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

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

Safety-Net

% Readmit

Low  Medium  High

P = .019

SATISFACTION

Safety-Net

Average Score

Low  Medium  High

P < .001
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
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
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)
Welcome

Tracy L. Johnson, PhD
Director of Health Care Reform Initiatives,
Denver Health and Hospital Authority

Denver, CO
Denver Health and Hospital Authority

Denver Health
An innovative healthcare system that is a model of success for the nation.

Our Areas of Focus

- Clinical Care: Highest quality, low cost provider
- Education: Academic center teaches the next generation of healthcare workers
- Research: Ongoing, leading-edge research

Community Health Centers
Offering total family care in neighborhoods where families need it the most

Public Health
Keeps the public safe through tracking communicable disease and promoting healthy behaviors

Rocky Mountain Regional Trauma Center
Region’s top Level I Trauma Center for adults and Level II Center for children – whole family care

School Based Health Centers
Keeping kids in school by providing vital health care to DPS students through 56 in-school clinics, free of charge

Denver Health Medical Center
One of Colorado’s busiest hospitals, ranked in top 5% for patient survival annually since 2011

Regional Poison Control Center
Trusted experts for multiple states and over 100 national and international brands

Denver Health Medical Plan, Inc.
Keeping our community healthy by providing healthcare insurance to 77,000+

Denver Care 1
Provides a safe haven and retreat for public workers

Denver Health Foundation
Provides additional resources that bridge the gap financially to fund special projects and specific needs

911 Response
Operates Denver’s emergency medical response system, the busiest in the state

NurseLine
Registered nurses advising on medical information, home treatment, and when to seek additional care, giving patients peace of mind 24/7

Correctional Care
Providing medical care to prisoners in Denver’s jails and via telemedicine
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)*

Tier 4
- Patients MMs: 40,379
- Adult 67%: 27,081
- Pediatric 33%: 13,298

Tier 3
- Patients MMs: 63,243
- Adult 87%: 54,750
- Pediatric 13%: 8,493

Tier 2
- Patients MMs: 340,687
- Adult 82%: 281,339
- Pediatric 18%: 59,348

Tier 1
- Patients MMs: 666,892
- Adult 28%: 192,290
- Pediatric 72%: 474,602

Baseline PM PMs
- Tier 4: $4,983
- Tier 3: $18,681
- Tier 2: $4,346
- Tier 1: $1,399

Staffing Model
- Multidisciplinary high-risk health diseases and clinics
- PN, RN, CG, PharmD, BHC, SW, HIT

Enhanced Clinical and HIT services
- High intensity or enhanced care team treatment clinics, intensive services
- Comprehensive care management
- Care management for chronic disease

Population/panel management

*Baseline period is November 2011 through October 2012. Antenatal 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. Unspecified are “NH” members associated with uninsured children.

## 21st Century Care Outcomes

<table>
<thead>
<tr>
<th>Driver</th>
<th>Baseline</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SMARTER SPENDING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult MCO Population</td>
<td>$5 million (DH savings)</td>
<td></td>
</tr>
<tr>
<td>Adult FFS Populations</td>
<td>$10.9 million (state/federal savings)</td>
<td></td>
</tr>
<tr>
<td><strong>POPULATION HEALTH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77% Composite Quality Score</td>
<td>81% (5% improvement)</td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT EXPERIENCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Visit Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77% (text/phone calls helpful)</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>60% (test follow-up)</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>66% (provider aware of specialty care)</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Visit-Based Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44% (appointment as soon as needed)</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>79% (understand provider explanations)</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>61% (asked about health goals)</td>
<td>61%</td>
<td></td>
</tr>
</tbody>
</table>

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

Tracy.Johnson@dhha.org
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)
  o 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
  o Grown to 40% of the Commonwealth’s budget
    o Over $15 billion per year
  o Serves 1.9 million MA residents
  o No major structural changes in the last 20 years

• CMS authorized a $1.8 billion investment over 5 years through an 1115 Waiver
  o 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

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

Performance Analytics

Cost & Quality performance information
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
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

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
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
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)
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)
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

Search: Health Care Payment Learning and Action Network
Thank You!

Partnering for the Future

LAN SUMMIT
Health Care Payment Learning & Action Network