Partnering for the Future

LAN SUMMIT

Health Care Payment Learning & Action Network

103 Panel: Alternative Payment Models and the Safety Net: Medicaid, FQHCs, and the Uninsured

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

Welcome

Henry Pitt

Chief Quality Officer, Temple University Health System

Associate Vice Dean, Temple University's Lewis Katz School of Medicine

SESSION OBJECTIVES

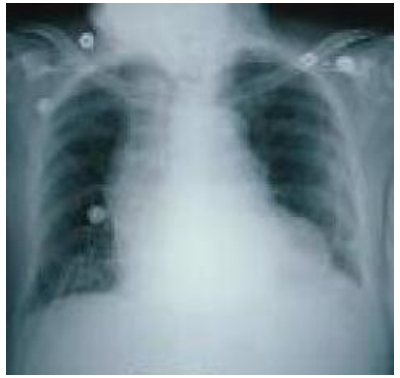
- **Safety net providers and administrators will provide their perspectives on how the movement toward APMs is affecting their patients and their care delivery systems**

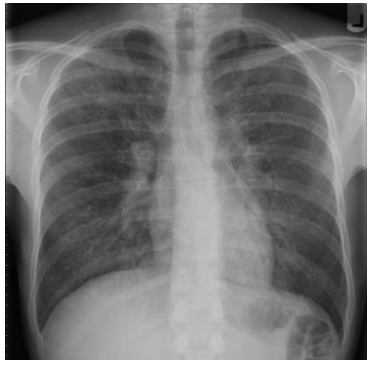
- **Attendees will learn about innovations happening in the safety net and in Medicaid, and understand the unique challenges facing these providers and patients**

IMPOVERISHED PATIENTS

- **Some hospitals care for a disproportionate share of impoverished patients**
- **These patients have a high disease burden including CHF, diabetes, COPD and cancer**

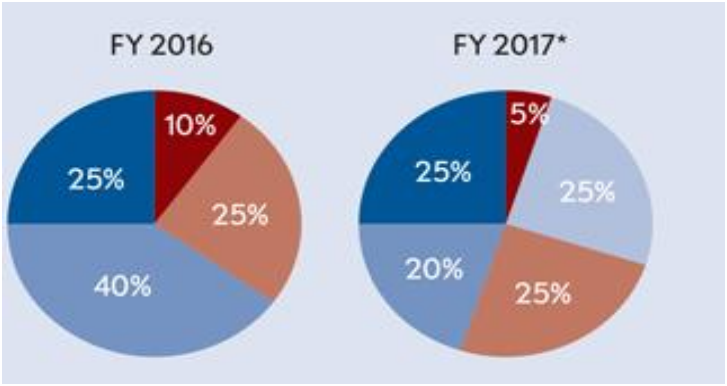
Poverty Neighborhood


CHF


COPD

REIMBURSEMENT PROGRAMS

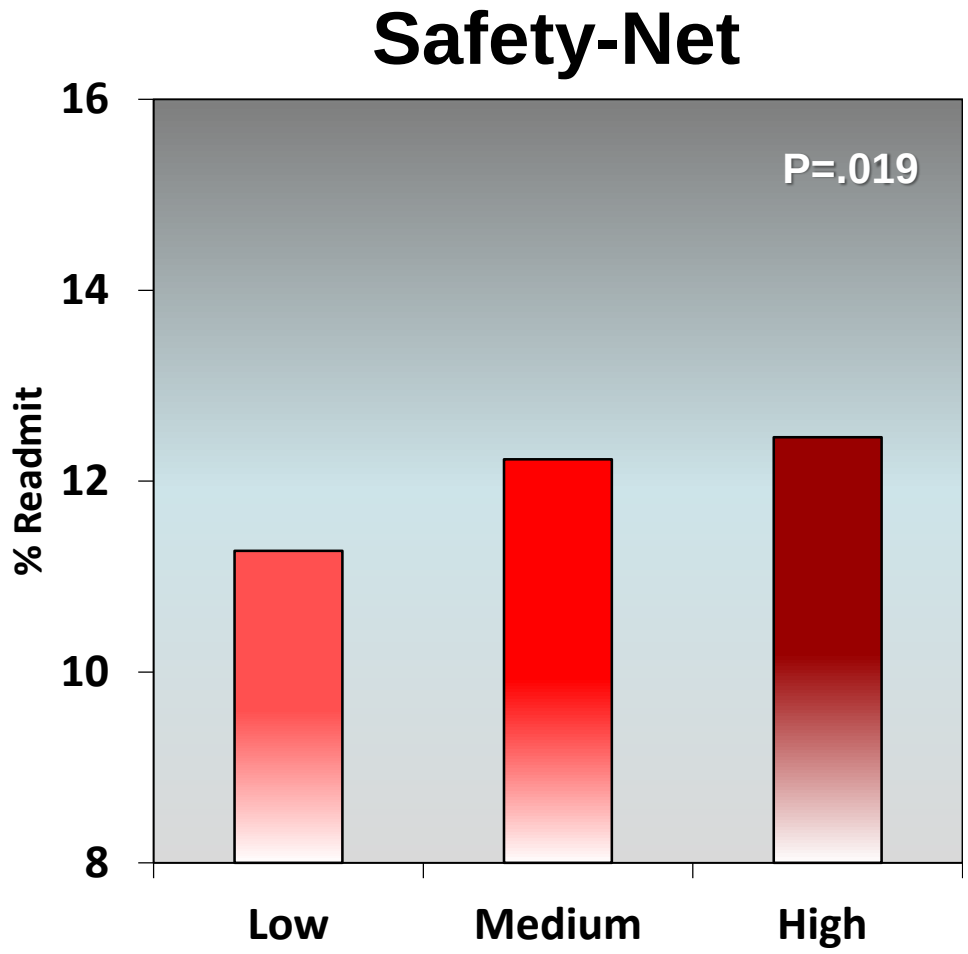
- **Current CMS (VBP*, RRP*, HAC*) and private payor quality reimbursement programs do not properly risk-adjust for safety-net mission**



