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

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Sophie Lazar, BHCHP

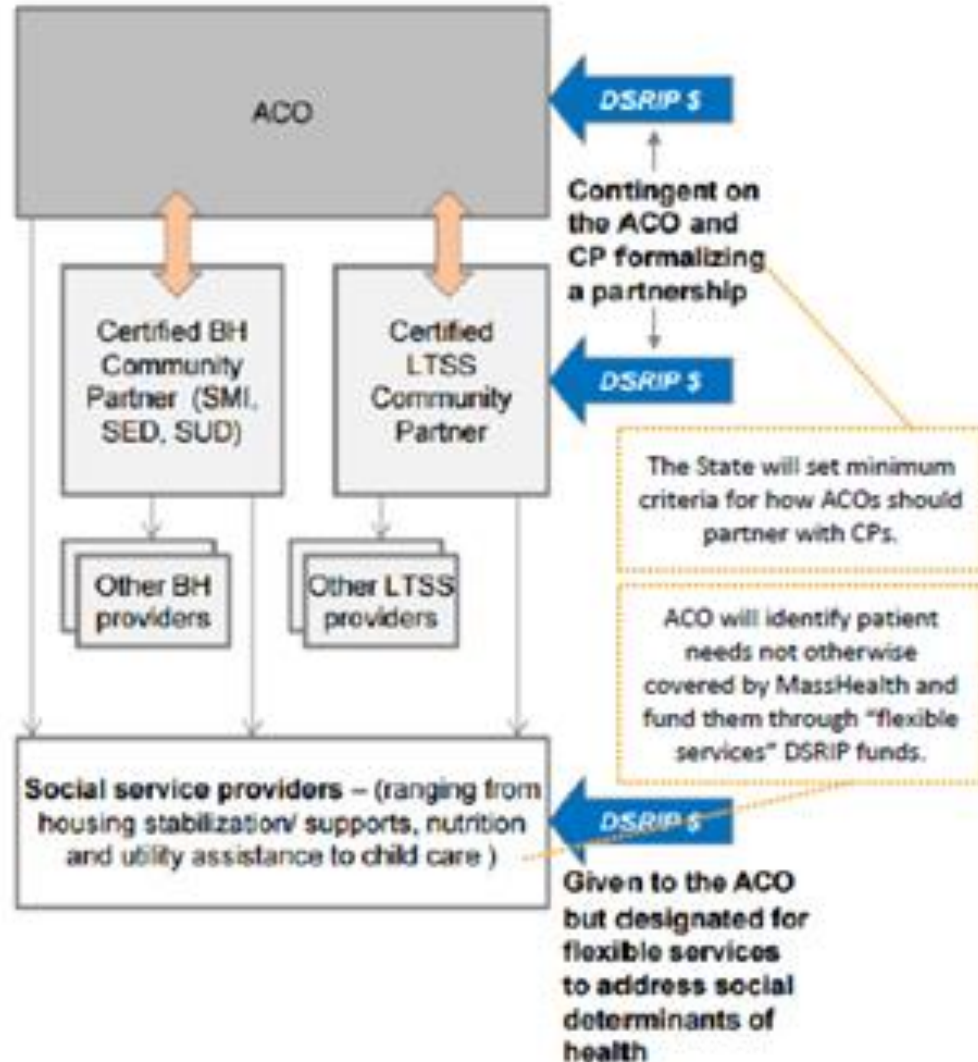
Daniel Moss, Victory Program

BHCHP Mission

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



Graphic from MassHealth

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

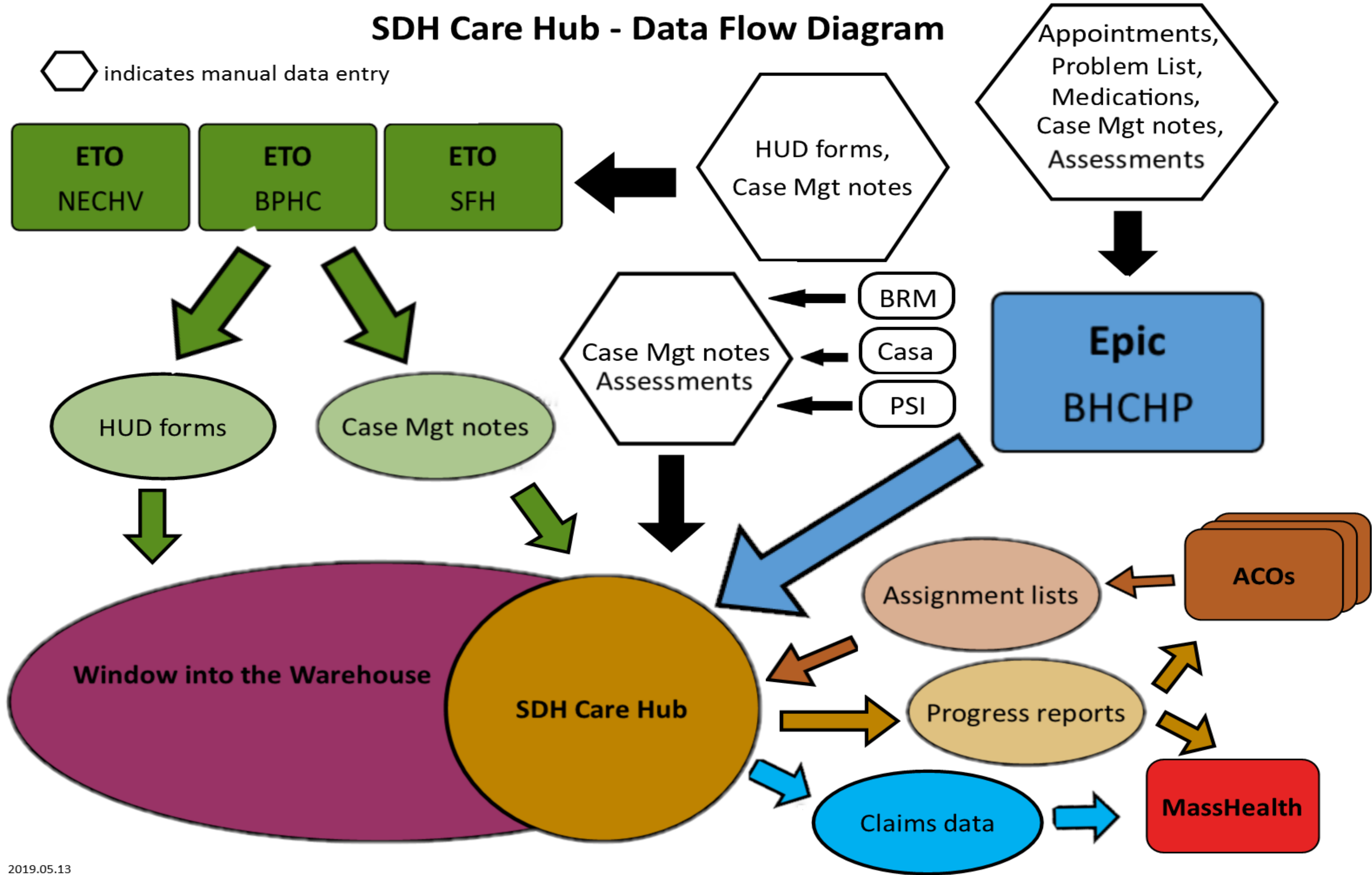
Payment

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

*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



SDH Care Hub - Data Flow Diagram
indicates manual data entry
ETO
NECHV
ETO
BPHC
ETO
SFH
HUD forms,
Case Mgt notes
Appointments,
Problem List,
Medications,
Case Mgt notes,
Assessments
BRM
Casa
PSI
Case Mgt notes
Assessments
Epic
BHCHP
HUD forms
Case Mgt notes
ACOs
Assignment lists
Window into the Warehouse
SDH Care Hub
Progress reports
Claims data
MassHealth
2019.05.13

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

« My Patients « Client Search

Basic Info & Programs | History | File Uploads | Health ▾

- Dashboard
- Care Plan
- Team Members
- Services
- Goals
- Files
- Metrics

Last Seen
1 day ago

Last Seen Location
Behavioral Health Community Partner, Confidential Project, and Female Day Program

Days in Last 3 Years
479 homeless
479 literally homeless

Homeless Span
Jan 23, 2004 to May

SO, TH, and SH

Veteran:
✕ No

Consent Form

CAS Client ID: 1827

Full HAN Release

Long-term Stayer

Chronically Homeless & in CAS **View in CAS**

Demographics

ID	Name	SSN	Age	Gender	Race	Ethnicity
Warehouse						
DND						
Health						
DND						
DND						
BPHC						

