A Brave New World: How Medicaid ACO Reform Impacts Care Delivery for the Homeless in Massachusetts

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Since 1985, our mission has remained the same:

To provide or assure access to the highest quality health care for all homeless individuals and families in the greater Boston area.
Massachusetts Medicaid Reform

How do ACOs and CPs relate?

• Delivery System Reform Incentive Program (DSRIP) provided catalyst for Medicaid Reform in MA
• ACOs/MCOs mandated to contract for Community Partner (CP) care coordination services
• Care coordination to help facilitate integration of BH, LTSS, and health care across continuum
Boston Coordinated Care Hub
Working with the ACOs/MCOs

- Contracts required with 8 ACOs and 2 MCOs in our geographic area;
- ‘Agreement’ needed on 14 ‘Documented Processes’ (ACOs hold the leverage) including:
  - Outreach
  - Administration of care management and care coordination
  - Authorization of services
  - Data sharing and IT systems
  - Conflict resolution
- Business Associate Agreements required
- We are able to generate referrals to ACOs
- Quarterly meetings
## Payment

<table>
<thead>
<tr>
<th></th>
<th>Program Funding*</th>
<th>Infrastructure – withhold**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start-up</td>
<td>$450,000 lump sum</td>
<td></td>
</tr>
<tr>
<td>BP1</td>
<td>$180 PMPM</td>
<td>$120 PMPM (reporting only)</td>
</tr>
<tr>
<td>BP2</td>
<td>$180 PMPM</td>
<td>$65 PMPM – (26%)</td>
</tr>
<tr>
<td>BP3</td>
<td>$180 PMPM?***</td>
<td>$51 PMPM – (43%)</td>
</tr>
<tr>
<td>BP4</td>
<td>$180 PMPM?</td>
<td>$45 PMPM – (61%)</td>
</tr>
<tr>
<td>BP5</td>
<td>$180 PMPM?</td>
<td>$39 PMPM – (79%)</td>
</tr>
</tbody>
</table>

*PMPM Program funding tied to our billing at least one Qualifying Activity per patient per month including: Outreach; Comprehensive Assessment; Care Plan Complete; Care Coordination; Care Transitions; etc.

** Withhold can be earned back if we meet Accountability Metrics

*** BP3-5 PMPM rates are under review
Behavioral Health (BH) Community Partners (CP) Functions

1. Outreach and engagement
2. Comprehensive assessment and person-centered treatment planning
3. Care coordination and care management across
   - Medical
   - Behavioral health
   - Long term supports and services
4. Care transitions
5. Medication reconciliation
6. Health and wellness coaching
7. Connection to social services and community resources, including flexible services
**Case Management Notes**

<table>
<thead>
<tr>
<th>Date Completed</th>
<th>Care Manager</th>
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<tbody>
<tr>
<td>Apr 2, 2013</td>
<td>Mohamed, Soofy</td>
</tr>
<tr>
<td>Mar 2, 2013</td>
<td>Mohamed, Soofy</td>
</tr>
<tr>
<td>Feb 2, 2013</td>
<td>Mohamed, Soofy</td>
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</tbody>
</table>

- **Assessment**
  - June 2018
  - June 2018
  - June 2018

- **Self Sufficiency Status**
  - Oct 2018
  - Oct 2018
  - Oct 2018

- **Comprehensive Health Assessments**
  - Feb 2018
  - Feb 2018

**Person-Centered Treatment Plan**

- **Objective**
  - Update care plan
  - Update care plan status

**Current Care Team**

- **24/7 Care Manager**
  - 24/7 Care Manager

- **Other Important Contacts**
  - Case Manager
  - 24/7 Care Manager

**Future Goals**

- No goals on file
<table>
<thead>
<tr>
<th>Agency</th>
<th>Patients Assigned</th>
<th>Consented</th>
<th>With CHA</th>
<th>Without CHA</th>
<th>With SSM</th>
<th>Without SSM</th>
<th>With Signed Care Plan</th>
<th>Without Signed Care Plan</th>
<th>With No Valid Qualifying Activities Between May 1, 2019 and May 31, 2019</th>
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</thead>
<tbody>
<tr>
<td>Boston Public Health Commission</td>
<td>100</td>
<td>73</td>
<td>57</td>
<td>43</td>
<td>66</td>
<td>34</td>
<td>45</td>
<td>55</td>
<td>51</td>
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<tr>
<td>Boston Rescue Mission</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>0</td>
<td>22</td>
<td>0</td>
<td>18</td>
<td>4</td>
<td>10</td>
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<tr>
<td>St. Francis House</td>
<td>101</td>
<td>82</td>
<td>51</td>
<td>50</td>
<td>79</td>
<td>22</td>
<td>35</td>
<td>66</td>
<td>76</td>
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<tr>
<td>Victory Programs</td>
<td>97</td>
<td>50</td>
<td>46</td>
<td>51</td>
<td>49</td>
<td>48</td>
<td>34</td>
<td>63</td>
<td>54</td>
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<tr>
<td>New England Center and Home For Veterans</td>
<td>45</td>
<td>31</td>
<td>29</td>
<td>16</td>
<td>32</td>
<td>13</td>
<td>24</td>
<td>21</td>
<td>38</td>
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<tr>
<td>Casa Esperanza</td>
<td>97</td>
<td>75</td>
<td>58</td>
<td>39</td>
<td>71</td>
<td>26</td>
<td>44</td>
<td>53</td>
<td>28</td>
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<tr>
<td>Pine Street Inn</td>
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<td>43</td>
<td>1</td>
<td>43</td>
<td>1</td>
<td>36</td>
<td>8</td>
<td>2</td>
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<tr>
<td>Boston Health Care for the Homeless Program</td>
<td>564</td>
<td>433</td>
<td>403</td>
<td>161</td>
<td>443</td>
<td>121</td>
<td>392</td>
<td>172</td>
<td>287</td>
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<tr>
<td>Totals</td>
<td>1070</td>
<td>810</td>
<td>709</td>
<td>361</td>
<td>805</td>
<td>265</td>
<td>628</td>
<td>442</td>
<td>546</td>
</tr>
</tbody>
</table>
How does this all work?
Staffing for Enhanced Care/BH CP Complex Care
BH CP Staff Trainings