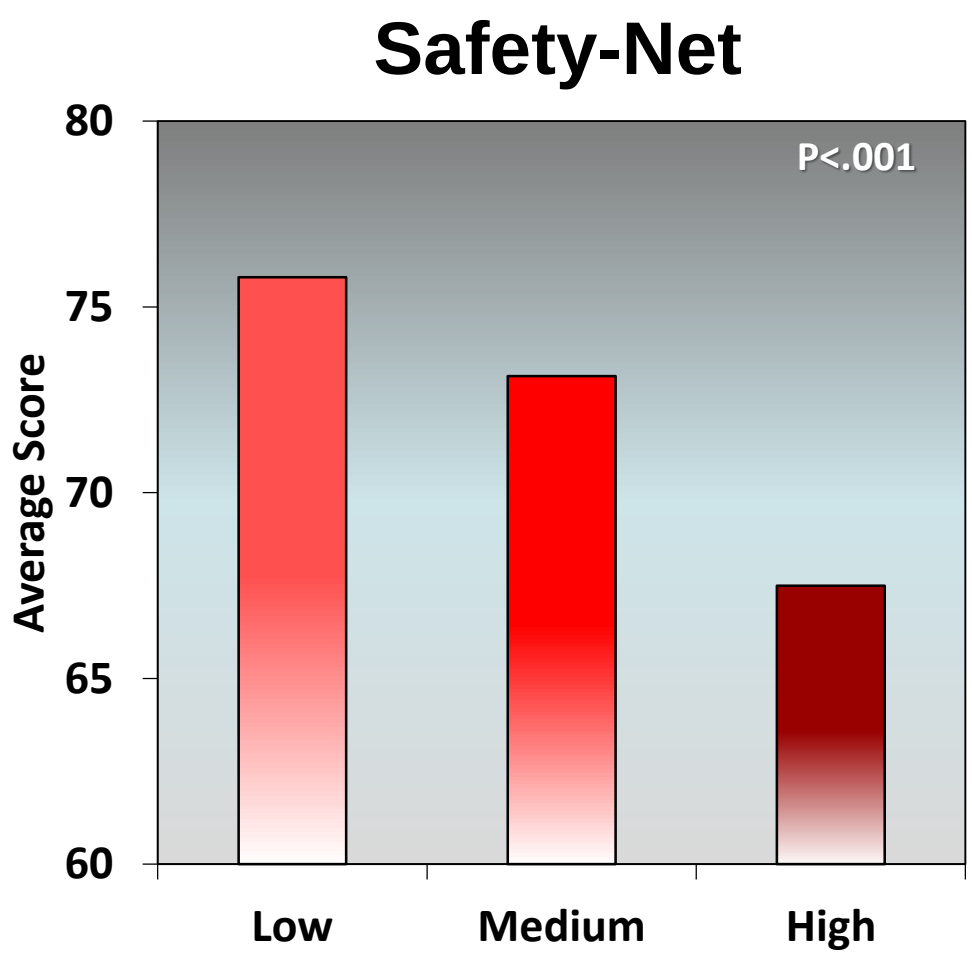
CMS VBP and RRP

***VBP = Value Based Purchasing**
RRP = Readmission Reduction Programs
HAC = Hospital Acquired Conditions

READMISSIONS



SATISFACTION



CONCLUSIONS

- **Readmissions are higher and patient satisfaction is lower in high safety-net mission hospitals**
- **Overall hospital quality, cost and value are adversely influenced by an increased safety-net mission**
- **Hospital quality, cost and value should be risk-adjusted for safety-net mission**

TRACY L. JOHNSON, PhD

- **Director of Health Care Reform Initiatives, Denver Health and Hospital Authority Denver, CO**

- **Assistant Professor Colorado School of Public Health**

Johnson

CHRISTINA SEVERIN, MPH

- **President and CEO**
  Community Care Cooperative (C3)
  Boston, MA

- **Accomplished health care executive with more than 25 years of experience in managed care**

Severin

SUSAN FREEMAN, MD

- **President and CEO**
  Temple Center for Population Health
  Philadelphia, PA

- **CMO, Temple University**
  Health System

- **Vice Dean of Health Care Systems**
  Temple University SOM

Freeman

ELLEN-MARIE WHELAN, NP, PhD

- **Chief Population Health Officer Center for Medicaid and CHIP Services (CMCS)**