Contact Information

No contact information on file

Current Program Enrollments

Entry
Aug 26, 2018
Jan 26, 2019

Case Manager

Name	Phone	Type
Mike Payne		Case Manager

Assessments

Assessment Type	Collection Date	Location
Project Annual Assessment	Jan 1, 2016	Shelter Services
Project Exit	Apr 27, 2018	Shelter Services
Project Start	Mar 6, 2019	Shelter Services

Residential Enrollments

	Program Name < Agency Name	Entry	Exit	Most Recent Day Served	Days S
				Totals:	
DND ES	Night Center < Bay Cove Human Services	Jan 26, 2019		Feb 25, 2019	

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

« My Patients « Client Search

Client Healthcare Dashboard for

Basic Info & Programs | HMIS | Dashboard | Care Plan | Team Members | Services | Goals | Files | Metrics

Patient Summary | Appointments | Problems | Medications

Patient Summary

0 Valid Qualifying Activities in May

SSN: Medicaid ID: Primary Care Provider: WISHIK-MILLER, GABRIEL R ACO: Boston Accountable Care Organization in partnership with BMC HealthNet Plan

Engagement Readiness & Forms

- ✓ Participation Form
- ✓ Release of Information form
- ✓ Self-Sufficiency Matrix
- ✓ Comprehensive Health Assessment
- ✓ PCTP Signed

Communication

Preferred Communication:

Demographics

AGE: | GENDER: | DISABILITY FLAG: **Unknown**

DOB: | RACE / ETHNICITY: | VETERAN STATUS:

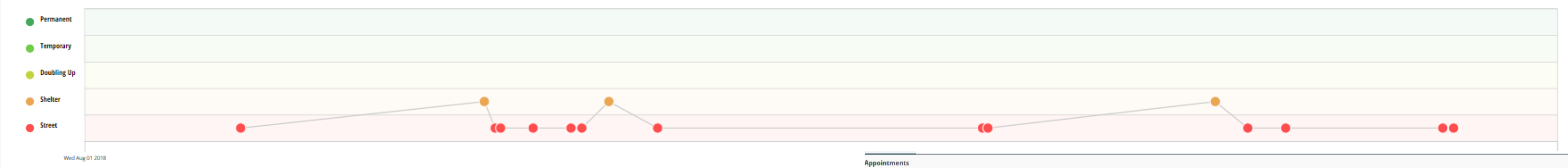
Allergies

none

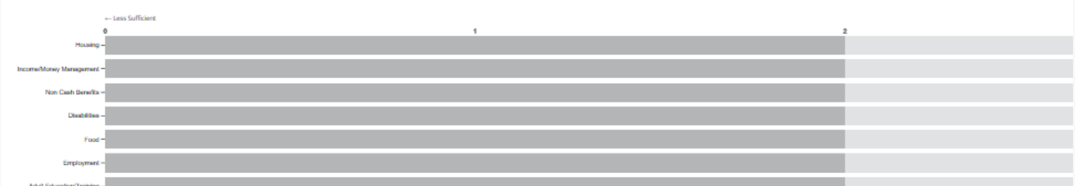
Advanced Directive

Would like to develop plan

Housing Status (August 2018 - April 2019)



Self Sufficiency Scores



Appointments

Upcoming Appointments

No upcoming appointments scheduled.

Past Appointments

SEARCH:

Date	Appointment	Doctor	SA
04/02/2019 7:30 PM	Appointment at BHC JYP CLINIC **Note:** Pt was escorted out of clinic	OPENACCESS SA1 58, EXTENDED CLINIC	BHC
03/29/2019 4:00 PM	Office Visit at BHC JYP CLINIC	KUMALAH-BAH, SAIO	BHC
03/29/2019 12:30 PM	Appointment at BHC JYP CLINIC **Note:** Pt was escorted out of clinic @12:30;	OPENACCESS SA1 58, ORANGE	BHC
02/26/2019 3:00 PM	Office Visit at BHC JYP CLINIC **Note:** pt wants bed @ BMH	MCNAMARA, MARGARET R	BHC
02/13/2019 1:30 PM	Office Visit at BHC JYP CLINIC	RABIDOU, CHRISTOPHER	BHC
01/17/2019 5:00 PM	Appointment at BHC JYP CLINIC **Note:** PT NA 5:19	OPENACCESS SA1 58, EXTENDED CLINIC	BHC
01/17/2019 10:30 AM	Office Visit at BHC ST. FRANCIS HOUSE CLINIC	KRUEGER, MEGHAN	BHC
01/15/2019 1:15 PM	Appointment at BHC JYP DENTAL	ANDERSON, MARY COLLEEN	BHC
01/14/2019 4:00 PM	Office Visit at BHC JYP CLINIC	KUMALAH-BAH, SAIO	BHC
12/06/2018 3:00 PM	Appointment at BHC JYP CLINIC **Note:** PT NA 1:39/ 2:03; 2:11	OPENACCESS SA1 58, ORANGE	BHC
11/29/2018 4:30 PM	Office Visit at BHC JYP CLINIC	OPENACCESS SA1 58, ORANGE	BHC
11/16/2018 12:00 PM	Office Visit at BHC JYP CLINIC	BAUER, YVONNE	BHC
11/09/2018 10:00 AM	Office Visit at BHC JYP CLINIC **Note:** PT NA 8:36	KING, JENNIFER	BHC
10/30/2018 11:30 AM	Office Visit at BHC JYP CLINIC	MCNAMARA, MARGARET R	BHC
10/22/2018 9:30 AM	Appointment at BHC MCINNIS HOUSE **Note:** BMC - Oral Surgery - Dr Caldroney - 830 Harrison Ave. Moakley 1400 / 617-414-4838 (driver) urgent appt	BMH TRANSPORTATION	BHC

