NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Medicaid Accountable Care Organizations: A Fancy New Model Tries to Improve Health

MAY 17, 2018

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SPEAKERS

- **Barbara DiPietro:** Senior Director of Policy, National HCH Council
- **Ross Owen:** Health Strategy Director, Hennepin County, MN
- **Danielle Robertshaw, MD:** Senior Medical Director, HCMC Community Connections Care Ring, Hennepin County Medical Center
- **Barry Bock:** CEO, Boston Health Care for the Homeless Program

BASIC IDEA OF AN ACO

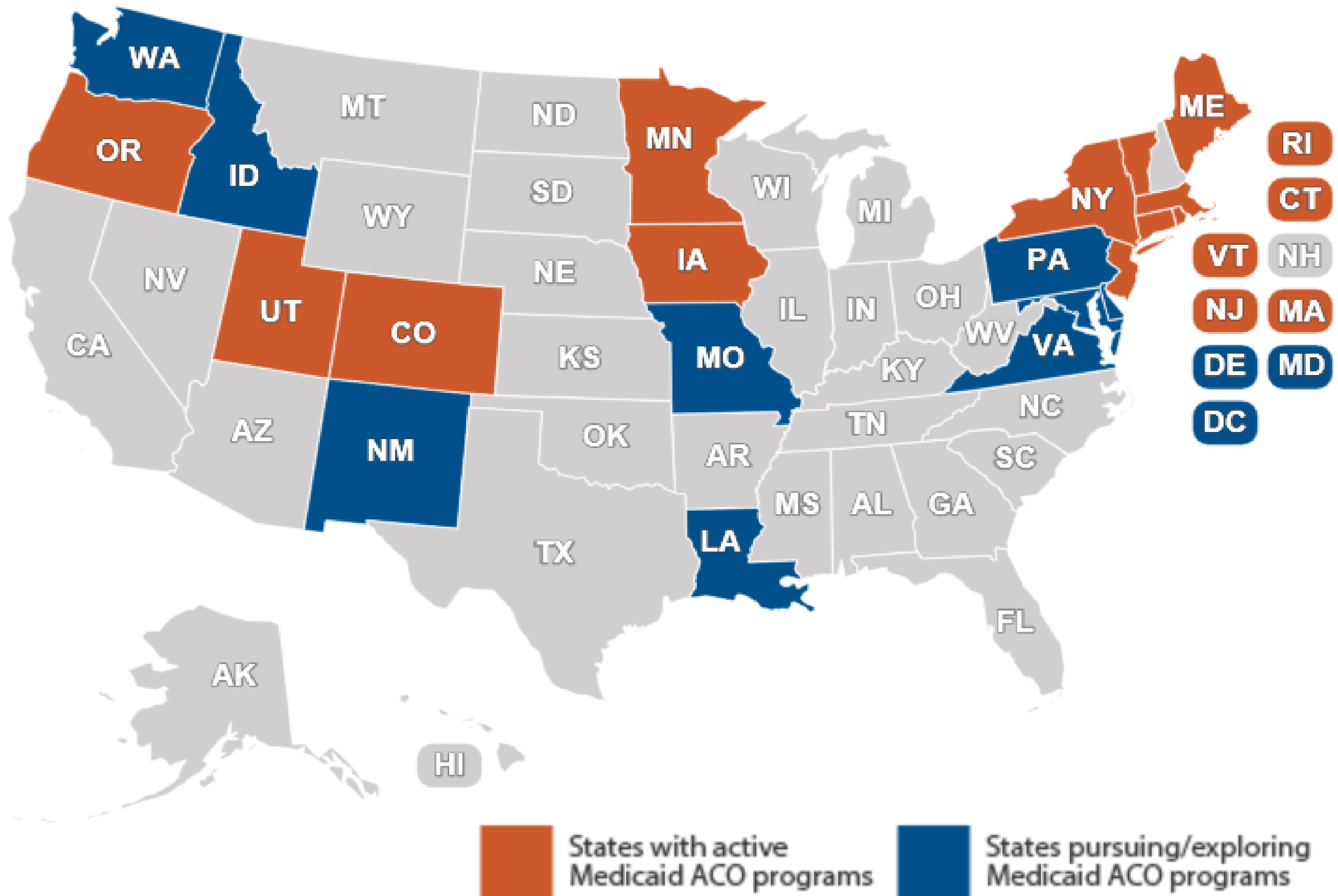
GOALS

1. Improve care coordination & service delivery
2. Hold providers financially accountable for patient outcomes

COMMON ACTIVITIES

1. Implementing value-based payments
   - Shared savings
   - Global budgets
2. Measuring quality improvement
3. Collecting & analyzing data

ACOs NATIONALLY



COMMON CHALLENGES

1. Treating complex, high-need populations (not exclusive to homeless)
2. Integrating primary care and behavioral health in a meaningful way
3. Coordinating care
4. Addressing social determinants of health
5. Changing the health care system, clarifying roles of all entities, accommodating other health reform goals, and blending with other state Medicaid initiatives

AREAS OF SPECIFIC INTEREST FOR HCHs

1. Identifying homelessness/housing status
2. Assigning patients to networks and providers appropriately & accommodating a mobile patient population
3. Identifying meaningful outcome measures that align with the patient population
4. Adjusting provider payments for patient risk/acuity/SDoH
5. Including other service providers (shelters, housing, medical respite, case management/outreach, etc.)