- **Senior Advisor, Center for Medicare and Medicaid Innovations (CMMI)**

Whelan

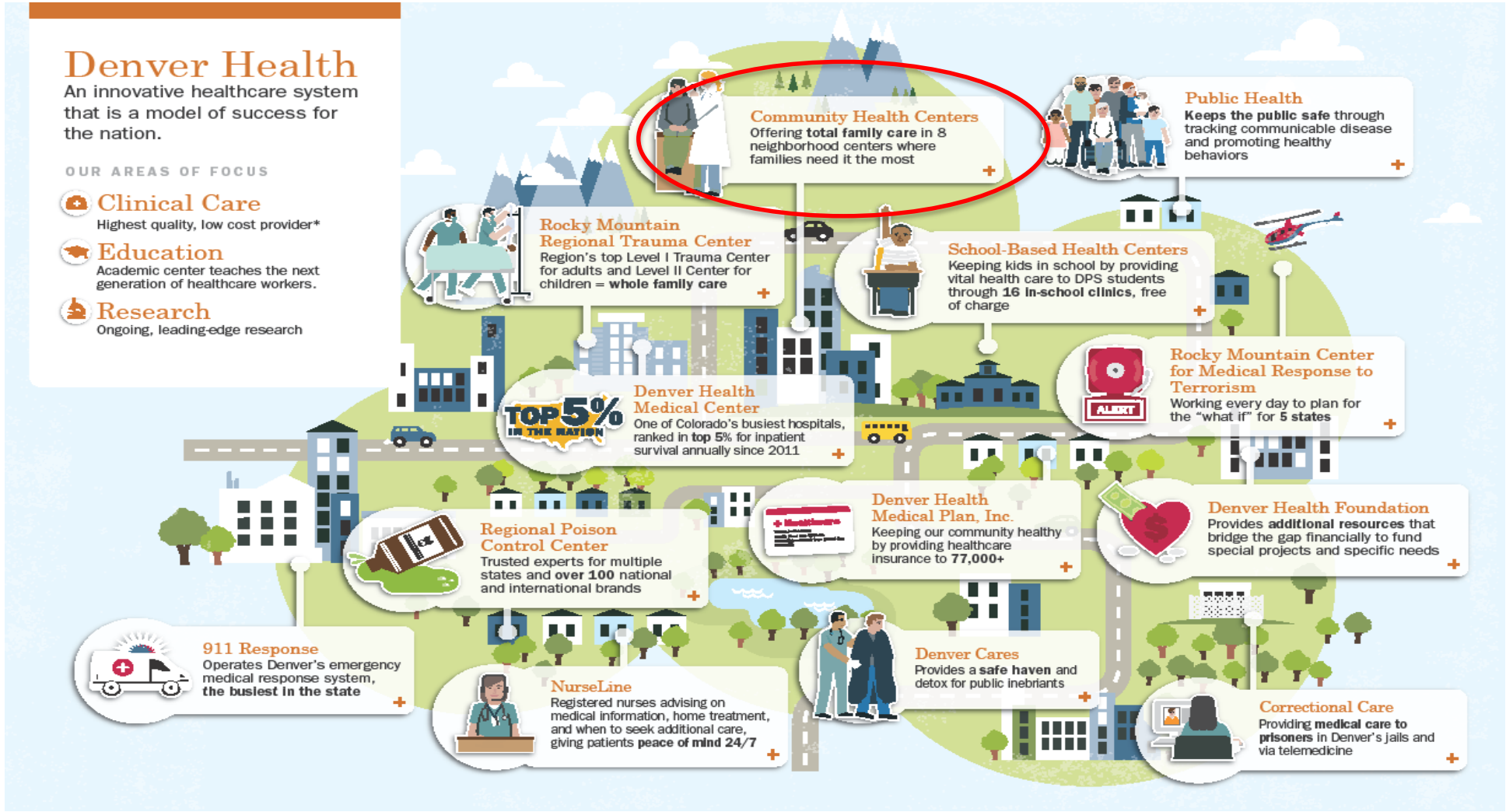
Welcome

Tracy L. Johnson, PhD

Director of Health Care Reform Initiatives,
Denver Health and Hospital Authority

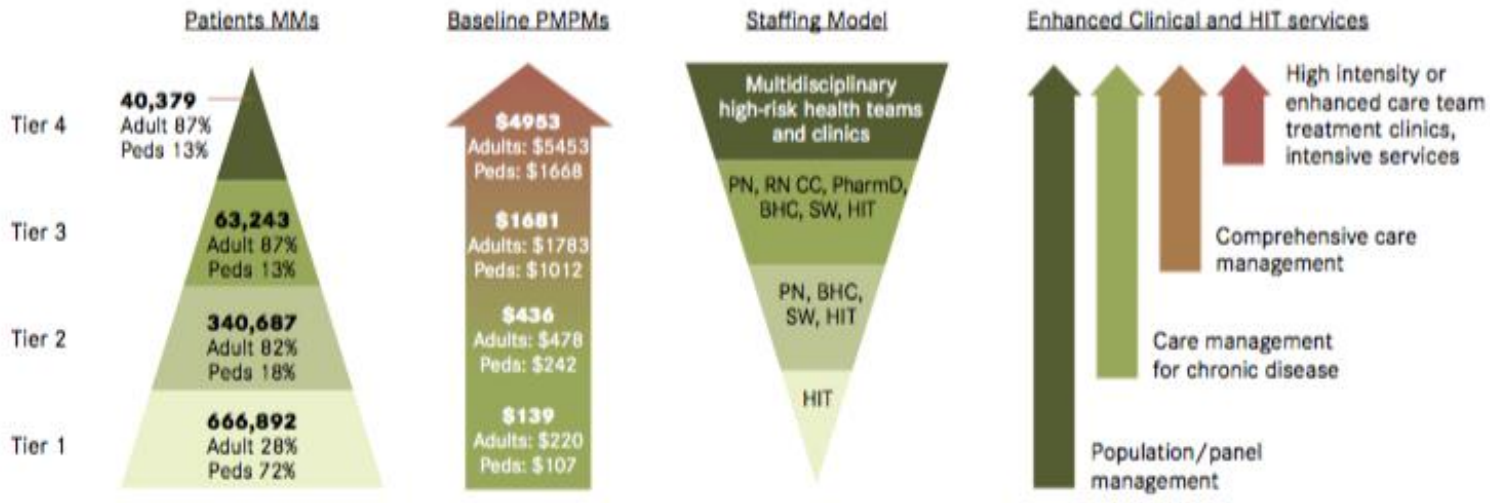
Denver, CO

Denver Health and Hospital Authority



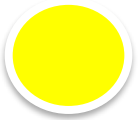
Tiered Primary Care Services

Figure. The 21st-Century Care Model: Adult and Child Proportions, per Member per Month Costs, Staffing and Services by Population Segment (risk tier)*



