

Community Health Teams Hybrid Model Business Case

Care Transformation Collaborative of Rhode Island

CTC-RI Board of Directors Meeting | October 22, 2021



Outline

- Problem Diagnosis
- Proposed Solution/Statewide Approach
- Costs
- Value Analysis
- Key Considerations and Next Steps
- Remaining Challenges



Brief Recap

Interviews with RI payers and SOC leaders regarding CHT services led to the following conclusions

Community Health Teams are an important resource to serve high risk/high cost clients with complex behavioral and social needs

There are efficiencies in having SOCs managing CHTs for their own clients

Problem



Clients outside of SOCs should also have access to CHTs

Proposed Solution

Stakeholder consensus around a "**Hybrid Model**" to deliver CHT services for adults, children, and families, via BOTH SOC AND regional teams. Regional teams serve individuals outside of SOCs and create partnerships with referral sources outside of primary care (e.g., health plans, hospitals) and connect referrals to primary care once engaged. Regional teams poised to provide whole family care and improve maternal and child health



Hybrid Model Organization

Definition: A complementary network of <u>BOTH</u> regional community-based health teams <u>AND</u> SOC/practice-based teams working to connect individuals and families with complex health and social needs to the local, community based supports needed to achieve optimal health and social well-being.

SOC/Practice-Based Teams

- Common standards and reporting
- Opportunity to refer patients to one another

Regional Teams

Community Health Team Convener Supporting Continuous Improvement



CTC-RI Charge

Develop a <u>business case</u> to show the need and financial impact for <u>Regional Teams</u> to offer CHT services to clients outside of SOCs



Who Would Be Served?

42% of Rhode Islanders Aged 20+ Not in a SOC; 18% Higher Risk

				Estimated		
				% Higher	# Higher	
		Risk ³	Risk			
		% Non-	# Non-	Non-	Non-	
	Members ¹	AE/ACO ²	AE/ACO	AE/ACO	AE/ACO	
Medicaid Managed						
Care	149,998	34%	50,999	16%	7,981	
Medicaid FFS	18,902	34%	6,427	12%	796	
Commercial	257,737	52%	134,018	11%	15,198	
Medicare FFS	88,538	35%	30,988	25%	7,877	
Medicare Advantage	82,528	35%	28,060	49%	13,738	
Totals	597,693	42%	250,492	18%	45,590	



From AE Certification Standards

Program requirements, this graphic illustrates the proposed EOHHS vision for the System of Care that each member in Medicaid managed care will receive. The MCO and AE must partner together to provide Care Programs to support the member that are: Person-centered and holistic Collaborative · Community-based Equitable Population health focused, but with attention to vulnerable populatio For Better Outcomes, Lower Co

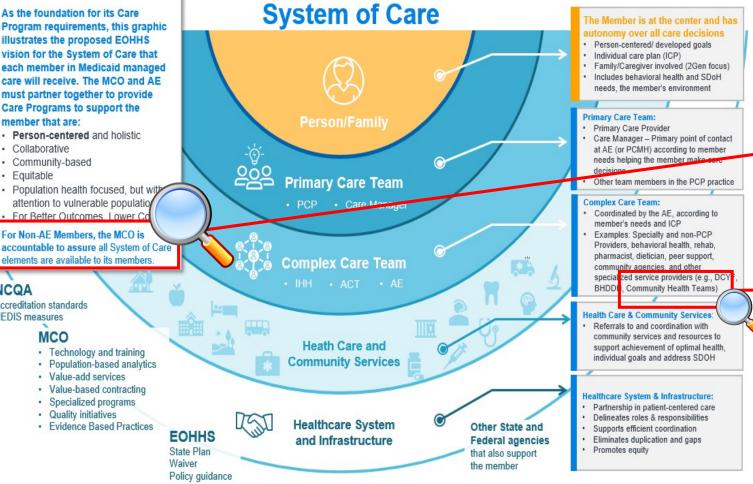
For Non-AE Members, the MCO is accountable to assure all System of Care elements are available to its members.

NCQA

Accreditation standards **HEDIS** measures

MCO

- Technology and training
- · Value-add services
- Value-based contracting
- Specialized programs
- · Quality initiatives



For Non-AE Members, the MCO is accountable to assure all System of Care elements are available to its members

Complex Care Team: Community Health Teams



Regional Teams Serve as a Resource to MCOs, Hospitals, CBOs and Practices Not Affiliated with a SOC

For Non-AE members, the MCO is accountable to assure all Systems of Care elements are available to members

Regional Teams

Network of teams for receiving referrals and engaging with primary care practices not affiliated with a SOC

Create efficiencies and standards by having a network of designated regional teams vs. multiple entities doing this work