BH CP Orientation
Patient outreach
Qualifying activities
Data and I.T.
HIPAA and confidentiality
Self-Sufficiency Matrix (SSM)
Comprehensive Health Assessment (CHA)
Person-Centered Treatment Plan (PCTP)

Care Management
Housing
Legal services
Food security
Transportation
SSI/SSDI
De-escalation and safety
Community resources

Population Health
(Team Coordinators)
Quality metrics
Quality improvement
Population management
Data Software
Leadership
**Patient Identification**

**June 2018**: MassHealth begins identifying members for the Community Partners (CP) Program based on service utilization data.

**July 2018**: BH CP begins, Community Partners begin supporting members identified by MassHealth. Boston Coordinated Care Hub initiates process to identify patient-agency relationships.

**Ongoing**: MassHealth continues to identify members for the BH CP Program on a quarterly basis.

**January 2019**: ACOs and MCOs begin accepting referrals for patients not identified by MassHealth or assigned to a CP. Can come from a provider or agency on the member’s behalf. Member’s ACO will determine whether to assign member to CP.
### Who is eligible for the CP?

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>BH CP</th>
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<tbody>
<tr>
<td><strong>Analytic</strong></td>
<td>Must have one of the following diagnoses:</td>
</tr>
<tr>
<td></td>
<td>• SUD, Schizophrenia, Bipolar, Mood Disorder, Psychosis, Trauma, Suicidal, Homicidal, depression, adjustment reaction, anxiety, psychosomatic or conduct disorder, PTSD</td>
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<tr>
<td></td>
<td>And one of the following utilizations:</td>
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<tr>
<td></td>
<td>• ESP Interaction, Detox, Methadone, IP (3+), ED (5+), select medical co-morbidities (3+), high LTSS util, current DMH enrollment</td>
</tr>
<tr>
<td><strong>Qualitative</strong></td>
<td>Self-referrals, caregiver referrals, referrals made by ACO care management, or providers. ACO will determine if referred members meet criteria to be assigned to a CP.</td>
</tr>
</tbody>
</table>
Initial Patient Assignment - 7/1/2018

• MassHealth sent assignment lists to CPs
• BHCHP shared list with partners, who noted relationships
• List included patients who:
  • Received primary care at BHCHP, but had multiple agency relationships
  • History of episodic care with BHCHP
  • Connected to care (and external providers) outside of the Boston Coordinated Care Hub
  • No connection with any care
• Based on relationships, we assigned patients to Care Coordinator panels, capped at 50 patients each
• In total, each patient has: Care Coordinator, Team Coordinator, Nurse Care Manager
Leveraging Data for the BH CP

- Implementation of new technology infrastructure to effectively manage data, share information across partner agencies, and track performance
- Evaluation of patient medical history to direct prospective outreach
- Surveillance and dissemination of patient ED and inpatient patterns of utilization
- Coordination of QI and metrics at a team level
Case Conferencing in the BH CP

BH CP staff facilitate collaboration with PCP on the Person-Centered Treatment Plan (PCTP)

Weekly meetings with broader care team to:

- Identify and clarify each patient’s status, needs, and goals
- Review progress and barriers toward care goals delineated in PCTP
- Map roles and responsibilities of care team members
- Strategize possible medical, behavioral, and social solutions along the continuum of care

A patient-centric means to measure social determinants of health

Teamwork with partner agencies throughout this process
Agency Overview

Victory Programs opens doors to recovery, hope and community to individuals and families facing homelessness, addiction or other chronic illnesses.
Outcomes and Lessons Learned
BHCHP PCTP (Care Plan) Completion Rate vs. 17 MA Behavioral Health Community Partners
Quality metrics

- BH CP engaged patients have higher rates of meeting key quality metrics.
- Longer engagement time does not always correlate with higher rates.
Utilization of high-cost services

- As expected, BH CP patients have higher rates of ED visits and IP discharges
  - 1.4x-1.8x higher
- Average visits per patient increased over time, but this is due in part to more facilities reporting in the latter half of 2018
Lessons Learned

**Good**

- Contracts with ACOs/MCOs help broaden our footprint across Boston-- >1000 pts
- Existing relationships & access to data streams help drive outreach activities
- Face-to-face case management enabled by decentralized care coordinators
- Care plan goals driven by patient
- Continuous changes, but MassHealth trying to do right thing

**Not So Good**

- Contracts with 10 ACOs/MCOs
- First 6-8 mos. focused on outreach vs. care; QAs are too ‘check box driven’
- Insufficient administrative support to Partners
- Care plan goals likely to become more medical
- PCP signature on care plan stands between us & payment
- Payments not risk adjusted

**Conclusion**

10 months completed; too early to know if we are improving outcomes, but traction is being reported by staff
Thank you!

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