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Problems

SEARCH:

Onset Date	Last Assessed	Problem	Comment	ICD10 List
Feb 26, 2019	Feb 26, 2019	Bilateral low back pain		M54.5
Feb 26, 2019	Feb 26, 2019	Chronic hepatitis C without hepatic coma (HCC-CMS)		B18.2
Nov 9, 2018	Nov 9, 2018	Primary osteoarthritis of right shoulder		M19.011
Oct 30, 2018	Oct 30, 2018	Puncture wound of finger, right, initial encounter		S61.239A
Oct 30, 2018	Oct 30, 2018	Encounter for removal of sutures		Z48.02
Oct 19, 2018	Oct 18, 2018	Complex care coordination		Z71.89
Oct 15, 2018	Oct 15, 2018	Closed fracture of face bones due to fall (HCC-CMS)		S02.92XA, W19.XXXA
Apr 12, 2018	Apr 11, 2018	Seborrheic dermatitis of scalp		L21.9
Apr 5, 2018	Apr 4, 2018	Slow transit constipation		K59.01
Aug 16, 2017	Aug 16, 2017	Tinea pedis of both feet		B35.3
Feb 13, 2017	Feb 10, 2017	Homelessness		Z59.0
Sep 22, 2016		Recurrent major depressive disorder (HCC)		F33.9
Jan 23, 2016	Jan 17, 2019	Nasal congestion		R09.81
Jun 24, 2015		Essential (primary) hypertension		I10
May 8, 2015	Apr 19, 2017	Monoplegia of upper extremity (HCC)		G83.20

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Medications

SEARCH:

Start Date	Ordered Date	Medication	Instructions
Apr 4, 2018	Apr 4, 2018	NALTREXONE ER 380 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE	
Feb 20, 2018	Feb 20, 2018	NALTREXONE ER 380 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE	
Aug 18, 2017	Aug 16, 2017	chlordiazepoxide (LIBRIUM) 25 mg capsule	Take 25 mg by mouth every 12 (twelve) hours as needed (s/sx of alcohol w/d)

BOSTON DND WAREHOUSE

ENDING VETERAN & CHRONIC HOMELESSNESS IN BOSTON

« My Patients « Client Search

Collaborative Care Plan for [redacted]

Basic Info & Programs | HMIS ▾ | Dashboard | Care Plan | Team Members | Services | Goals | Files | Metrics

Case Management Notes

+ Add Case Note

Assessment	Date Completed	Case Manager
Case Management Visit From Epic	Apr 9, 2019	BERARD, SHIRLEY
Case Management Visit From Epic	Mar 11, 2019	BERARD, SHIRLEY
Case Management Visit From Epic	Mar 4, 2019	BERARD, SHIRLEY
Interim Notes From Epic	Feb 26, 2019	DALAL, ELYSE
Interim Notes From Epic	Jan 15, 2019	DALAL, ELYSE
Case Management Visit From Epic	Jan 14, 2019	BERARD, SHIRLEY
Telephone From Epic	Dec 18, 2018	DALAL, ELYSE
Case Management Visit From Epic	Nov 15, 2018	BERARD, SHIRLEY
Case Management Visit From Epic	Nov 6, 2018	BERARD, SHIRLEY
Case Management Visit From Epic	Nov 1, 2018	BERARD, SHIRLEY

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Last updated: May 14, 2019 12:04 pm