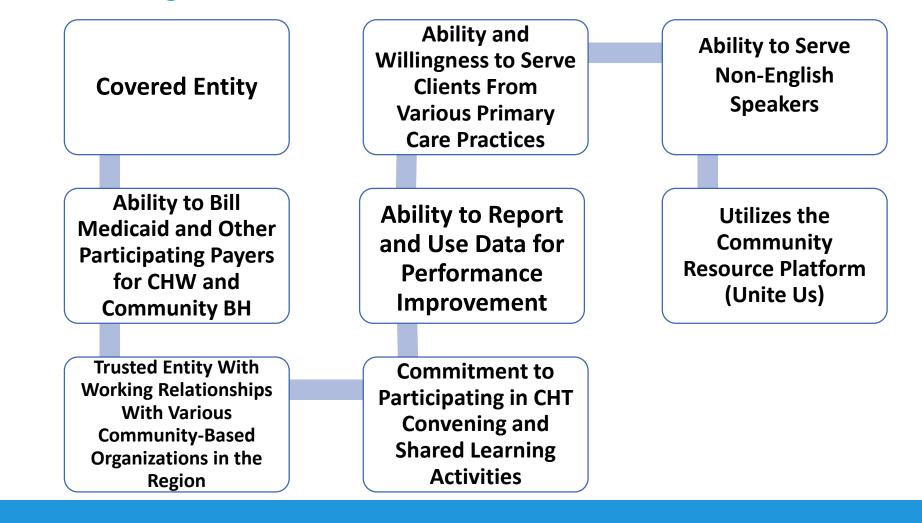
Creates partnerships with referral sources outside of primary care, such as health plans, hospitals, CBOs

Supports essential care coordination efforts across multiple systems



Who Would the Regional Teams be? Build Upon Existing Infrastructure

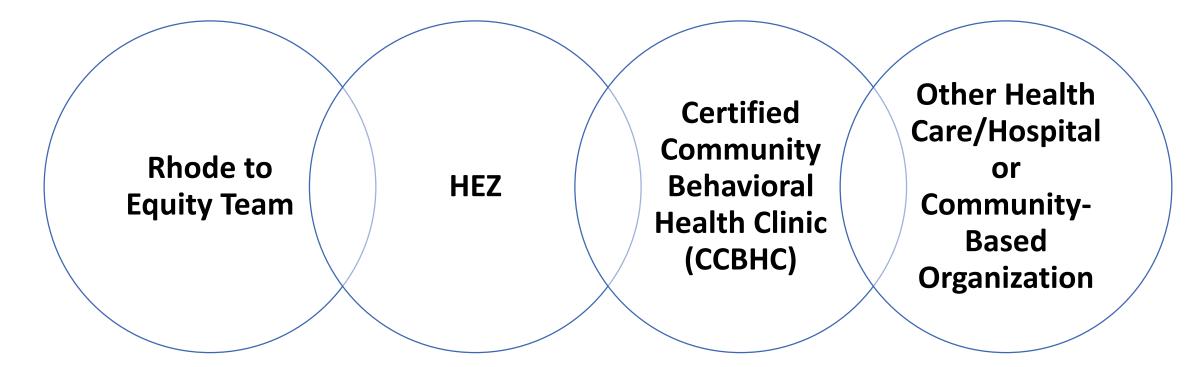
Criteria





Who Would the Regional Teams be? Build upon Existing Infrastructure

Community Organizing Entity Examples:





<u>What Are the Financial Assumptions for Regional Network Sustainability?</u> *Most Services Would Be Covered by Insurance*

Assumes Successful Implementation of Medicaid Payment for CHW Services to Cover Full Costs Assumes Commercial and Medicare Advantage Will Cover Full Costs of CHW Services Assumes Health Plan Payments Would Cover Full Cost of BH Services

Current Issues with Billing for Community-Based BH Services:

- Place of service restrictions

- Inadequate payment for community-based BH services

- Collateral BH services not covered (engagement, care coordination, travel) Assumes Payer Blind Model, Funding Source for Gaps (Uninsured, Medicare FFS)