HENNEPIN COUNTY
MINNESOTA

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May 17, 2018

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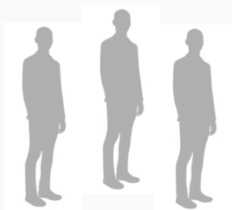
Hennepin County

Hennepin County Profile

- Largest Minnesota county by population, includes Minneapolis
- 1.2 million residents
- Relatively favorable health outcomes on average
- Persistent and stark racial and ethnic health disparities

Hennepin

Hennepin Health - Structure



Prospective enrollment in health plan

- Defined clinic network
- Shared electronic health record
- Collaborative decision-making
- Data and service integration
- Measuring impact
- Risk-sharing funding model

Capitated reimbursement from State Medicaid Agency

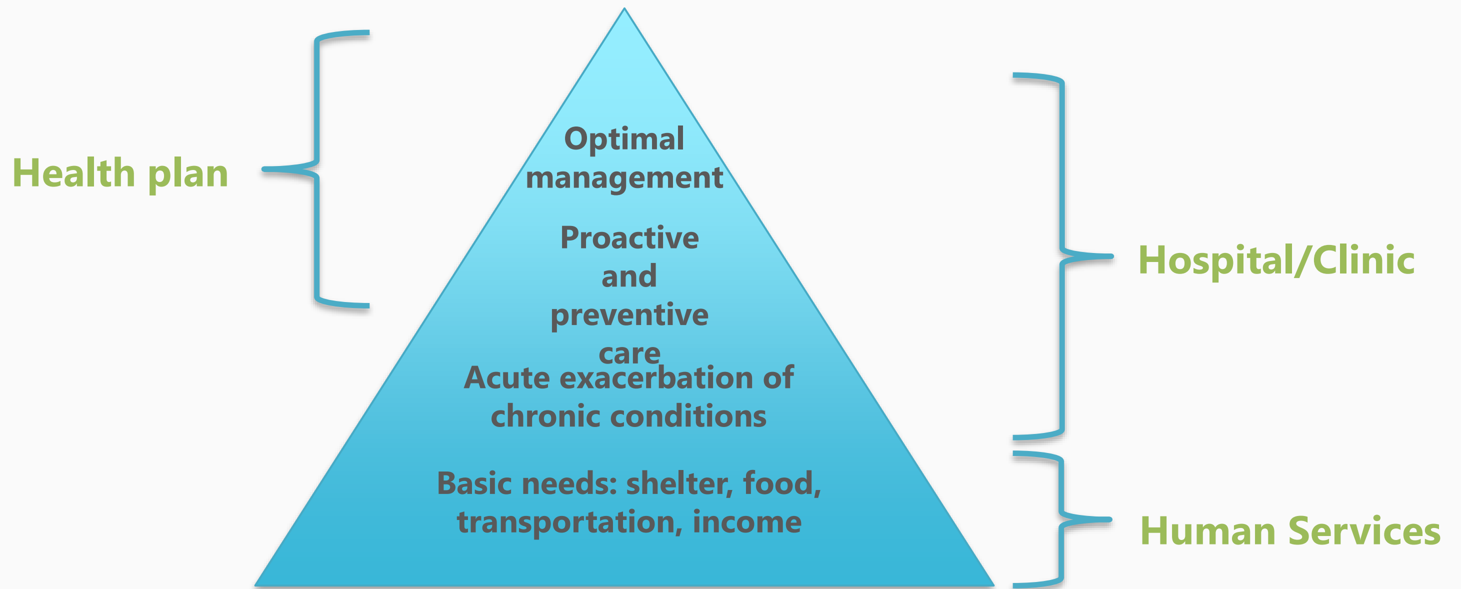
Human Services

Public Health, including Health Care for the Homeless

Financial Model: Impact

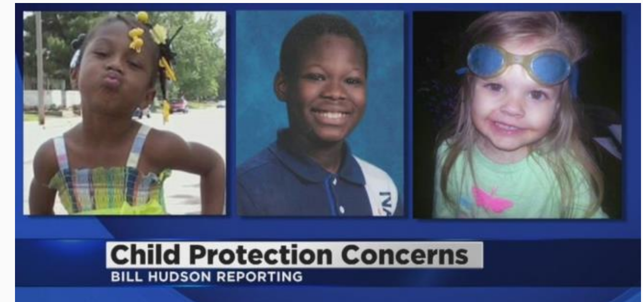
	Before Hennepin Health / Traditional Health Care	With Hennepin Health
Method of Paying Providers for Care	Fee-for-Service (*Volume*)	Total-Cost-of-Care (*Value*)
Health Plan <---> Provider Financial Incentives	Opposed	Aligned
Remaining Funds if Financially Successful	Health Plan Margin	Reinvestment to Further Improve the System
Services Offered to Patients	Medicaid Benefit Set (*Rigid*)	Medicaid Benefit Set + Care Coordination + Targeted Social Service Interventions (*Flexible*)