Update

Self-Sufficiency Matrix Forms

+ Add SSM

Assessment	Date Completed	Case Manager
SSM	Oct 17, 2018	Elyse Dalal

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Previous Next

Comprehensive Health Assessments

+ Add CHA

Assessment	Status	Completed By
CHA	Reviewed on Oct 30, 2018	Elyse Dalal

Showing 1 to 1 of 1 entries

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Person-Centered Treatment Plan

+ Create a Care Plan

	Initiated	Signatures	Downloadable Care Plan
Make Copy Update Signature Dates	Oct 24, 2018	✓ Patient Signature (Oct 17, 2018) ✓ PCP Signature (Oct 23, 2018) Careplan expired Apr 23, 2019	PDF: Care Plan PDF: Coversheet

Current Care Team

ACO Care Manager

Claralys Gonzalez, Point of Contact
The Dimock Center (C3)
cgonzal2@dimock.org
(617) 442-8800 Ext 1260

ACO Care Manager

Stephanie Ramirez, Point of Contact
The Dimock Center (C3)
sramire3@dimock.org
(617) 442-8800 Ext 1579

Other Important Contact

CHRISTINA M FILIPOWICH (Care Manager)
bhchp.org
cfilipowich@bhchp.org
857-324-3733

Other Important Contact

ELYSE DALAL (Team Coordinator)
bhchp.org
edalal@bhchp.org
857-324-3738

Other Important Contact

SHIRLEY BERARD (Care Coordinator)
bhchp.org
sberard@bhchp.org
617-869-0128

Provider (MD/NP/PA)

GABRIEL R WISHIK-MILLER
Unknown
857-654-1000

Current Goals

No goals on file

Weekly Dashboard to Partners – 5/14/2019

Start date *

May 1, 2019

End date *

May 31, 2019

Update Date Range

Selected date range limits missing Qualifying Activity column. Only patients enrolled before the end date are included. All other columns include all patients.

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

How does this all work?

Staffing for Enhanced Care/BH CP Complex Care

CP Program Director
Mary Takach

CP Program Manager
Diana Aycinena

LICSW Liaison
Patsy Foley

CP IT Special Projects
Lisa Nguyen

PSI/SFH Team Coordinator:
Sophie Lazar

- PSI/SFH Care Coordinator
- PSI Care Coordinator
- SFH Care Coordinator
- SFH Care Coordinator

BPHC/MGH WI/Casa/BRM/NECHV Team Coordinator:
Jane Zhao

- Boston Public Health Commission Care Coordinator
- Boston Public Health Commission Care Coordinator
- Victory Programs Care Coordinator
- Casa Esperanza Care Coordinator
- Victory Programs Care Coordinator
- Casa Esperanza Care Coordinator
- Boston Rescue Mission Care Coordinator
- New England Center & Home for Vets Care Coordinator

Street Team Coordinator:
Beckie Tachick

- Street Care Coordinator

Green/Blue Team Coordinator:
Pam Sprouse

- Green Care Coordinator
- Blue Care Coordinator
- Red Care Coordinator

Orange Team Coordinator:
Elyse Dalal

- Orange Care Coordinator
- Orange Care Coordinator
- Orange Care Coordinator
- Orange Care Coordinator

Purple Team Coordinator:
Esme Marie

- Purple Care Coordinator
- Purple Care Coordinator
- Purple Care Coordinator

Consortium Nurse Care Manager

Consortium Nurse Care Manager

Street Nurse Care Manager

JYP Nurse Care Manager

JYP Nurse Care Manager

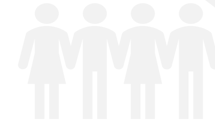
BH CP Staff Trainings

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

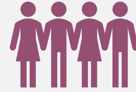


Population Health

(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?

