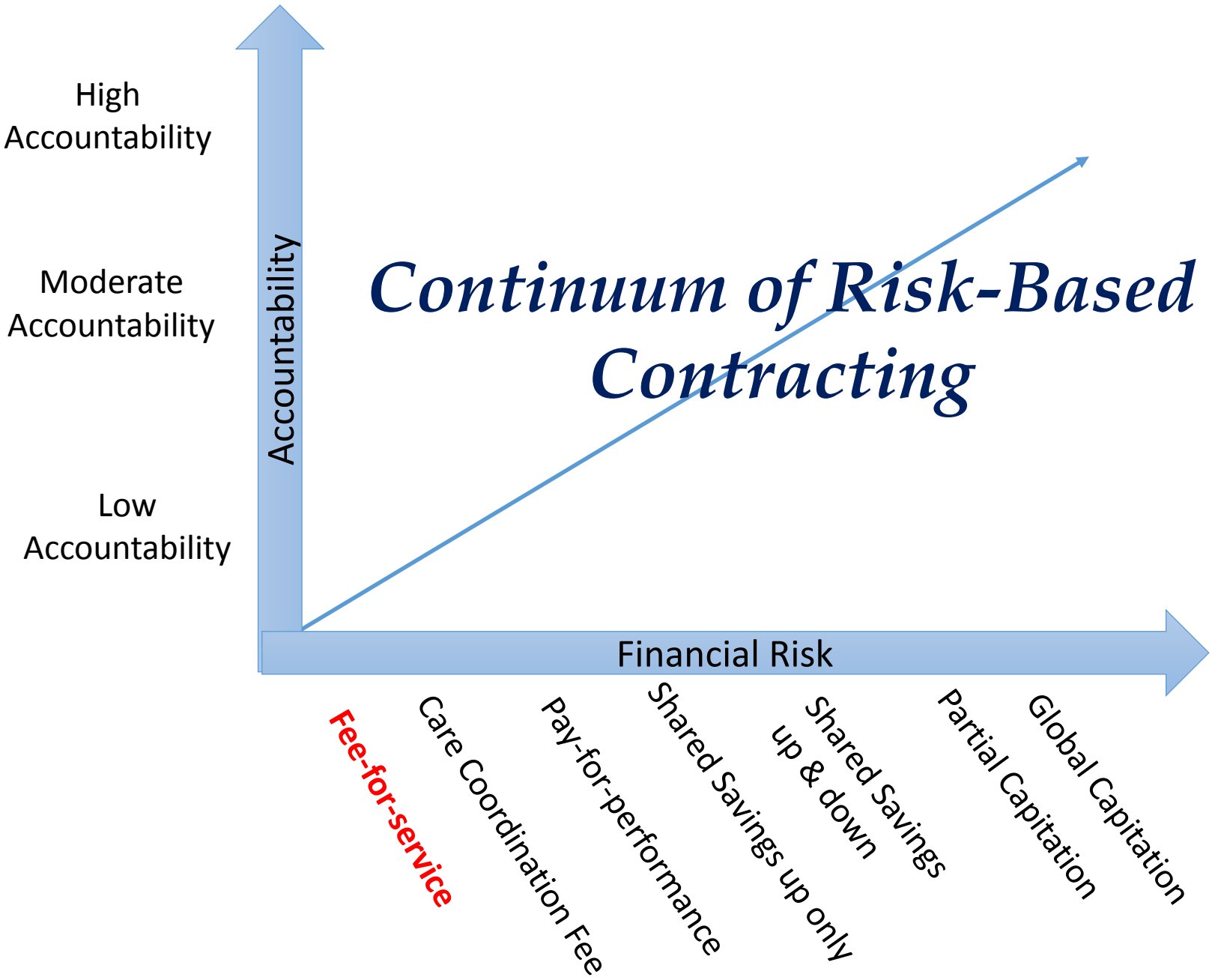
Outreach and engage; connect to care as relationship established

HMA

ALTERNATIVE PAYMENT MODEL FRAMEWORK



Health Care Payment Learning for Action Network (CMS)