Opportunities for Improvement



Hennepin

Multiple Systems, Aligned Opportunities
A Broader Role in Community Health



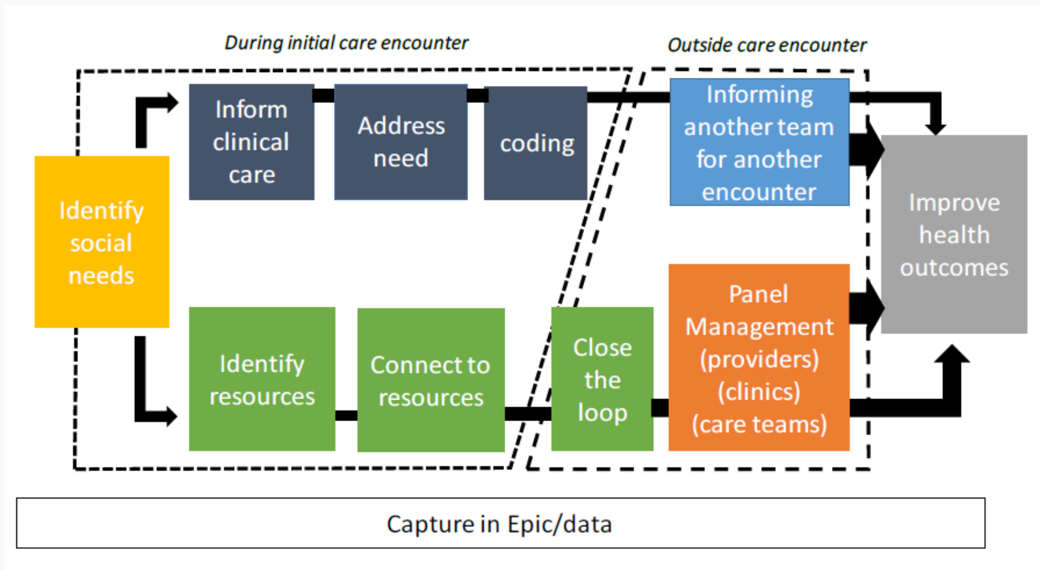
Hennepin

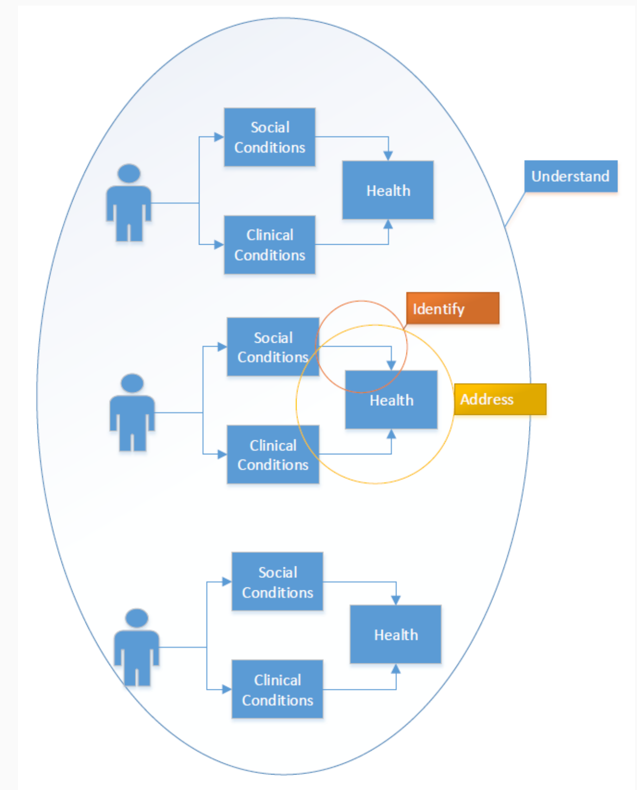
- Jim – late 40s, sleeps “all over” (outside, stays with friends/family, various shelters)
    - Active substance use disorder, untreated mental health
    - Frequent ED, detox & jail visitor
    - Intermittent clinic visits (HCH)
    - Goal: “be a role model for my kids and grandkids so they want to see me”
- Beth – late 20s, in overnight shelter > 1 year
    - Untreated mental health, active substance use disorder
    - Frequent psychiatric hospitalizations
    - Rare clinic visits (HCH)
    - Goal: “just be stable”

Evolving health care delivery

- Reinvestment initiatives
- Expanded Medicaid benefits
- Identifying social factors
- Application of data to drive change

Identifying housing status (then what?)



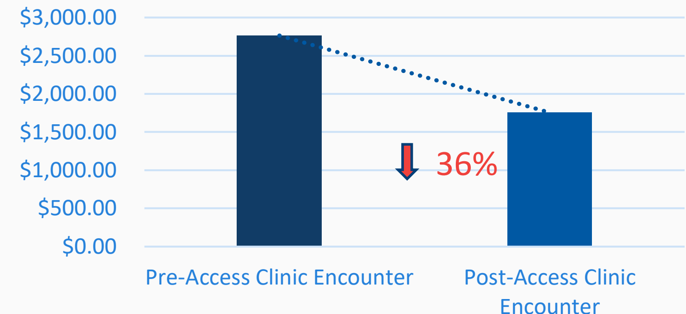


Hennepin Health Access (HHA) Clinic

Reinvestment initiative 2014

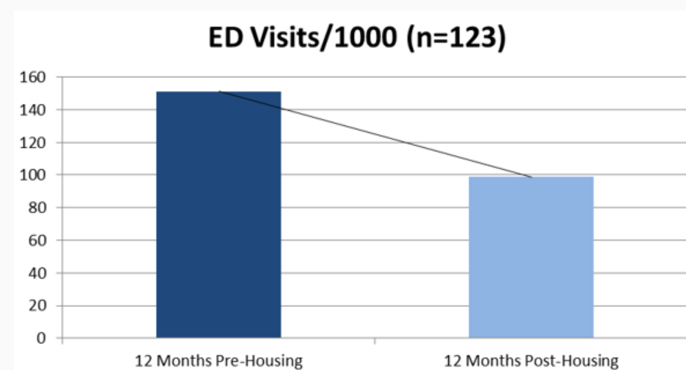
- Coordinated Care Center – "Ambulatory ICU"
  - What if you met these patients earlier??
- HHA target population - high impactable ED (and hospital) utilization

- Health Care for the Homeless model
  - Integrated, coordinated, multidisciplinary team
  - Enabling services & flexible access
  - Transitional - stabilize and warm hand-off
- Tracking systems – dashboards, reports



Social Services Navigation Team

- County-employed social workers working in the community
- Linked to clinic and health plan-based teams
- Addressing social needs and barriers, often housing, employment, or behavioral health-related
- Paid with Medicaid health plan funds



What about Jim and Beth?

- Jim – enrolled in Hennepin Health
  - Connected with HH ED In-Reach →HHA Clinic, HH Social Service Navigators
  - Completed CD treatment, connected to mental health care, moved into housing
  - Job training & placement (HH Vocational Services)
  - *Connected with children & grandchildren*
- Beth – enrolled in Hennepin Health
  - Connected with HCH respite team→ out-patient psychiatry, methadone program, HHA Clinic
  - Applied & approved for long-term disability (income, housing support & services)
  - *Clean without hospitalizations > 9 months*
  - *Moving into her own apartment with services next month*

Boston Health Care for the Homeless Program:

Picture of a Practice
and
Impact of Payment Reform

Barry Bock

BOSTON HEALTH CARE *for* *the* HOMELESS PROGRAM

May 2018

Boston Health Care for the Homeless Program

- Mission: To assure access to quality care for homeless people in the Boston area
- Model: Bring health care to community settings where people are trying to meet basic survival needs
- Founded in 1985
- $54 million annual budget
- Revenue
  - Paid visits, grants
- Alliances with teaching hospitals: BMC & MGH
- Research and Policy Institute

- Primary care
- Behavioral health
- Medical respite
- Oral health
- Pharmacy
- Spread across the city
  - Street outreach
  - >45 shelter clinics
  - Hospital-based clinics
  - McInnis House and Kirkpatrick House
  - Inpatient wards

Medicine *Where* It Matters

Hospital-based Clinics

BHCHP maintains strong ties to our local hospitals, including Mass General Hospital and Boston Medical Center, in the care of our patients. With onsite clinical space, our staff provides primary care, monitors our homeless patients who are hospitalized, and supports the follow up and discharge planning after a hospital stay.

Family Team Sites

As the number of homeless families in and around Boston continues to grow, BHCHP works hard to meet the demand for quality health care in family shelters, such as Crittenton Women's Union, and motels across the region.

Jean Yawkey Place

As BHCHP's integrated medical facility in the South End, Jean Yawkey Place unites medical care, behavioral health, and oral health services under one roof through our outpatient and dental clinics, pharmacy, and respite program known as the Barbara McInnis House.

Shelter-based Clinics

In order to be easily accessible to homeless people, BHCHP provides care in shelters, day programs and other unique locations throughout greater Boston, including Pine Street Inn & St. Francis House.

CHELSEA
CHARLESTOWN
EAST BOSTON
CAMBRIDGE
WEST END
NORTH END
BEACON HILL
DOWNTOWN
CHINATOWN
BACK BAY
KENMORE
FENWAY
ALLSTON / BRIGHTON
SOUTH END
MISSION HILL
SOUTH BOSTON
BOSTON HARBOR
ROXBURY
JAMAICA PLAIN
ROSLINDALE
DORCHESTER
QUINCY BAY
MATTAPAN
QUINCY

KEY

- Adult Shelter-Based
- Hospital-Based
- Family Team - Shelter
- Family Team - Motel
- Multidisciplinary Center

1 Boston Medical Center
2 Bridge Home
3 Bridge Over Troubled Waters
4 Cardinal Medeiros Center
5 Casa Esperanza Men's Program
6 Casa Esperanza Women's Program
7 Casa Nueva Vida
8 Charles River Hotel
9 Crittenton Women's Union
10 Crossroads Family Shelter
11 Days Hotel
12 Entre Familia
13 Families in Transition
14 Father Bill's Place
15 Friends of the Unborn
16 Hope House
17 Jean Yawkey Place
18 Kingston House
19 Kit Clark Adult Day Health
20 Lindemann Mental Health Center
21 Massachusetts General Hospital
22 Nazareth Residence
23 New England Center For Homeless Veterans
24 Pilgrim Shelter
25 Pine Street Inn at Shattuck
26 Pine Street Inn Men's Clinic
27 Pine Street Inn Women's Clinic
28 Portis Family House
29 Project Hope
30 ReVision House
31 Rosie's Place
32 Safe Harbor
33 Salvation Army
34 Shepherd House
35 SOAR
36 Sojourner House
37 Southampton Street Shelter
38 St. Ambrose
39 St. Francis House
40 St. Mary's Center for Women & Children
41 Temporary Home for Women and Children
42 The Eighth Pole at Suffolk Downs
43 The Night Center
44 Transitions
45 Women's Hope
46 Women's Lunch Place
47 Woods Mullen Shelter

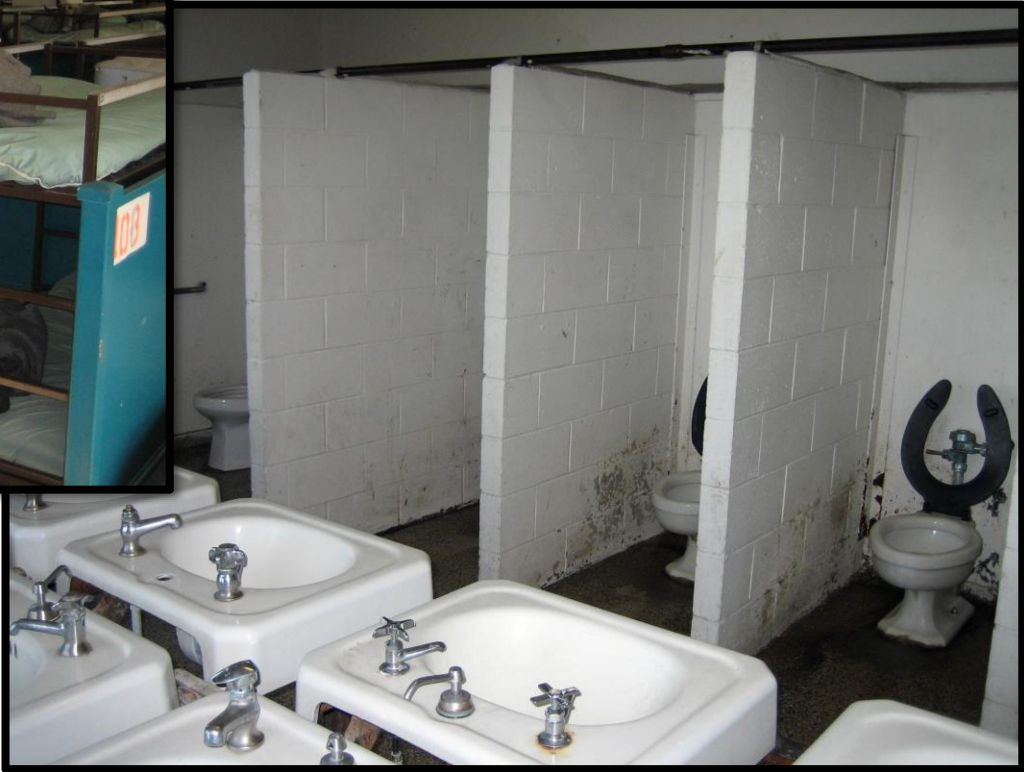
Not shown:

- Alleyways, park benches, under bridges
- Asian Task Force Against Domestic Violence *(Boston)*
- Colonial Traveler *(Saugus)*
- Finex House *(undisclosed location)*
- Holiday Inn *(Brockton)*
- Home Suites Inn *(Waltham)*
- New England Motor Court *(Malden)*
- Paul Sullivan Housing *(varied)*
- Super 8 Hotel *(Brockton)*
- Town Line Inn *(Malden)*

*as of June 2015

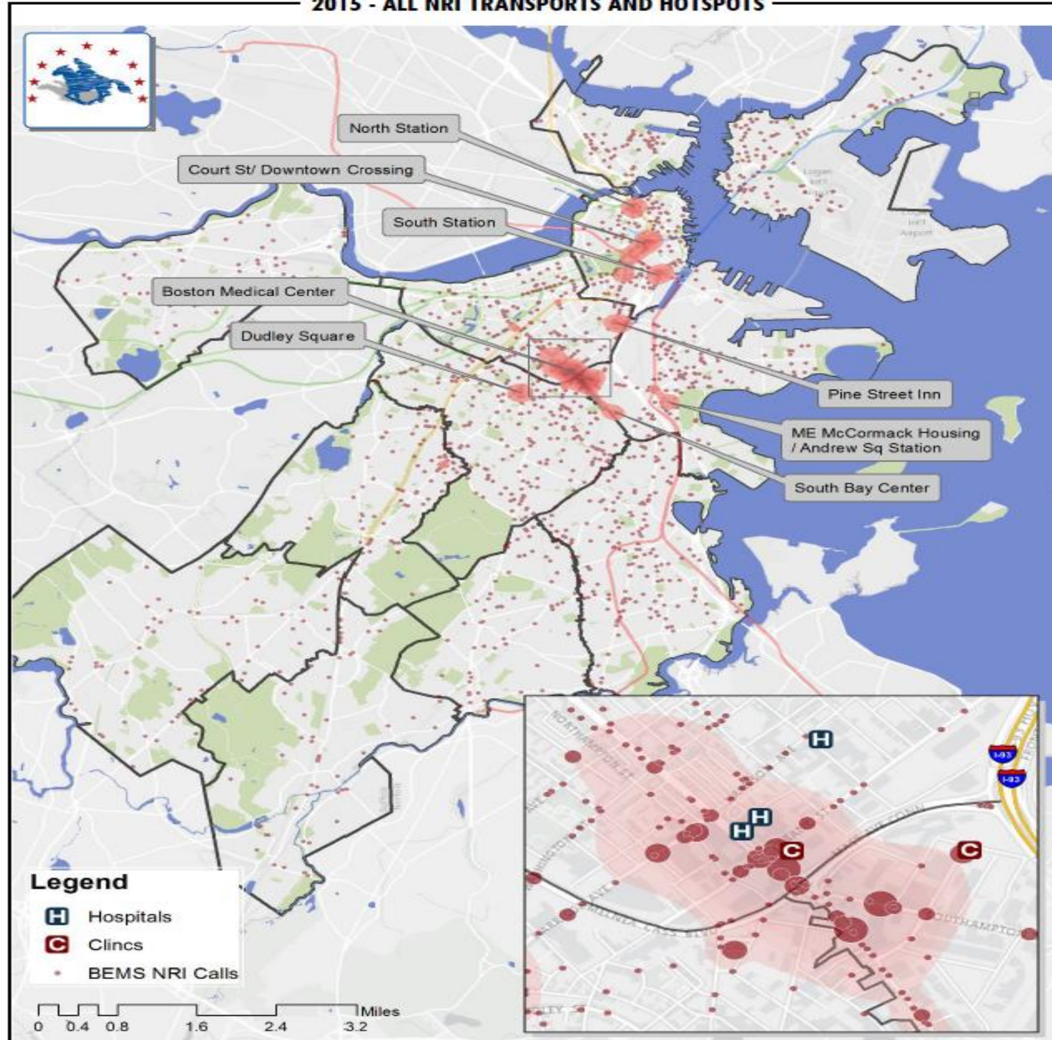
NOTRE DAME

Toasteds



Mortality

- Seven large scale mortality studies in USA
  - **Drug overdose has replaced HIV as the emerging epidemic**
  - Heart disease, cancer next most common
- Mortality rates 4.5 – 9.0 times that of the general public
- Average age at death = 51
- Death from undertreated medical illness and complications of substance use



2015 - ALL NRI TRANSPORTS AND HOTSPOTS
North Station
Court St/ Downtown Crossing
South Station
Boston Medical Center
Dudley Square
Pine Street Inn
ME McCormack Housing / Andrew Sq Station
South Bay Center
Legend
Hospitals
Clincs
BEMS NRI Calls
Miles
0 0.4 0.8 1.6 2.4 3.2

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 World is Changing: Realities and Opportunities

The World Is Changing

- A health care system in crisis
- Massachusetts Payment Reform (Chapter 224)
- Overarching aims:
  - Improve quality of care
  - Reduce health care disparities
  - Improve health and functional outcomes
  - Contain costs