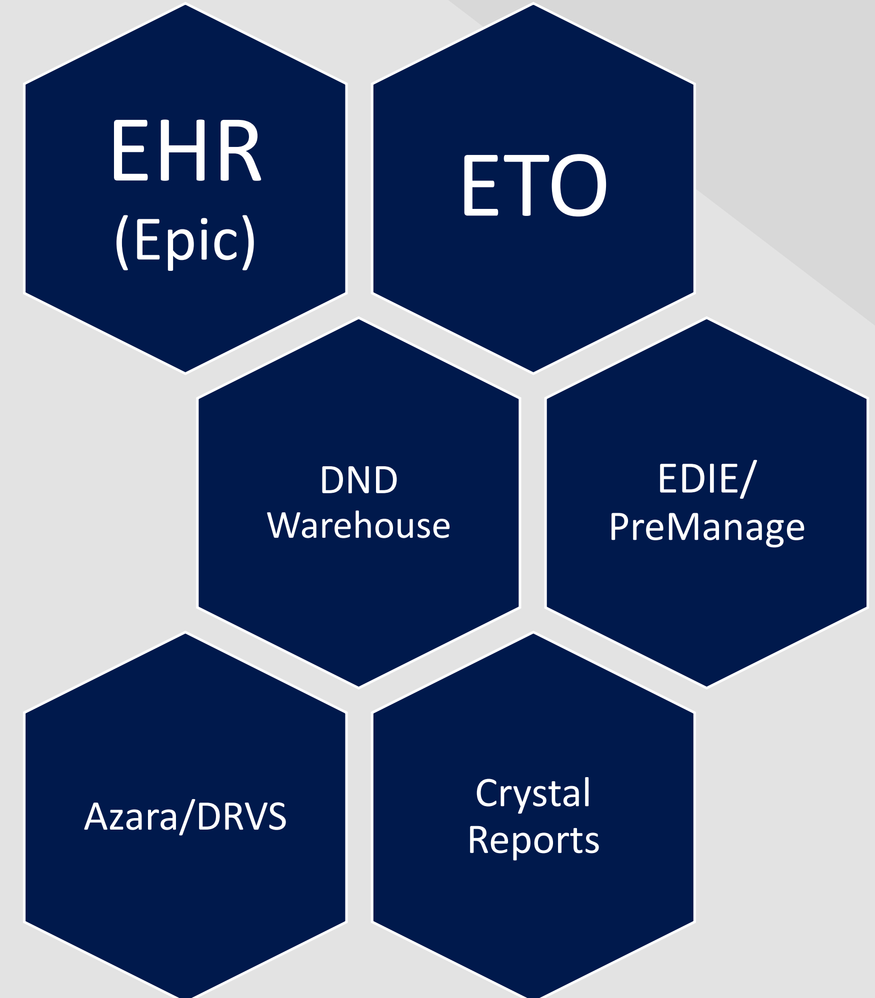
Referral Type	BH CP
Analytic (from EOHHS via claims identification, 12 month claim lookback period)	Must have one of the following diagnoses: • SUD, Schizophrenia, Bipolar, Mood Disorder, Psychosis, Trauma, Suicidal, Homicidal, depression, adjustment reaction, anxiety, psychosomatic or conduct disorder, PTSD And one of the following utilizations: • ESP Interaction, Detox, Methadone, IP (3+), ED (5+), select medical co-morbidities (3+), high LTSS util, current DMH enrollment
Qualitative	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.

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

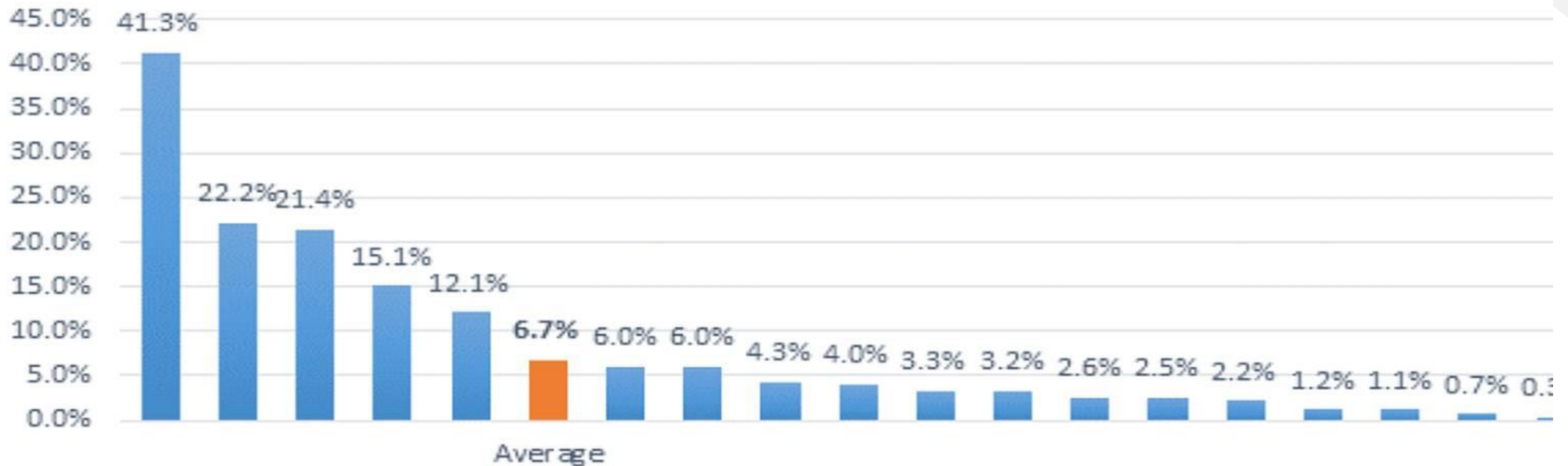
Teamwork with partner agencies throughout this process