High Accountability
Moderate Accountability
Low Accountability
Accountability
Continuum of Risk-Based Contracting
Financial Risk
Fee-for-service
Care Coordination Fee
Pay-for-performance
Shared Savings up only
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

FFS	Care Coordination Fee	P4P	Shared Savings (up only)	Shared Savings (up and down)	Partial Capitation	Global Capitation
PPS Service Unit Based	Delegation of specific Activities (data provided, shared HRA, Care Plans, risk stratification)	P4P Based on Outcomes - ED utilization - Admissions - Readmissions	Shared Savings earned Gainsharing	Shared Savings earned or lost	Partial Capitation Risk for Specific Set of Services	Full Risk for all services
FFS	FFS Plus Add On Payments		Outpatient Capitated Rate Inpatient and Outpatient Capitated Rate		Sub Capitated Rate	Capitated Rate with Guardrails

	Fee for Service	Care Coordination Fee	Pay for Performance	Shared Savings Upside Only
How it works	• Starting point is Medicaid or Medicare fee-for-service rates • May be negotiated up or down by a few percentage points	• PMPM payment for specific populations or activities • May have no contingencies attached to payment • May be contingent on accreditation or other parameters	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	• Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved • Allows much more flexibility in practice redesign, innovative care and financial incentives for overall appropriate cost management and premium management
Implications to Provider	• Encourages volume-based vs. value-based medicine	• Helps to fund people, processes and technology for upgraded care • Sometimes can only be used for care and cannot be used for reserves	• Helps to fund upgraded care • Helps to focus on specific areas of improvement • May be used to build reserves	• Perfect way to gain understanding and control of holistic financial performance without taking any financial risk • Allows provider to get ready to take financial risk, if desired • Gain-share money can be distributed in ways that incent desired behavior changes • May be used to build reserves

	Partial Risk (Up and down)	Partial Capitation	Global Capitation
How it works	• Based on a target medical-loss-ratio, the provider earns a percentage of savings achieved or pays a percentage of the deficit • Step one of financial risk • With risk comes enhanced reward opportunities – higher percentages on upside along with responsibility for downside • Even more flexibility for providers to influence their own practice redesign, innovative care	• A percentage of premium is paid for one area of care; outpatient, inpatient • Total financial responsibility within limited area of care • Provides maximum flexibility for that area of care	• Percentage of premium for total care • Can be accompanied by delegation of care management, claims and other functions • Total financial risk and reward for high quality care and cost management • Maximum flexibility
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

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

VALUE-BASED PAYMENT (VBP) READINESS

- *Performance is not a naturally occurring phenomenon and a contract is not a plan*
- VBP will requires 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

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

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HEALTH MANAGEMENT ASSOCIATES

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

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

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.