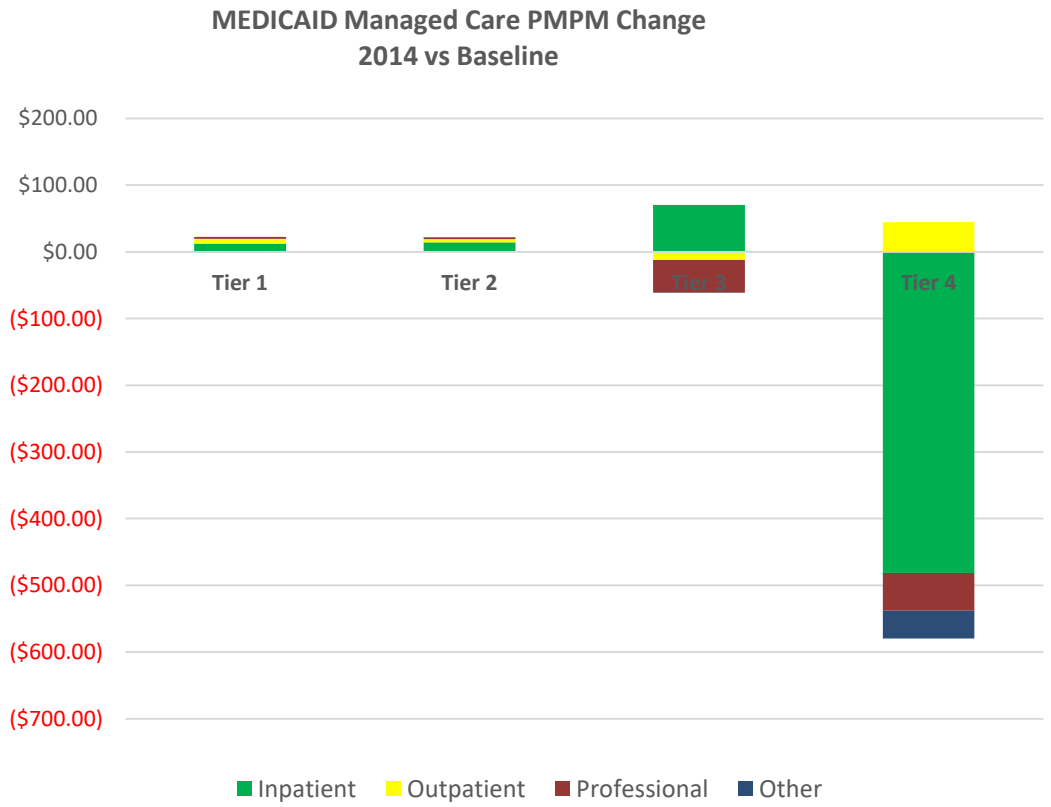
BHC indicates behavioral health consultant; HIT, health information technology; MM, member months; peds, pediatric patients; peds, pediatric patients; PharmD, clinical pharmacist; PMPM, per member per month; PN, patient navigator; RNCC, registered nurse care coordinator; SW, social worker.
*Baseline period is November 2011 through October 2012. Attributed patients included managed care members identified through member files. Fee-for-service patients were identified through billing data and re-determined on a monthly basis. Unpictured are 14,387 member months associated with untiered children.
Source: Johnson TL, Brewer D, Estacio R, et al. Augmenting predictive modeling tools with clinical insights for care coordination program design and implementation. *EGEMS (Wash DC)*. 2015;3(1):1181. doi: 10.13063/2327-9214.1181. The data have been updated from the original.

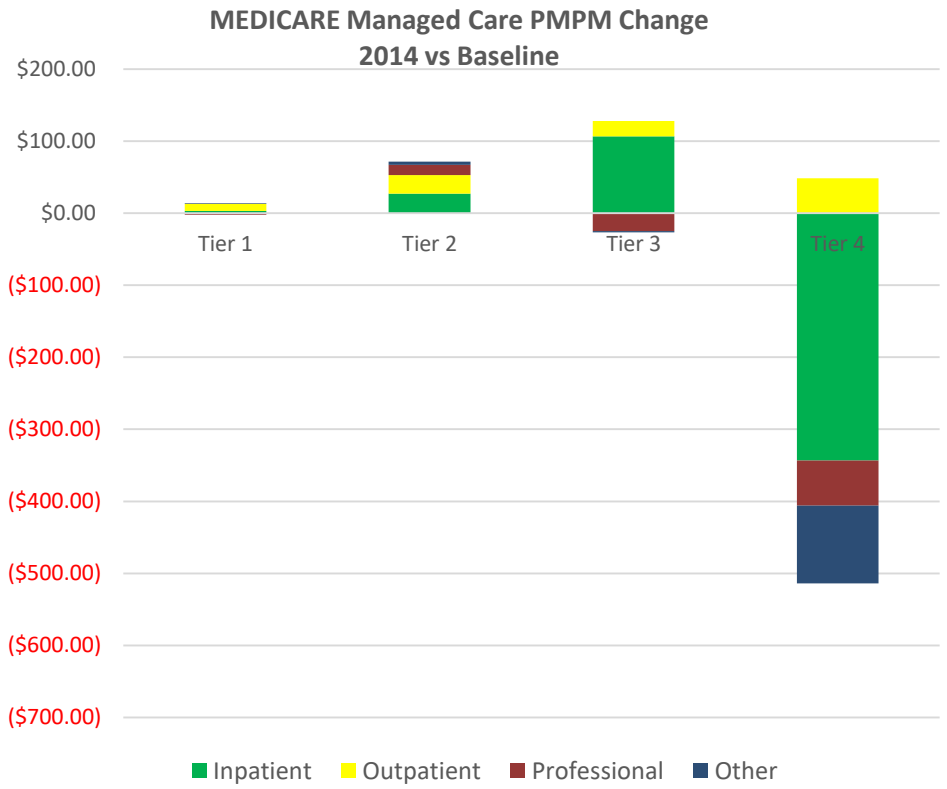
21st Century Care Outcomes

Driver	Baseline	Actual	
SMARTER SPENDING Reduce claims costs by 2.5% relative to trend over 3 years	Adult MCO Population	**$ 5 million** (DH savings)	
	Adult FFS Populations	**$ 10.9 million** (state/federal savings)	
POPULATION HEALTH Improve population health by 5% over 3 years	**77%** Composite Quality Score	**81%** (5% improvement)	
PATIENT EXPERIENCE Improve patient experience with between visit care by 5% over 3 years, without decreasing satisfaction with visit-based care	**Between Visit Care**		
	77% (text/phone calls helpful)	**90%**	
	60% (test follow-up)	**69%**	
	66% (provider aware of specialty care)	**74%**	
	Visit-Based Care		
	44% (appointment as soon as needed)	**54%**	
	79% (understand provider explanations)	**83%**	
	61% (asked about health goals)	**61%**	

Cite: Johnson T et al. Population Health in Primary Care: Cost, Quality and Experience Impact. AJAC. September 2017.