Agency Overview

Victory Programs opens doors to recovery, hope and community to individuals and families facing homelessness, addiction or other chronic illnesses

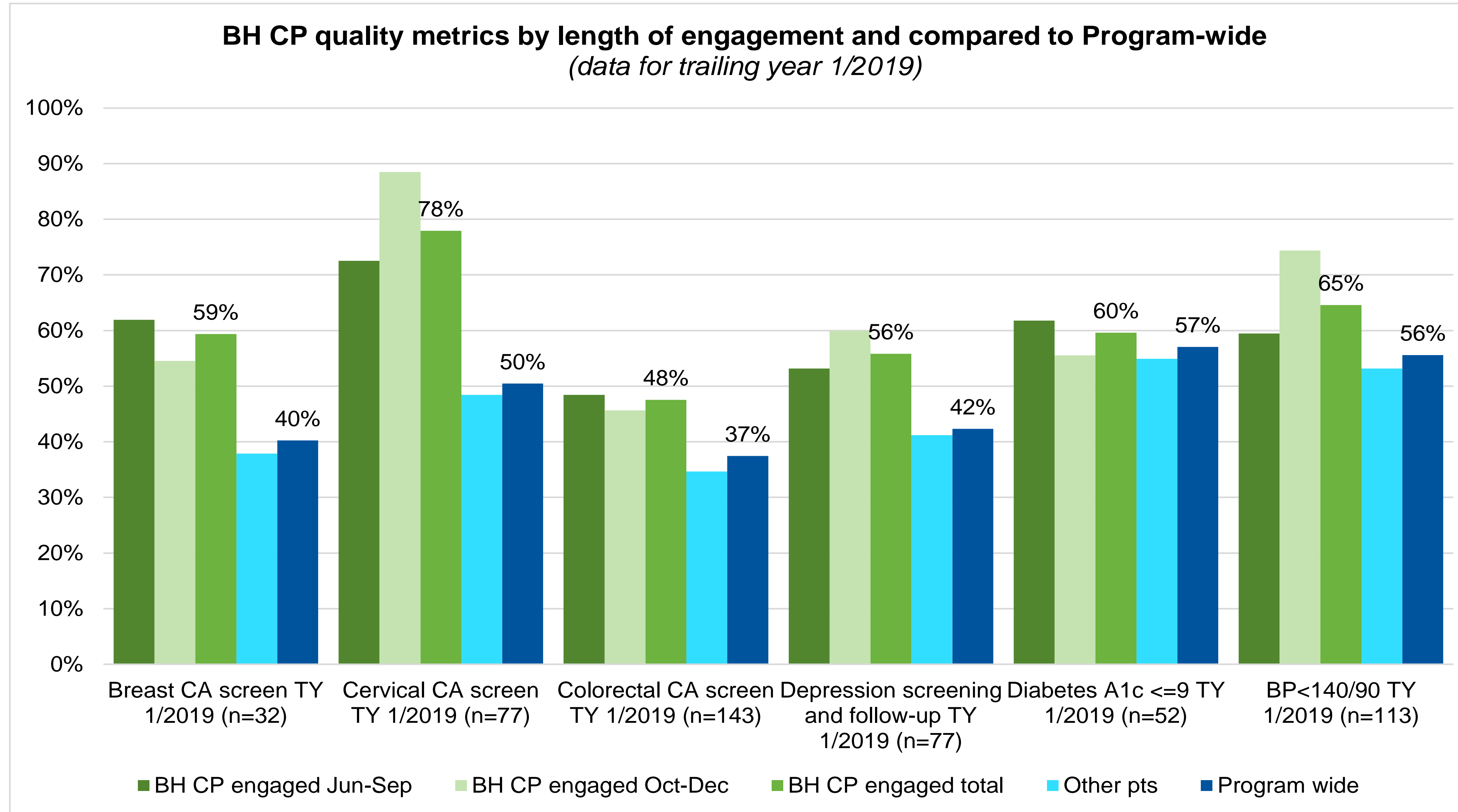
Outcomes and Lessons Learned

BHCHP PCTP (Care Plan) Completion Rate vs. 17 MA Behavioral Health Community Partners