Realities and Opportunities

- We are now part of larger care delivery networks
  - ACO **(1700 attributed/11,700 patients)**
  - Behavioral Health Community Partner (CP)
- 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
- Reasonable access and strong integration between behavioral health and primary care is expected
- We will broaden our ability to perform *care coordination* for all our patients, and *complex care management* for highest-risk patients, especially during *transitions of care*

Realities and Opportunities

- At least part of our reimbursement is 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
- Although MassHealth will "risk adjust" payments based on certain social determinants of health including homelessness, that payment is not yet passed down to BHCHP from the larger ACO system

Implications for our Care Model

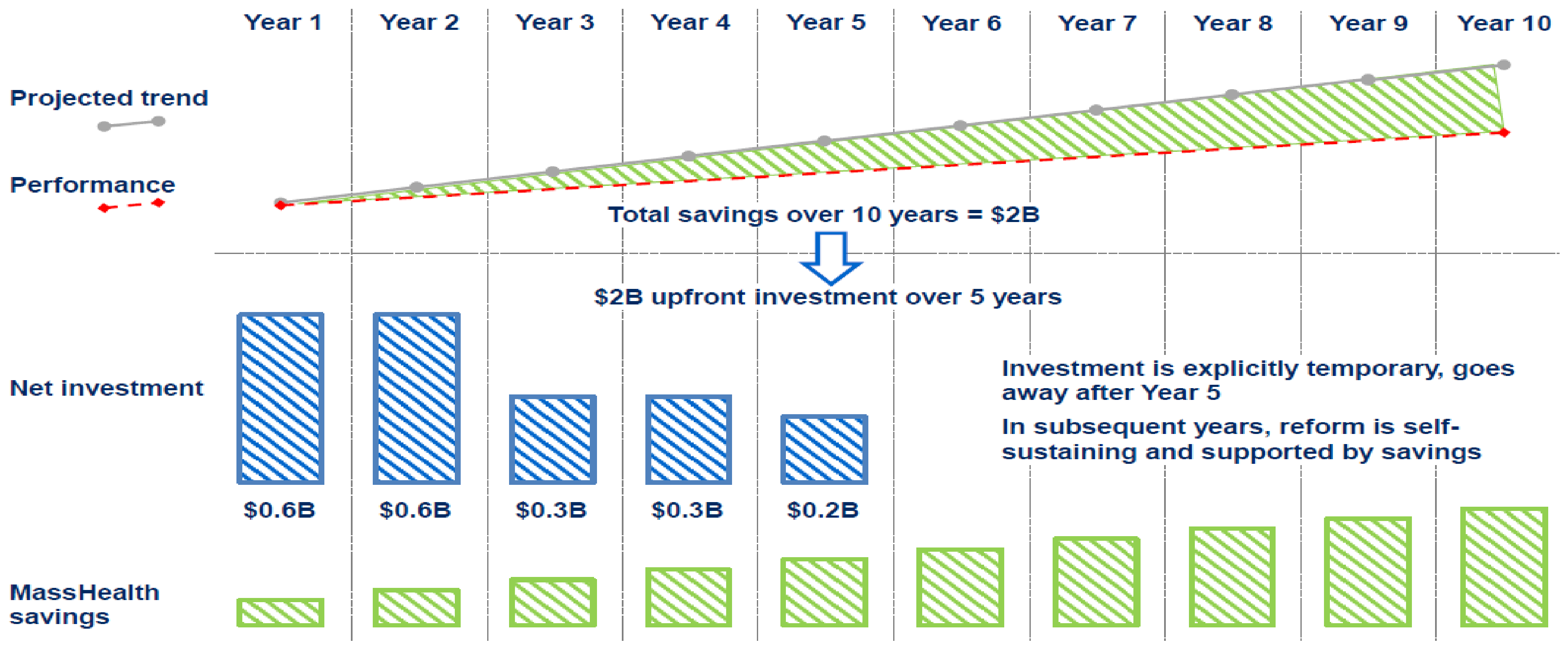
Key Responsibilities

- 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

Massachusetts Reform Initiatives

New 1115 Waiver: Complete Restructuring

D CMS Investment and Targets: Concept Overview



Clinical Care Model: Primary Care Payment Reform Initiative

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

MassHealth has begun risk adjusting for SDH

	Relative weight	Measured by MassHealth	Actions for accurate capture
Homelessness/ Unstable housing	**Medium**	▪ Appropriate ICD-10 Code for Homelessness or housing instability ▪ 3 or more addresses in 1 year	▪ Screen for housing instability and enter ICD-10 Code ▪ Verify patient's address is updated with MassHealth
Behavioral health	**High**	▪ Serious Mental Illness ▪ Substance Use Disorder	▪ Screen and enter appropriate ICD-10 Code (see next page)
Disability	**High**	▪ Dept. Mental Health Client ▪ Dept. Developmental Services Client ▪ Otherwise entitled to Medicaid due to disability	▪ Appropriate referrals to DMH and DDS by care managers – Apply best practices across ACO partners
Neighborhood stress	**Varies (can be negative)**	▪ Zip code - neighborhood stress score assigned with high % low income, unemployed etc.	▪ Verify patient's address is updated with MassHealth

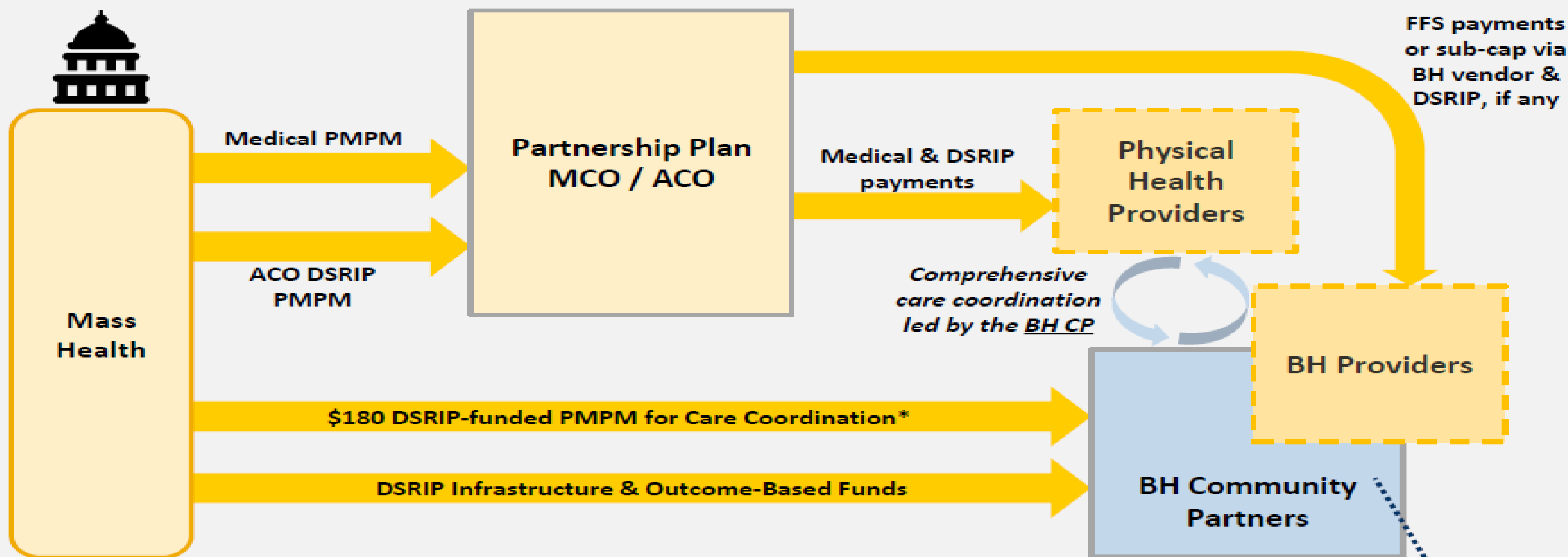
Accountable Care Organizations

Behavioral Health Community Partners

Objectives for Behavioral Health (BH) Community Partners (CPs)

- Support members with high BH needs and their families to help them **navigate the complex system of BH care** in Massachusetts
- **Improve member experience, continuity and quality of care**
- Create opportunity for ACOs and MCOs[2] to **leverage the expertise and capabilities of existing BH community-based organizations** servicing populations with BH needs
- **Invest in the continued development of BH infrastructure** (e.g. technology, information systems)
- **Improve collaboration** across ACOs / MCOs, CPs, community organizations addressing the social determinants of health, and BH, LTSS, and physical delivery systems in order to break down existing silos and **deliver integrated care**
- **Avoid duplication of care coordination and care management resources** (i.e., across EOHHS[3] and its vendors)
- **Support values** of community-first, SAMHSA recovery principles, and cultural competence

BH CPs will be paid directly by MassHealth from DSRIP funds, through June 2022, and are not at risk for TCOC performance



- BH CPs must also be or include a BH service provider
- MassHealth has indicated that self-referral will be monitored, but has not set specific limits
- BH CP financial conflicts of interest must be disclosed to MassHealth and to members
- BH CPs must inform members of multiple service options and 2+ service providers (where applicable)
- Earlier indication of an “administrative separation” requirement not included in BH CP RFR / model contract

* Only for months in which the CP documents a “qualifying” outreach or coordination activity; funding for outreach to new members limited to 3 months

Source: BH CP RFR and Model Contract; MassHealth CP public meeting presentation

BHCHP’s Approach to CPs: Interview Barry

- What was your original concept for a consortium of homeless and addiction service providers?
- Who is part of the consortium?
- How will care be coordinated across the consortium members?
- What does it take to pull off the formation of a consortium legally and functionally?

Targeted Cost Challenge Investment Awardee Highlight:
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

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

PANEL DISCUSSION

QUESTIONS/GROUP DISCUSSION