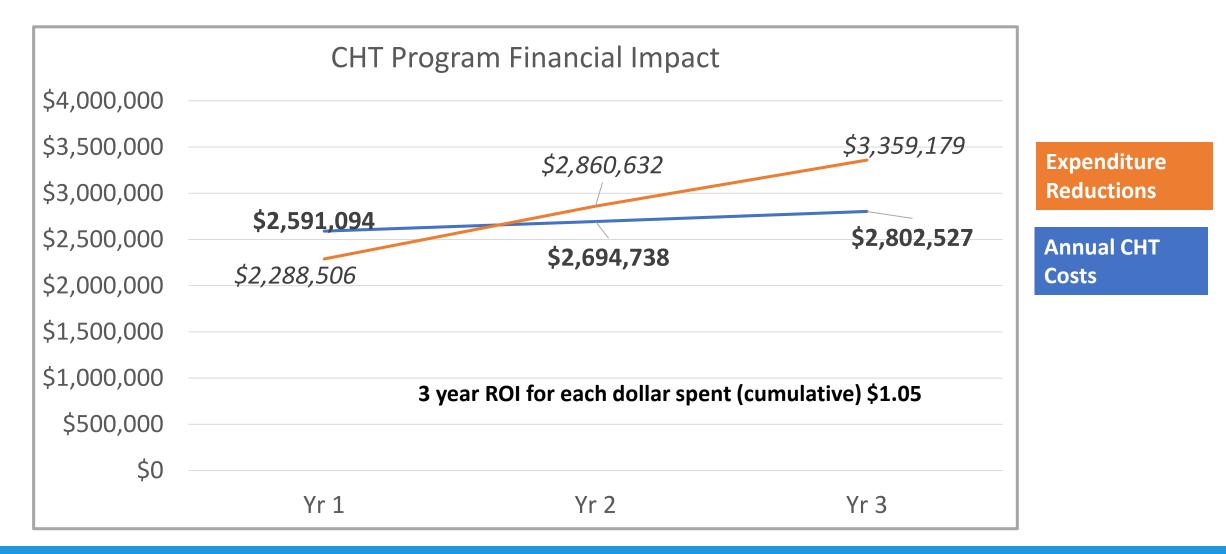
What is the Cost of a Network to Serve High and Rising Risk?

					СНТ				
_		CHT Staffing		Ig	Capacity		Annual CHT Costs		
		Team		BH	Estimate		BH Clinician	Team Lead	
	CHT Size	Lead	CHWs	Clinicians	150/CHW/yr	CHW Costs	Costs	Costs	Total
CHT 1 La	rge	1	6	2	900	\$388,125.00	\$215,625.00	\$93 <i>,</i> 437.50	\$697,187.50
CHT 2 M	edium	0.5	4	2	600	\$258,750.00	\$215,625.00	\$46,718.75	\$521,093.75
CHT 3 M	edium	0.5	4	2	600	\$258,750.00	\$215,625.00	\$46,718.75	\$521,093.75
CHT 4 Sm	nall	0.5	2	1	300	\$129,375.00	\$107,812.50	\$46,718.75	\$283,906.25
CHT 5 Sm	nall	0.5	2	1	300	\$129,375.00	\$107,812.50	\$46,718.75	\$283,906.25
CHT 6 Sm	nall	0.5	2	1	300	\$129,375.00	\$107,812.50	\$46,718.75	\$283,906.25
					<mark>3,000</mark>	\$1,293,750.00	\$970,312.50	\$327,031.25	<mark>\$2,591,093.75</mark>

TOTAL ANNUAL COSTS \$2.6M, Estimate 70% covered by billing Additional \$780K investment needed for full population health access



What is the Cost Impact For Insured Adults?



Performance ADVANCING INTEGRATED HEALTHCARE Improvement to support **Role of the Convener to** complex care bring key stakeholders management **Standards Regional Team Focused** Supporting around together (CHTs, AEs, use of CRP receiving payers, state agencies, referrals, data (Unite Us) and reporting CHT clients) for a CTC-RI statewide multi-payer convening body learning and action supporting the **CHT Network to** collaborative ensure Quality Supporting alignment workforce Improvement around: initiatives development Convener Costs: \$300,000 annually for Project Management/ **Coordination and Consultants** Shared/ (MLBP, Clinical, Data Reporting, collaborative Informing learning, public policy including medical legal 14 support

Other



Key Considerations and Next Steps



Establish interagency coordination for planning and implementation of a Regional CHT Network, including an organized approach; secure multi-sector funding



Establish multi-payer agreement to sustainably cover CHW and community BH services



Outline a process for implementation

- Regional team selection
- Leverage Rhode to Equity/ HEZ/ CCBHC/ other programs as existing infrastructure to build on
- Formalize convener role



Challenges Remaining

3

4

• Clients who are Medicare FFS or uninsured may not be able to be served

• This will lead to issues with continuity of services when people churn through insurance

• Unknown how Commercial/Medicare Advantage plans will want to support these services

- FFS Billing? (CHW services currently not covered; current BH clinician payment rates inadequate to cover community based BH services)
- Case Rate? (significant lead time needed for developing case rate and getting new service approved in vendor contracts)

• BH services covered do not account for the full scope of community oriented services provided by the BH Clinician on the CHT

• Existing contracts support office based, psychotherapy visits by certain credentialed providers. Does not account for care coordination, travel, care team planning

When will teams be able to start billing Medicaid for CHW services?

HSTP Funding support for CHTs ends December 31, 2021

How to address maternal and child health?