Reduced Inpatient Spending for High Risk Adults Drives Reductions in Overall Total Cost of Care





Cite: Johnson T et al. Population Health in Primary Care: Cost, Quality and Experience Impact. AJAC. September 2017.

Thank you !

For additional information:

Tracy Johnson, PhD, MA,
Co-PI, Evaluation Lead

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Welcome

Christina Severin

President & CEO, Community Care Cooperative

C3 Overview

- In 2016, 15 Federally Qualified Health Centers (FQHCs) formed a new MassHealth ACO called Community Care Cooperative (C3) (www.C3aco.org)
  - As of 1/1/2019, we will have 17 FQHCS
- We are the largest FQHC-ACO in the U.S. taking “upside” and “downside” risk
- We serve about 115,000 MassHealth beneficiaries statewide
- We have a 5-year award to run a MassHealth Primary Care ACO
- Our 2018 operating budget is $41M
- We are managing over $500M in Total Cost of Care
- We are a 501c3 tax exempt non-profit that is owned by our FQHC-Members

Our Statewide Footprint

Origins of the MassHealth ACO Program

- MassHealth program was deemed financially unsustainable
  - Grown to 40% of the Commonwealth's budget
    - Over $15 billion per year
  - Serves 1.9 million MA residents
  - No major structural changes in the last 20 years
- CMS authorized a $1.8 billion investment over 5 years through an 1115 Waiver
  - An expansive "restructuring" initiative to move from an MCO program to an ACO program

MassHealth Contract Principles

- Substantial two-sided risk
- Quality impacts financial performance
  - 21 contracted quality measures
- Over the five years, the methodology for budget setting moves from largely experience-based to largely market price-based
  - Therefore, hard to imagine that their won't be winners and losers
- Uses a sophisticated risk adjustment methodology that includes a complex Social Determinant of Health and Neighborhood Stress adjusters

How we Harness Data Assets to Power the Model of Care

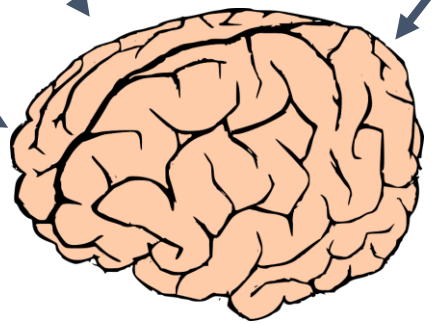
Patient screens

EHR

SDoH data

Claims

ADT & Auth alerts



"The Main Brain"

Data Warehouse with a Rules-based engine

Performance Analytics
Cost & Quality performance information

Risk of Big Events
Complex Care

Risk of Re-admissions
Transitions of Care

Care & Social Needs
Care Coordination

Gaps in Quality & Care
Population Health & Risk Adjustment

Welcome

Susan L. Freeman, MD MS

President and CEO

Temple Center for Population Health, LLC

Chief Medical Officers, TUHS

Vice Dean, Health Care Systems, LKSOM

Temple Health

- **Academic-medical-center** dedicated to delivery of quality care to patients and achieving excellence in education and research.
- **Temple University, Lewis Katz School of Medicine** (900+ students)
- **Temple University Health System** - five major facilities:
  - **Temple University Hospital (TUH)**
    - **TUH Episcopal Campus (Behavioral Health)**
    - **TUH Northeastern Campus (Ambulatory)**
    - **550 residents and fellows**
  - **Fox Chase Cancer Center**
    - **NIH-designated comprehensive cancer center**
  - **Jeanes Hospital**
    - **Community teaching hospital**
- **Employed physician practice groups**:
  - **Temple University Physicians (Faculty)**
  - **Fox Chase Medical Group (Faculty)**
  - **Temple Physicians, Inc. (Community-based practices and urgent care)**
- **Temple Center for Population Health**:
  - Temple Care Integrated Network (Clinically integrated network in North Philadelphia)
  - Temple SNF Narrow Network
  - Access center; care transition programs; care management
  - Chronic disease management programs in the community
  - Patient centered medical homes
  - Community partnerships
- **Largest employer in North Philadelphia**






TUHS is an Urban Healthcare Provider

- 3000 births, 95% MA
- Payer Mix:
  - Medicaid - 34% (46% at TUH) Medicare - 43% (High Dually Eligible population)
- Largest volume of penetrating trauma
- Largest PA MA provider
- No public hospital in Philly
- No CON laws

- Financial:
  - $2.0B in revenues
- Inpatient & Observation:
  - 38,700 acute discharges
  - 9,900 observation cases
- 7,000 + Medicaid apps/yr.
- 170,000 ED Visits