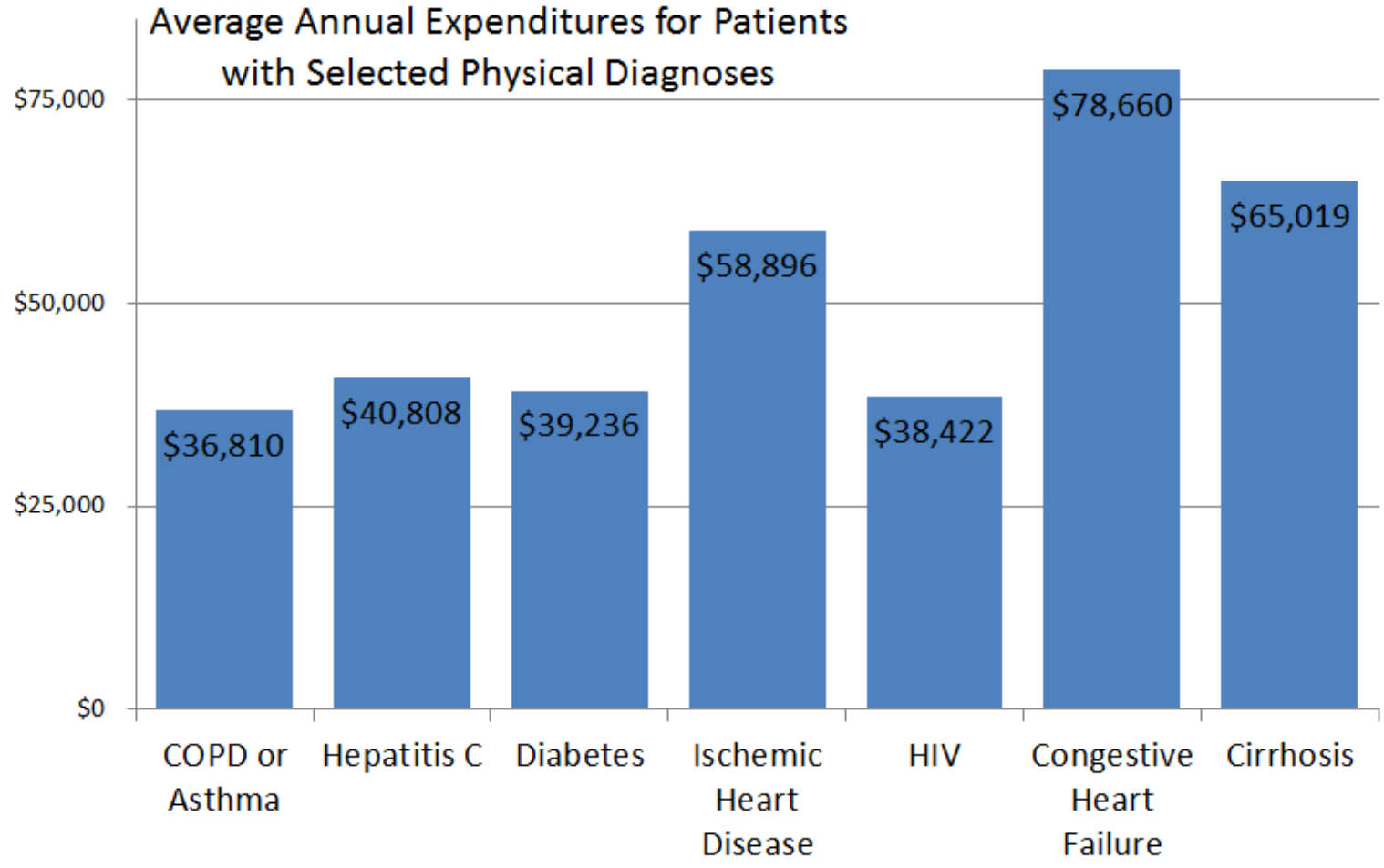
M Bharel 9/18/13

Compared with the overall MassHealth membership, BHCHP patients are much sicker, much more expensive and have far more hospital stays.

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

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.