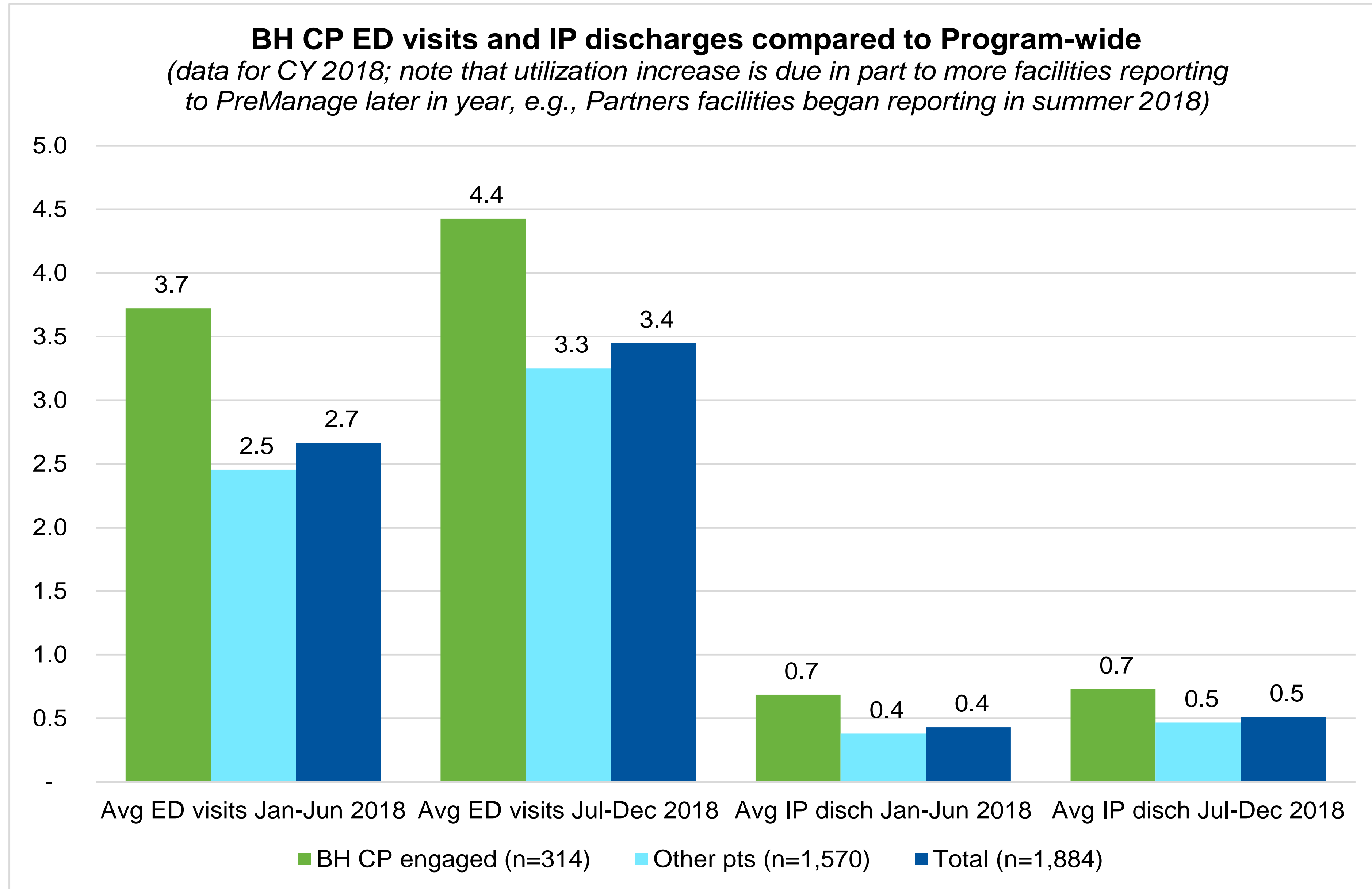
Quality metrics

- 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!

Contact information:

Mary Takach, BHCHP: mtakach@bhchp.org

Sophie Lazar, BHCHP: slazar@bhchp.org

Dan Moss, Victory Programs: dmoss@vpi.org