Baystate Health

BeHealthy Partnership
Baystate Health Care Alliance in Partnership with Health New England

Medicaid ACO: The First Six Months

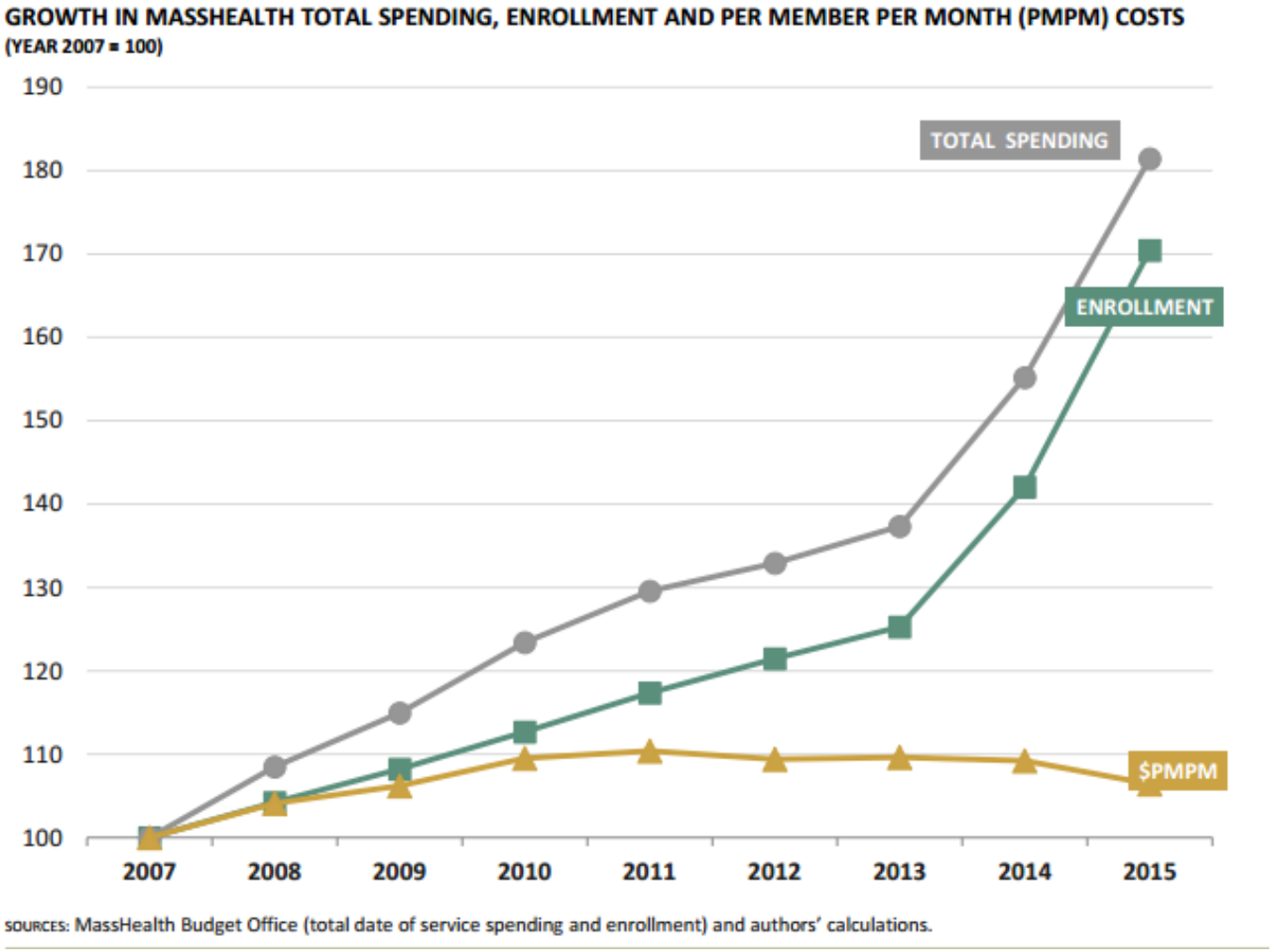
Mark A. Keroack, MD, MPH
President and Chief Executive Officer, Baystate Health