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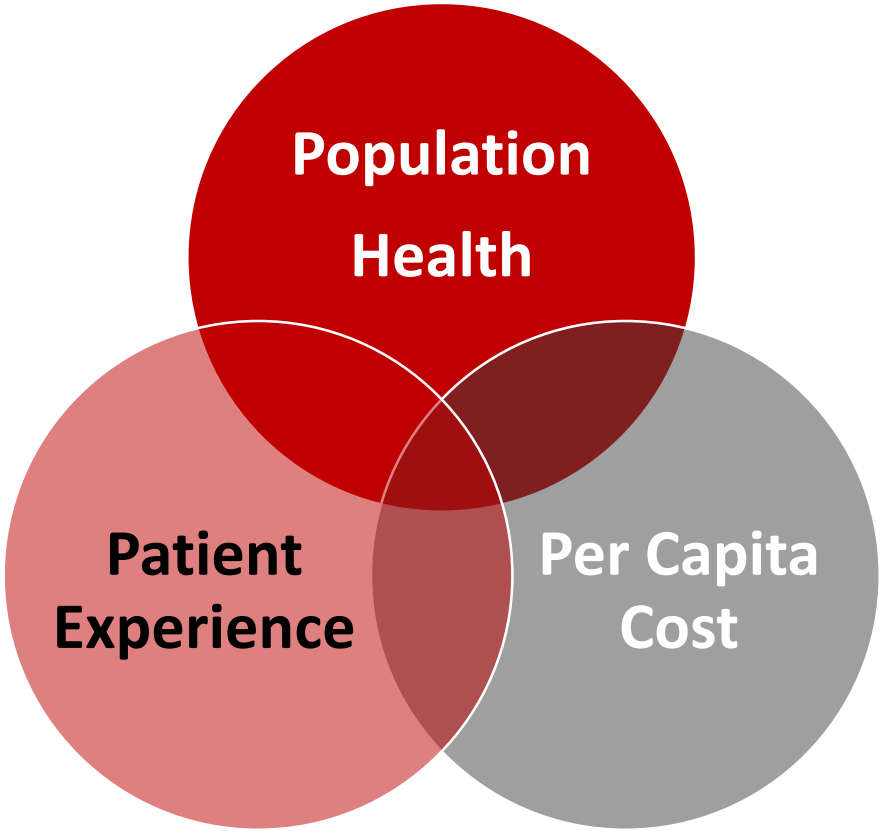
Why is Achieving the Triple Aim Challenging?



- Disease burden
- Socioeconomic factors (deep poverty)
- SDH
- Lack of investment
- Lack of a unified urban approach
- Lack of health literacy
- Health care disparities
- Access to primary care
- Access to behavioral health
- The opioid epidemic
- Legacy systems and lack of interoperability

Berwick, et.al. The Triple Aim: Care, Health and Cost. Health Affairs. 2008;27:3(759-69)

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Temple Center for Population Health Value-Based Strategies

Value-Based Financial Models

- Risk Based Contracts
- Quality/Cost
- Advanced and Alternative Payment Models

Value-Based Care Models

- Temple Care Integrated Network
- Alternative Care Locations
- Ambulatory Transformation and PCMHs

Population Health Management

- Transitions of Care
- Post-Acute Narrow Network
- Social Determinants of Health

Analytics

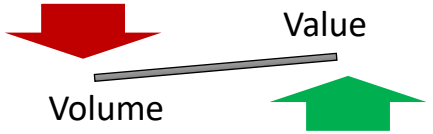
- Predictive Analytics and Risk Stratification
- Targeted Interventions
- Data Driven Transformation

Goal: Attain a sustainable, coordinated model of health care delivery through clinical and business integration, community engagement and a balance of medical and nonmedical interventions to promote high value care and healthy populations

Value-Based Financial Models

- Pay for Performance
- Alternative (Advanced) Payment Models
  - Bundled Payments
  - CPC+
- Shared Savings
- Shared Risk (Member-owned MCO)

Future: Full Risk



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Value-Based Care Models

- **Temple Care Integrated Network (TCIN)**
- FQHC leasing space adjacent to the ED
- Patient Centered Medical Homes (PCMH)
- Comprehensive Primary Care Plus (CPC+)
- Transformation of Care (TCPi, Trauma Informed)
- Behavioral Health Screening (NIDA)
- Patient and Family Advisory Councils

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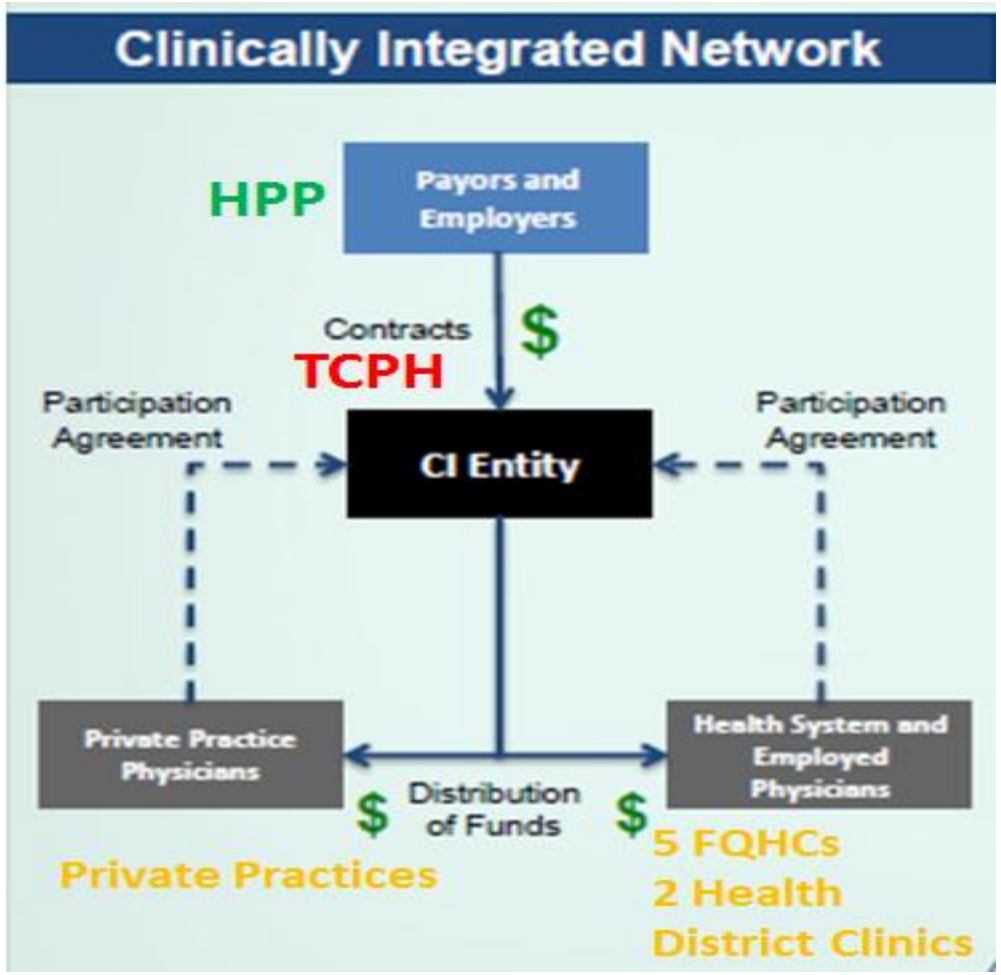
Temple Care Integrated Network

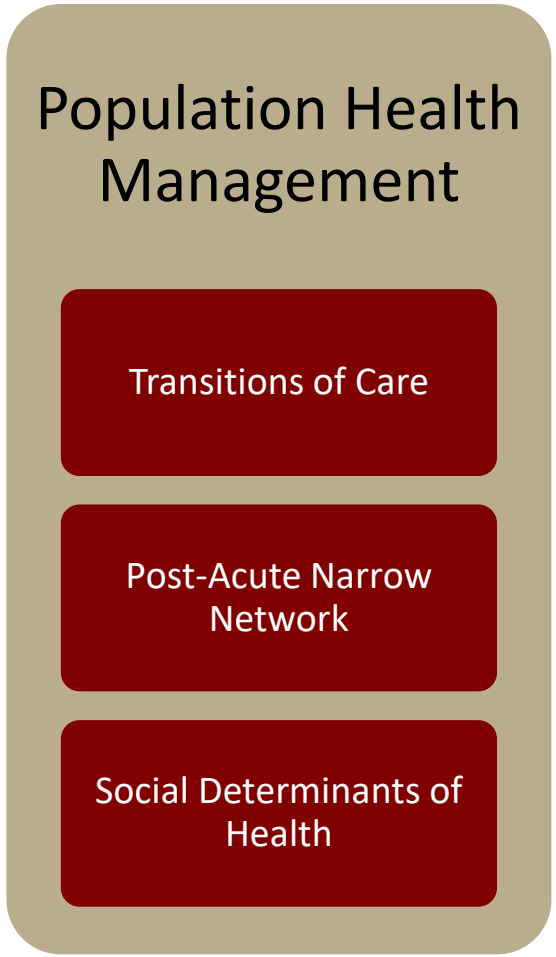


A transformational strategic alignment of physician practices and payors, in collaboration with the health system to deliver evidence-based, coordinated, efficient, high quality care to a defined community of patients.

Benefits:

- Improved communication
- Transitions of care
- Access to data/transparency
- Physician engagement
- Aligned performance incentives
- Accountability
- High value care
- Focus on health outcomes and improving health in North Philadelphia

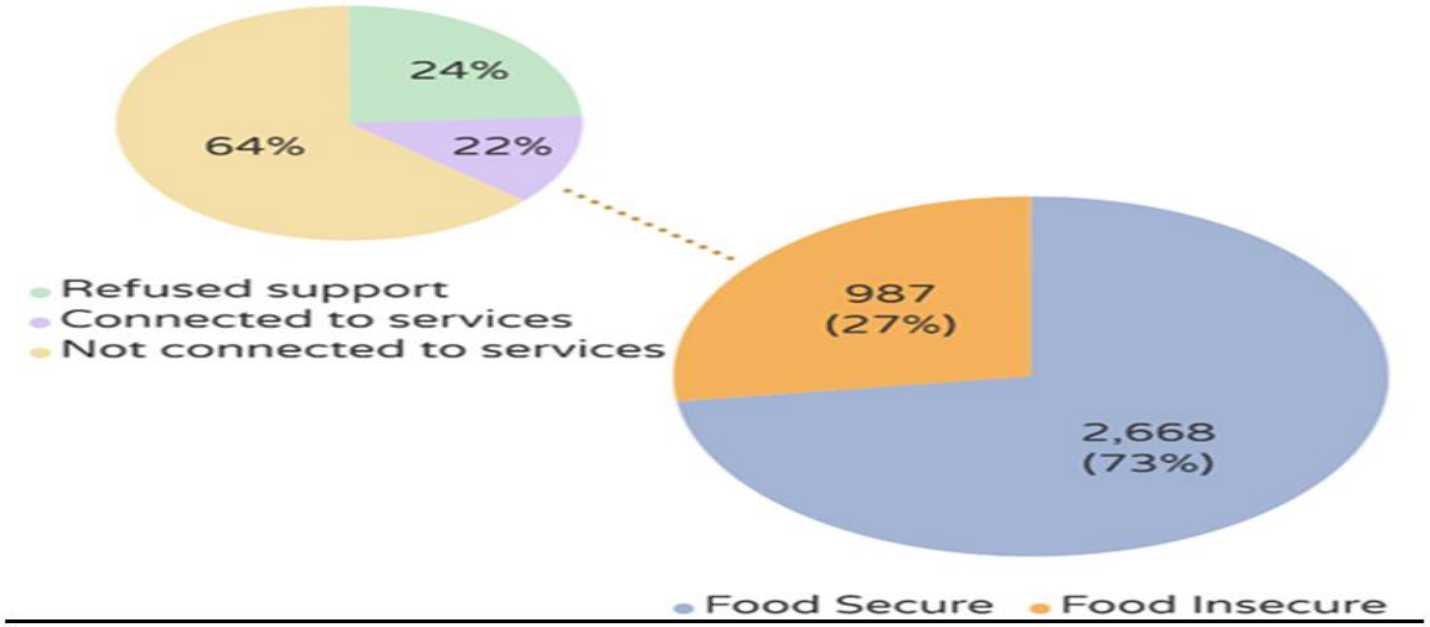
Population Health Management



- SNF Collaborative
- Longitudinal and episodic care management
  - Community Care Transitions (CHW, SW, Nurse)
  - Temple Care Transitions (CHW/Nurse dyad)
- Linking inpatient care with ambulatory follow-up
- Addressing the readmission rate
- Addressing low acuity ED utilization
- Addressing preventable admissions
- Utilization of Community Health Workers
- Disease management in defined populations
  - Diabetes Prevention Program (DPP/CDC funded)
  - Self-blood pressure monitoring program
  - Commercial programs
- Screening for SDH
- Community agency engagement to address the SDH
- Community network to address the opioid epidemic

Addressing Food Insecurity

- Temple participated in Collaborative Opportunities to Advance Community Health (COACH) sponsored by HAP and facilitated by HCIF
- All patients discharged from TUH receive a follow-up phone call – questions regarding food insecurity were imbedded
- 27% were food insecure but two –thirds never connected with recommended resources for many reasons
- Current efforts are directed at warm hand-offs and CHW interactions to improve access and addressing patients who remain food insecure despite food assistance



Analytics

- Database
- Analytics
- Dashboards
- Predictive Modelling
- Risk Stratification
- Resource Management
- Health Share Exchange
- Education
  - Health System Science curriculum
- Research
  - PacMAT grant ($1M DOH)
  - CDC 1422 DPP and SBPM
  - Paramedic Program (pending)
  - NIDA (BH-Works screening tools)
  - TCPi (Transformation of Care)

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Transformation of Care

- Cost savings require new approaches to old problems
- Emphasis on a Culture of Health
- Community engagement on a new level
- Trauma informed strategies in the clinical setting as a matter of routine
- Networks of providers, patients, agencies, government
- Addressing the cultural transformation in schools (ACEs; youth sports, education)

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Health Care Payment Learning & Action Network

Thank You!

Susan.Freeman@tuhs.temple.edu

Welcome

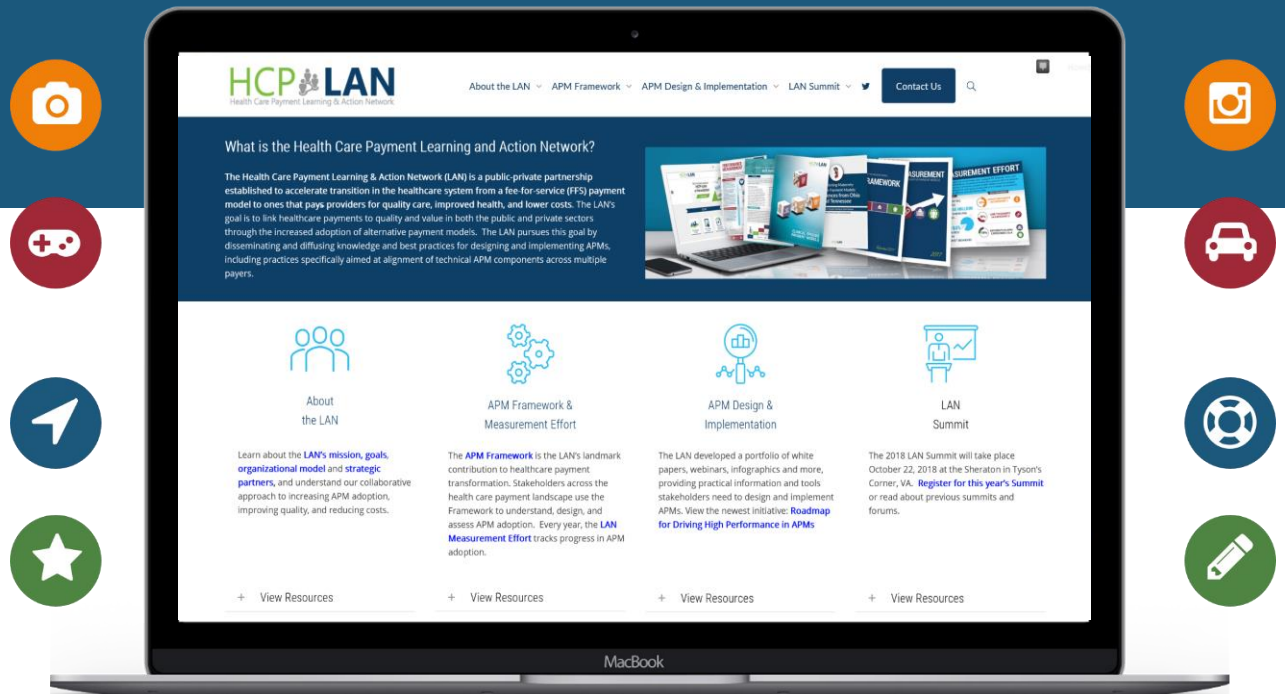
ELLEN-MARIE WHELAN, NP, PhD

Chief Population Health Officer
Center for Medicaid and CHIP Services (CMCS)

Senior Advisor, Center for Medicare and Medicaid Innovations (CMMI)

Visit the LAN Website for our Resources

https://hcp-lan.org/



Exit Survey

We want to know what you think!

Please take a moment to complete the exit survey so we can continue to improve and enrich the LAN. Use the link in ***Guidebook*** for this session to provide us your feedback.

Contact Us

We want to hear from you!

www.hcp-lan.org

@Payment_Network

PaymentNetwork@mitre.org

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Thank You!