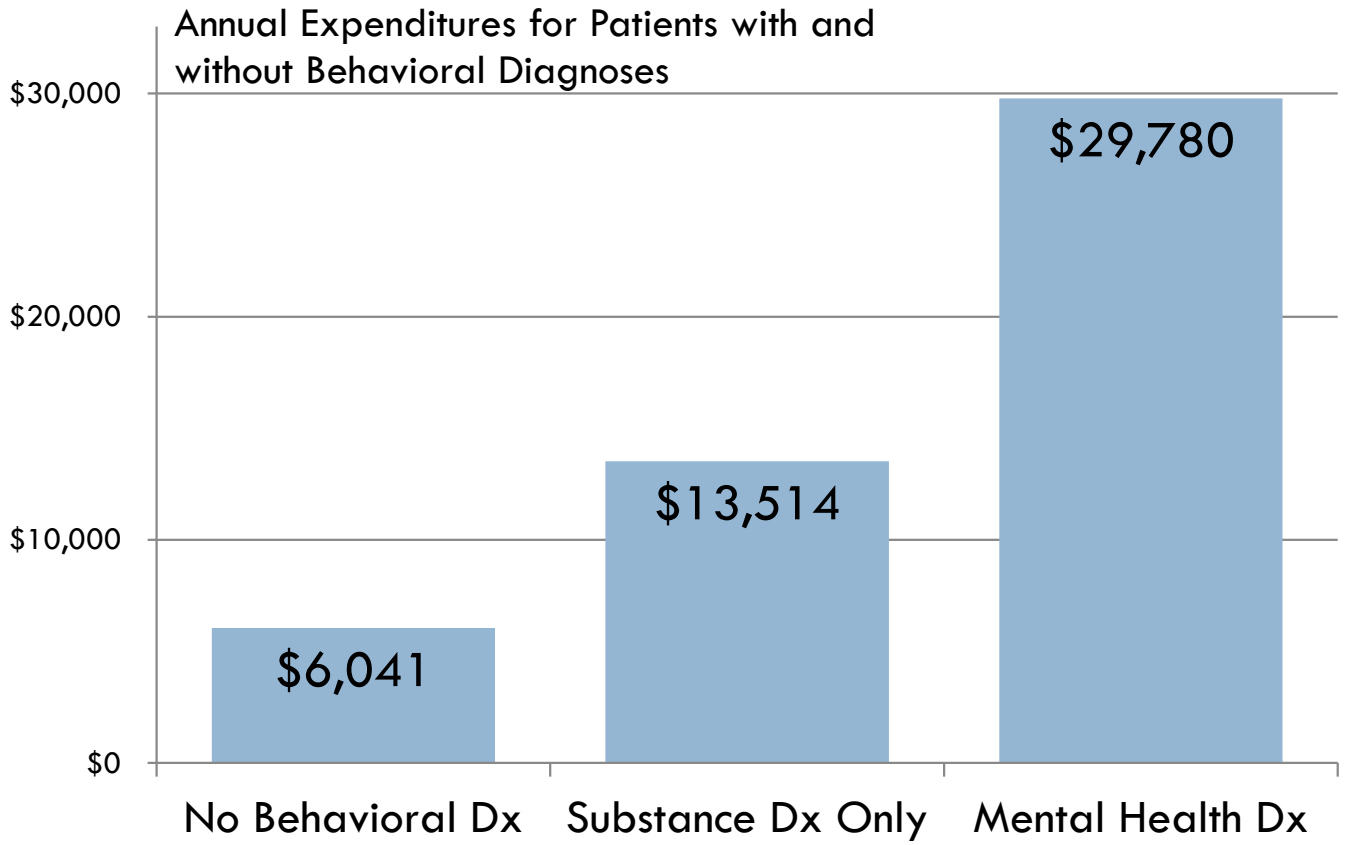
The average expenditures for patients with selected physical diagnoses are far above the average for all patients of $23,000.



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.

N	1,711	1,473	1,191	560	409	265	254

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.