Andrew W. Artenstein, MD
Chief Physician Executive and Chief Academic Officer, Baystate Health

Medicaid Background

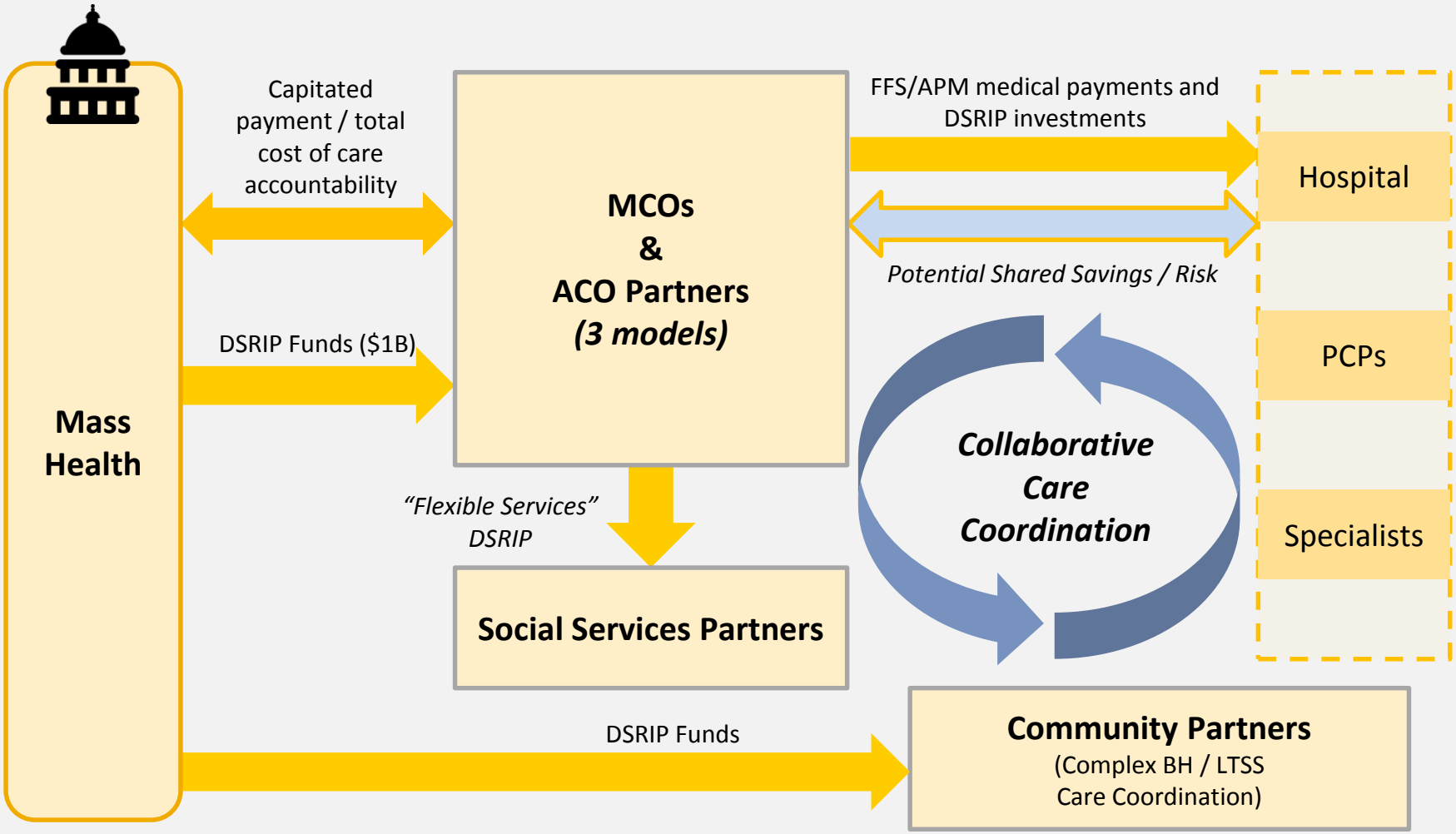
- Begun as Safety Net program in 1965 and now insures over 70M Americans (1 in 4)
- America's largest insurer and growing rapidly
- 1115 Waivers allow for innovation but must be cost neutral and further the goals of the program
- Since 2012 Supreme Court Ruling on Medicaid Expansion, eight states have applied for waivers
- Approaches include managed care, personal responsibility (e.g., copays), work requirements, payment reform

Impetus for Change in Mass.



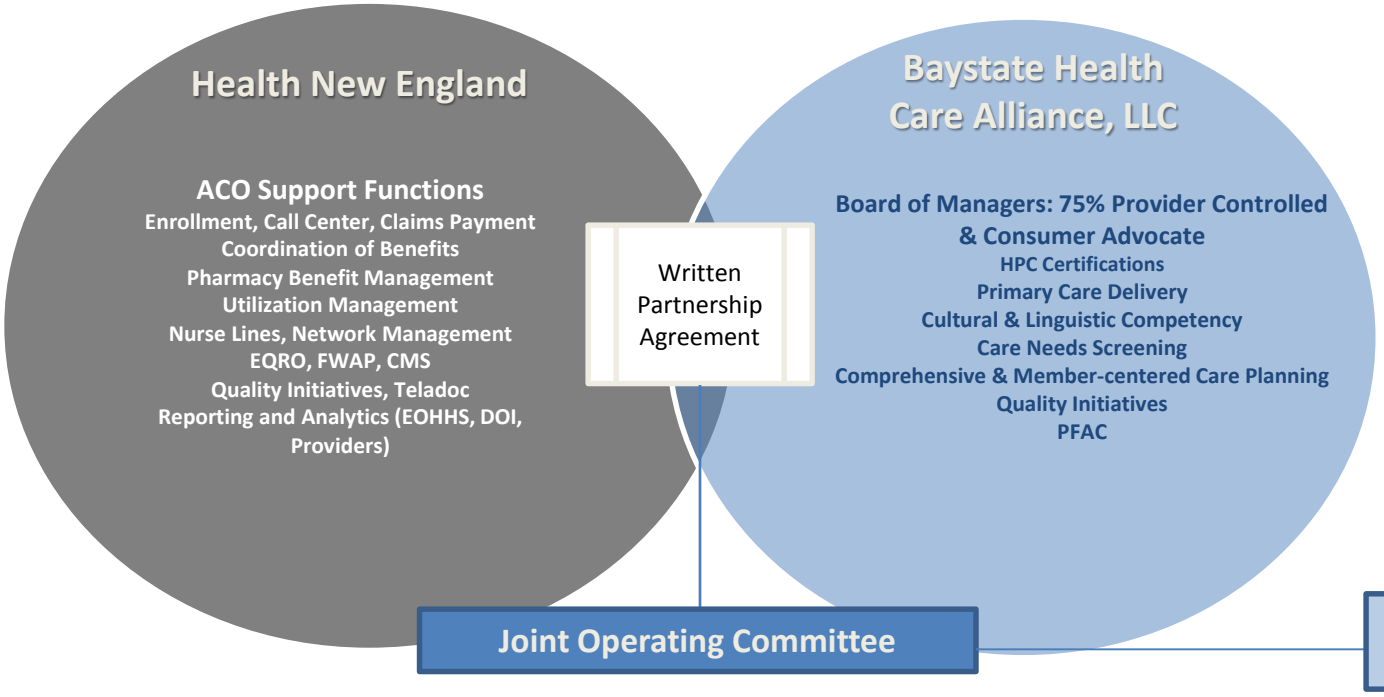
Source: Massachusetts Medicaid Policy Institute, June 2016

ACO Program Requires Community Collaboration



Expectation of 2.5% statewide total cost of care for enrollees by 2024

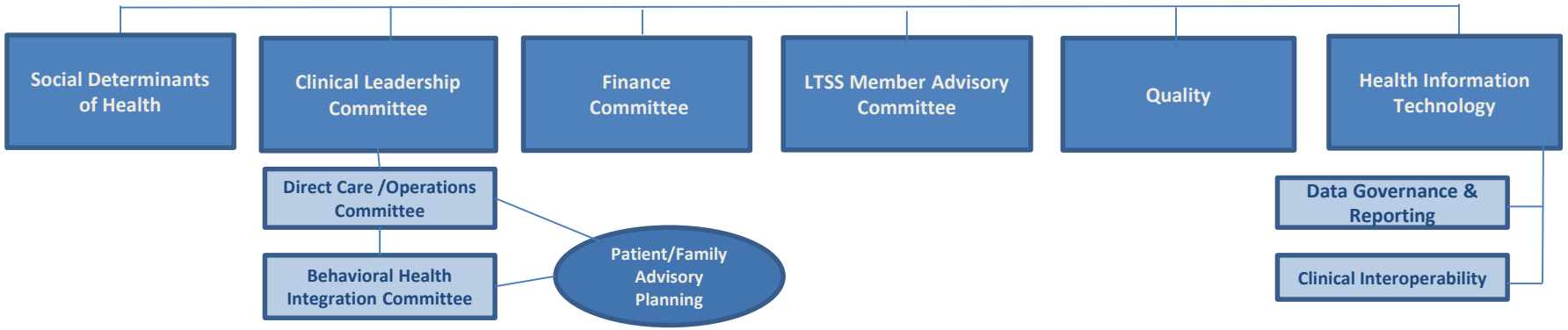
Be Healthy Partnership: Structure of Shared Responsibilities



Governance: Be Healthy Partnership Plan

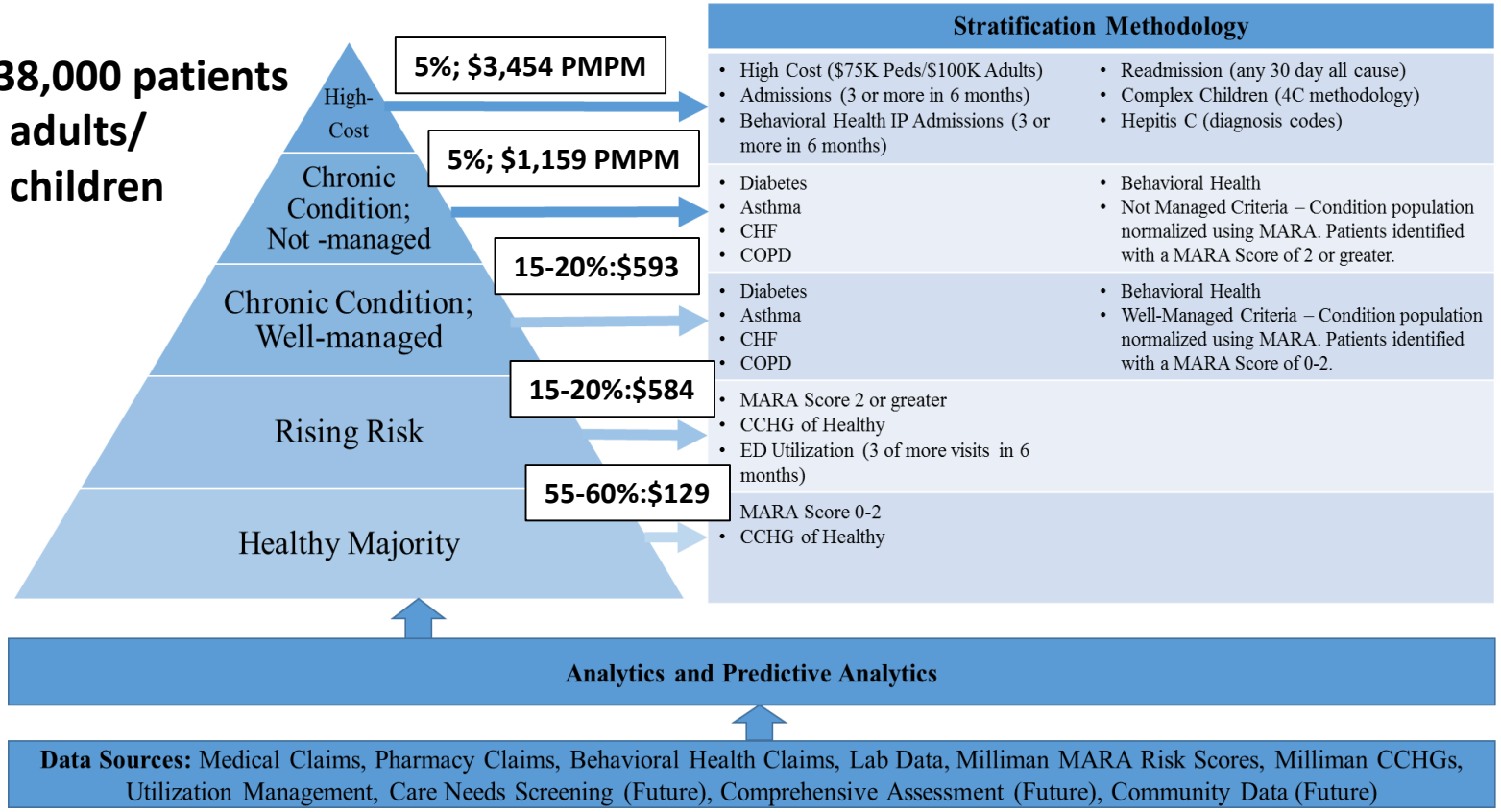
Joint Operating Committee & Joint Decision Making for Use of DSRIP Payments

Functional Integration, Care Coordination, Data Integration



Risk Stratification Model

N = 38,000 patients
65% adults/
35% children



What We Know To Date About The BeHealthy Population

- We have completed over 10,000 “care needs screenings” (CNS): 28% of our patients
- Data to be used to enhance budget (e.g. care of homeless add $50 pmpm), to justify DSRIP spend, and in grant applications
- CNS data to date:
  - 51% English, 32% Spanish, 15% other (34% of Caring)
  - 9% no housing (n=868); 5% worried about losing housing soon
  - 17%: Lack of transportation interferes with medical care
  - 27% sometimes or often worried food will run out

BeHealthy Partnership: Clinical Transformation Tactics

- New Care Team design: heavy on nursing, care coordination, and community health workers (CHW) to identify and manage high- and rising risk patients, coordinate behavioral health and substance use care, and connect resources to address social needs impacting health (e.g. alternatives to VNA for med admin; transportation models; CHW huddles, group visits)
- "Ambulatory ICU": aimed at decreasing ED utilization in complex, high-risk adults through intensive outpatient management (e.g. DISPATCH health, telehealth, remote monitoring)
- "Rapid Response" Team: focusing on high cost pediatric patients with complex medical-, social-, and behavioral health needs
- Integrated Behavioral Health and Community Partner Programs: proactively managing outpatients to reduce hospital use
- Medication Management Team: pharmacy- and clinical group focusing on adherence, med rec to reduce adverse reactions, and decreasing spend
- Transitions of Care: multidisciplinary team including recovery coaches and CHW focusing initially on seamless transitions to home and community-base care for psych- and substance use to reduce readmissions and improve health (n=40 to date)

ACO Activities Supporting Clinical Transformation

- Practice transformation coaches at each CHC to drive change
- Enhanced interpreter/translation services
- Wellness programs in development
- Quality initiatives underway (moving target under MA)
- Academic evaluation through UMMS-Baystate Institute for Healthcare Delivery and Population Science
- Social Determinants of Health work in early phases in collaboration with community partners
- Exploring primary care capitation and behavioral health alternative payment contracting
- Inpatient- and bridge clinic for MAT of substance use

Challenges

- A new collaboration and mixing cultures: FQHC with 4 Baystate Health CHCs + a payer partner—learning to share
- Talent recruitment and training
- Inadequate- and delayed population data from MA
- “Continuation of care” provisions over initial quarter of program and associated budgetary issues
- Unrealistic MassHealth demands related to assessments for previous community-assigned patients have overwhelmed care teams
- Primary care cap payments for hospital and FQHC health centers
- Challenges of 42CFR and sharing substance use diagnostic- and treatment information
- Lack of community resources to address social determinants
- Requirement and need to continue previously MassHealth approved home care for many months.
- Care Needs Screenings are highly labor-intensive