N	1,355	755	4,383

M.Bharel, in press *AJPH*

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

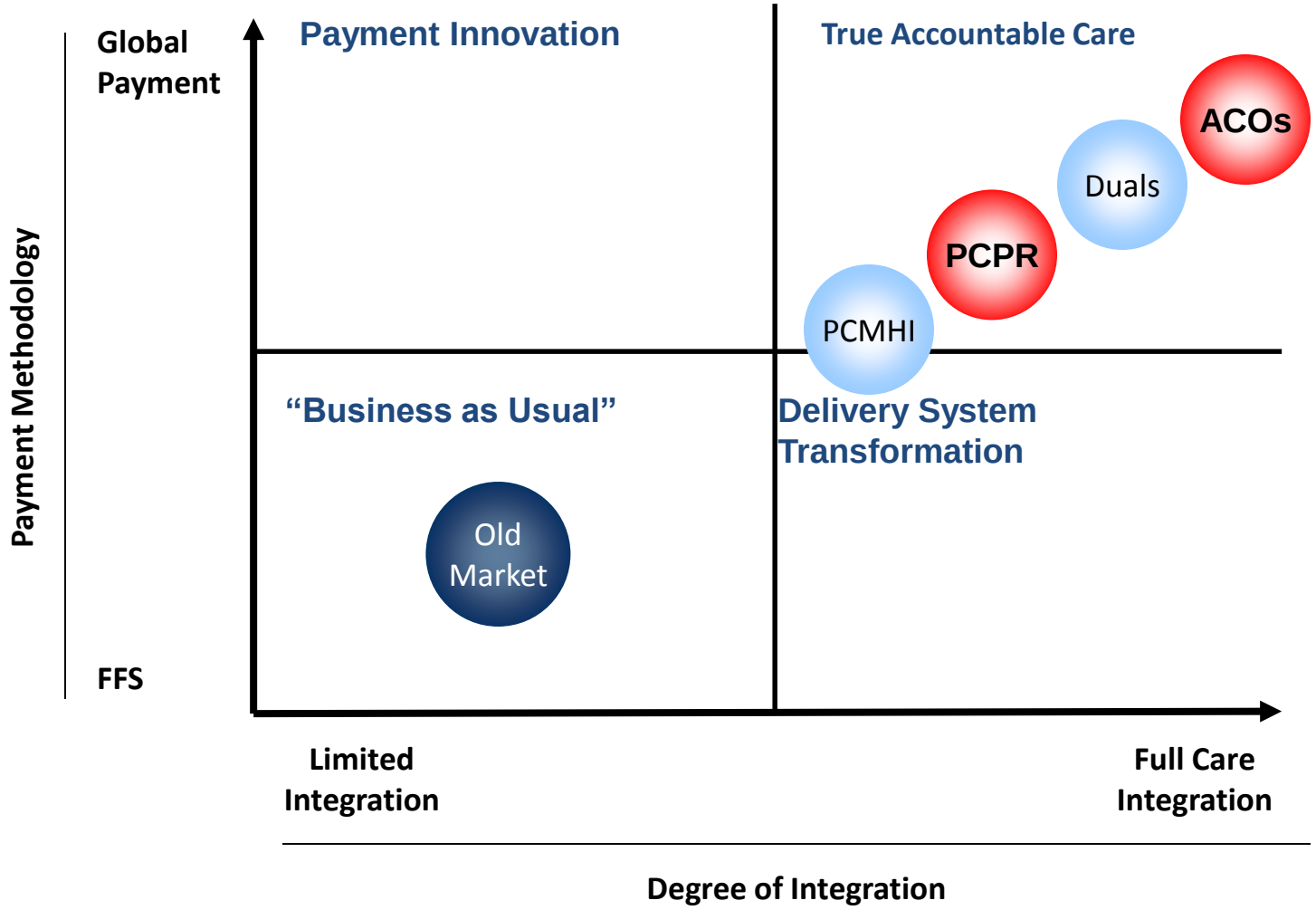
Key Responsibilities

- 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

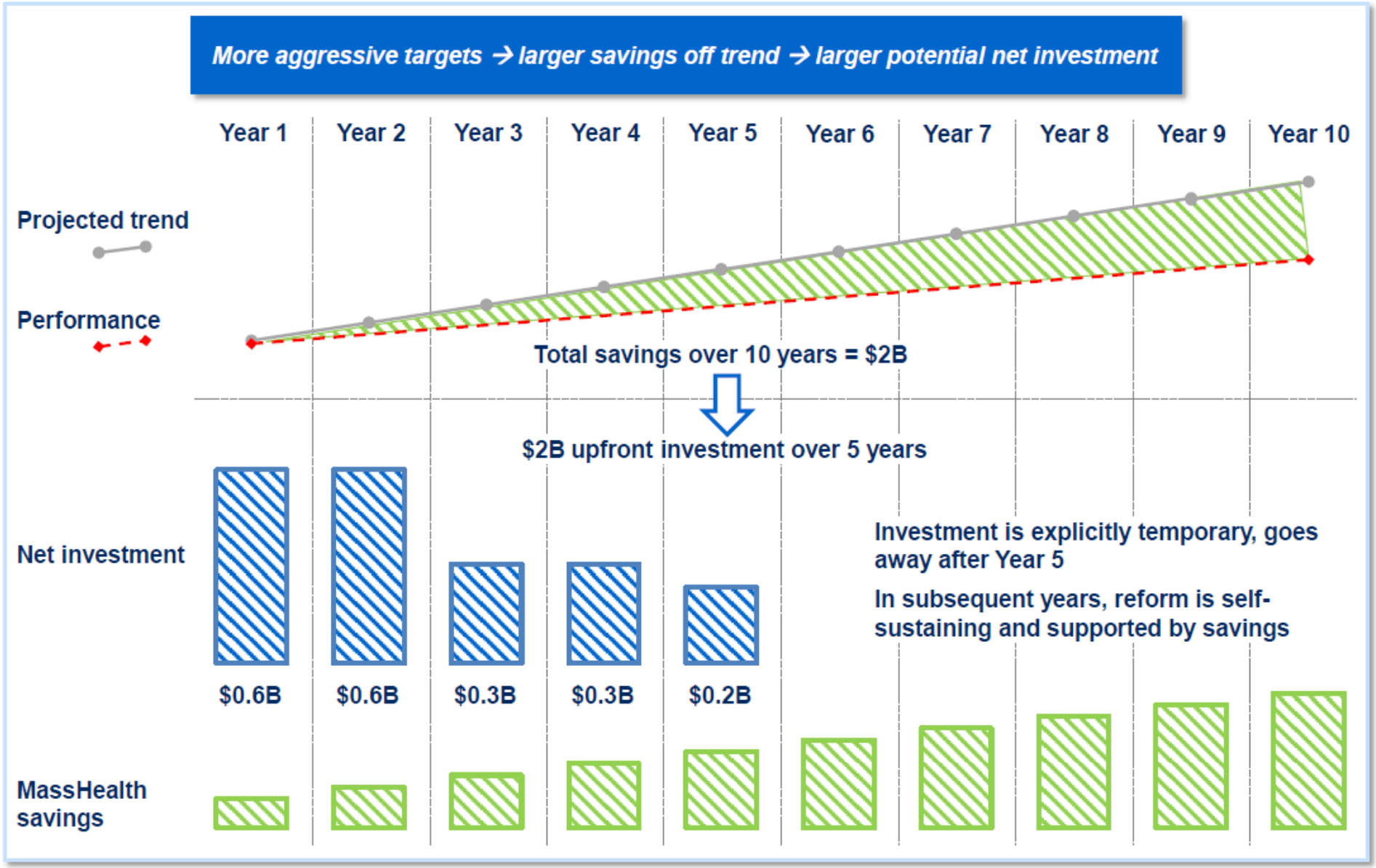
Progression of Massachusetts Reform Initiatives

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

Progression Towards Accountable Care



D CMS Investment and Targets: Concept Overview



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:

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

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).*

Source: BH CP RFR and Model Contract

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

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

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.

Evidence Base

- Yamhill Community Care Organization's Community Hub, Oregon; 2015
- Veteran's Health Administration's Homeless Patient Aligned Care Team Program, USA; 2016

Total Initiative Cost	Estimated Savings
$919,085	$1,496,000

HPC

Source: Health Policy Commission Board Meeting, July 27, 2016

HEALTH POLICY COMMISSION (HPC) GRANT OVERVIEW

Grant Objective: Coordinate care across 10 agencies to better serve people experiencing homelessness, improving their access to services that address the social determinants of health and reducing their avoidable ED and hospital utilization by 20%.

Timeline: 2-year grant: Planning Phase begins mid-December 2016. Implementation Phase begins around May 2017.

Target Population: To start, 60 homeless individuals with high costs/ high health care utilization.

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 highest-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 (ETO)

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 doctor/nurses
- Joint training and case 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 hospitalizations/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

Bay Cove Human Services · Boston Health Care for the Homeless Program · Boston Public Health Commission · Boston Rescue Mission · Casa Esperanza · Massachusetts Housing and Shelter Alliance · New England Center for Homeless Veterans · Pine Street Inn · St. Francis House · victory programs

PART 3:
PRACTICE TRANSFORMATION

Discussion

PART 4:
THE PATH FORWARD

Bobby Watts

CEO, National HCH Council

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL