Community Care Program Final Presentation

Prepared for **Columbus Consolidated Government**

April 8, 2025

Presented by:

Bob Paskowski, CPA – Principal, Healthcare Consulting

Incomplete Work Product

Agenda

1. Project Overview

- Background and Team
- Project Approach and Workstream Structure

2. Project Summary

- Goals for the Program Redesign Effort
- Community Care Program – Historical View
- Key Learnings from Interviews – Current State View
- Community Care Program – Future State
- Fund Distribution Model Concepts
- Care Delivery Model Concepts – Potential Future State

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- Initial Provider Network Recommendation
- Reimbursement Model Recommendation
- Key Performance Indicators (KPIs)

4. Estimated Timeline and Milestones

5. Q & A

Project Overview

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Project Background

Program Objectives:

1. **Identify** a fair, diverse, and inclusive group of **healthcare organizations** located in Muscogee County **to serve as a network of providers (the Network)** for the provision of medical services
2. **Assess the impact of providing care** to the Target Populations on local hospitals, health providers, and other key stakeholders
3. Recommend a **methodology** for the City to use **for selecting providers to participate in the Network**
4. Development of a contemporary **reimbursement payment model** to appropriately distribute funding to the Network
5. Recommend **tracking mechanisms** and key KPIs to evaluate the **effectiveness of the Program**
6. Assess the need for establishing **actuarial reserves** for the fund to be maintained year to year

Key Terms:

Target Population: Underserved and Inmate populations

Medical Services: Includes (but not limited to the following) limited acute inpatient care, outpatient care, x-ray, laboratory, primary medical care, and mental/behavioral health services.

Funding: A community health care fund established to provide additional funding for the Target Population medical and mental/behavioral health needs.

Program: A fair, inclusive, and equitable plan to pay local providers for medical or mental health services related to serving the Target Populations.

Provider: An organization that provides some type of medical or mental health services to patients.

Third-Party Administrator (TPA): A separate entity that performs administrative services for a health plan, which may include billing, claims processing, record keeping, and regulatory oversight on paying providers for medical services.

Project Background: Population and Services Eligibility

Which ***population*** is eligible for the Program?

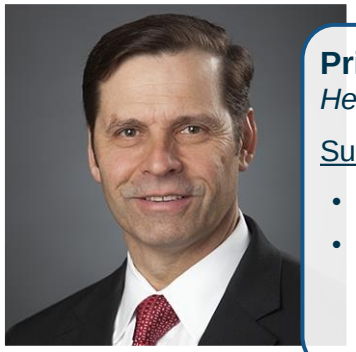
- **Inmate:** incarcerated persons in the Muscogee County Jail and for the 3-month period following discharge.
- **Underserved:** (1) must be a resident of Muscogee County, (2) not covered under a private or governmental insurance plan, *AND* (3) meet the income requirements of the Community Health Plan program defined as having a yearly income below 125% of the poverty income line guidelines for family units.

What ***medical services*** are eligible/covered under the Program for each population, how have the monies historically been spent?

- **Services:** including, but not limited to, limited acute inpatient care, outpatient care, x-ray, laboratory, primary medical care, and mental/ behavioral health services
- **Use of funds:** since the inmate population is more limited and is currently served by inhouse providers, only 16% of the funds have historically been expended on this population, with 84% of the funds used for the underserved.

Project Team

Bob Paskowski, CPA

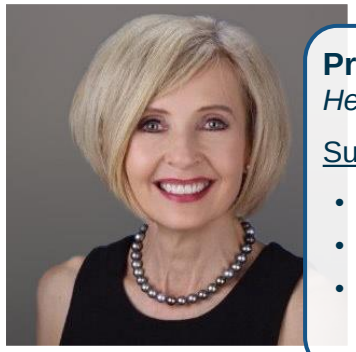


Principal
Healthcare Consulting

Subject Matter Expert

- Population Health
- Network Operations

Jane Jerzak, CPA, RN



Principal
Healthcare Consulting

Subject Matter Expert

- Population Health
- Value-Based Care
- RN

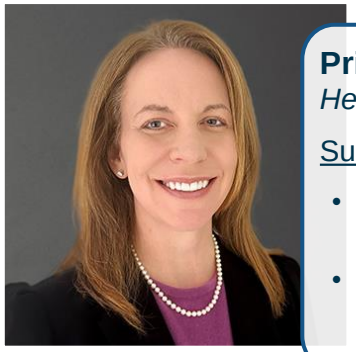
Brian Fuller, MBA

Principal
Healthcare Consulting

Subject Matter Expert

- Enterprise Growth
- Healthcare Network Development

Lee Ann Odom, LPT, LNHA



Principal
Healthcare Consulting

Subject Matter Expert

- Service Line Development
- Clinical Operations

Jason Hardin, CPA

Director
Business Intelligence & Analytics

Subject Matter Expert

- Business Intelligence
- Financial Modeling and Analysis

Colleen Merrill

Senior Consultant
Healthcare Consulting

Project Management

Project Approach and Workstream Structure

Columbus Consolidated Government
City Council

Office of the City Manager
Pam Hodge, Deputy City Manager of Planning

Advisory Committee
Joanne Cogle, Glenn Davis, Toyia Tucker

PYA Project Management Office (PMO)
Bob Paskowski, Jane Jerzak, Colleen Merrill

Provider Network Development

PYA: Brian Fuller, Lee Ann Odom

- Objective 1: Identify the Network
- Objective 2: Assess impact of providing care on providers and services
- Objective 3: Recommend methodology for provider selection

Contracting & Reimbursement Models

PYA: Bob Paskowski, Jane Jerzak

- Objective 4: Develop contemporary reimbursement payment model for funding the Network

Measuring Program Effectiveness

PYA: Lee Ann Odom, Jason Hardin

- Objective 5: Recommend tracking mechanisms and KPIs for Program effectiveness

Minimum Actuarial Reserves

PYA: Bob Paskowski

- Objective 6: Assess need for establishing Actuarial reserves for fund maintenance

Project Summary

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Goals for the Program Redesign Effort

Expand the reach

Provide more care to a growing number of underserved in the community with a primary care/preventative care focus to reduce spending on high-cost ER and inpatient care. Include in the scope, post incarcerated persons assimilating back into the community for three months.

Expand mental health support

Ensure the program includes mental health services and support (more than acute episodic care) as well as substance abuse treatment to support back to work initiatives.

Expand the funding to more community providers

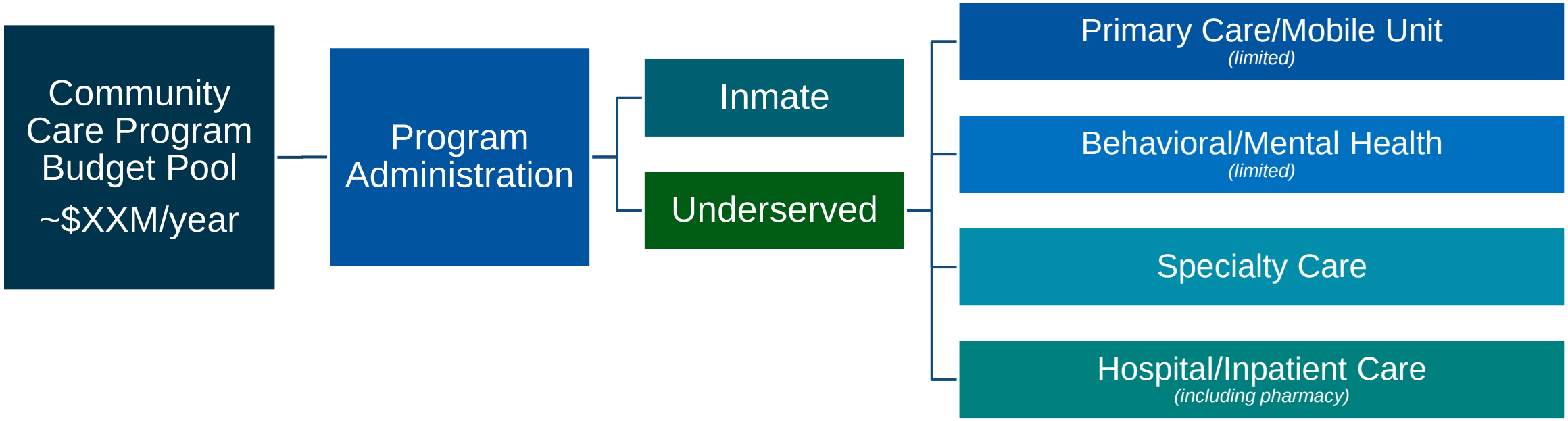
Expand the funding to more community providers caring for the underserved population (including small faith-based organizations and organizations providing care management services over time).

Integrate and coordinate care with local publicly funded resources

211 system, EMS system etc.

Community Care Program – Historical View

- Spending focus has historically been on **specialty care** and **hospital inpatient/outpatient care** for approximately 400 – 550 families per year administered and operated by a single provider system.



Key Learnings from Interviews – Current State View

Growing number of community members are unhoused.

- Increasing the need for healthcare services for the underserved population
- This population is often tied to a substance abuse issue (and need for mental health services)

Providers have served this population without City-based reimbursement.

- Multiple providers welcomed the opportunity to serve a greater number of patients – with funding.
- One provider continues to serve this population (emergent services at a minimum) without reimbursement.

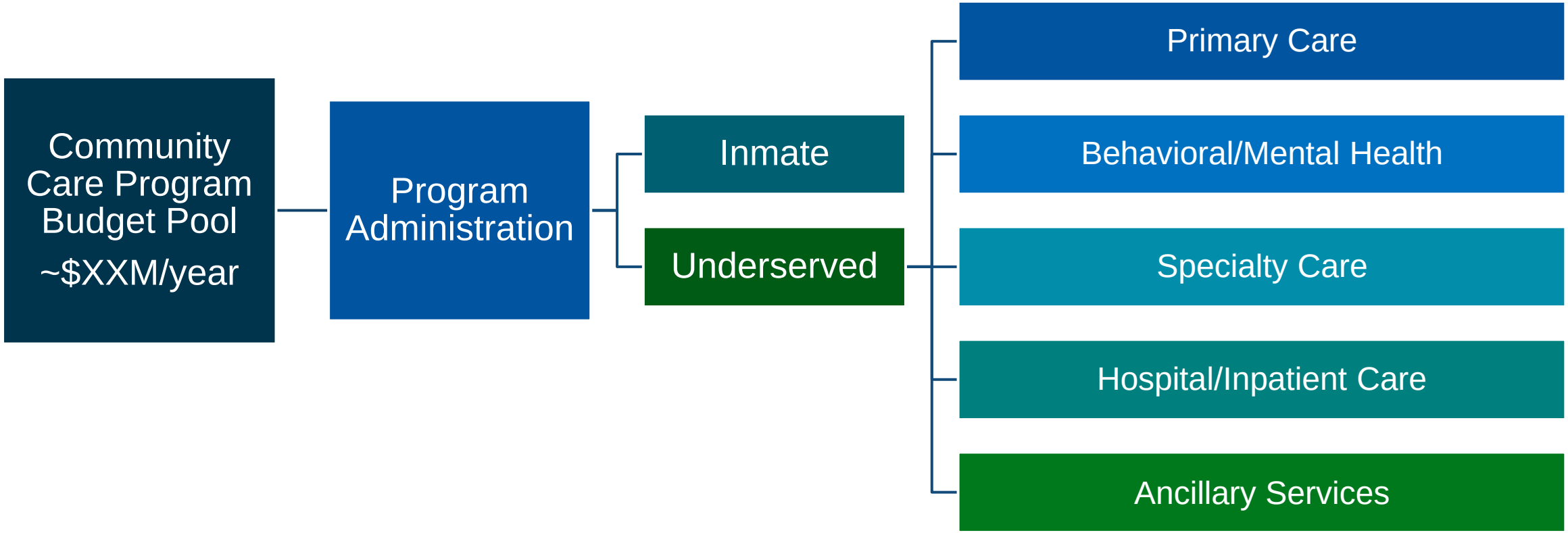
Social Determinants of Health (SDoH) impact the high use of emergency health services.

- Transportation issues, lack of medicines, etc.
- Lack of coordination among care providers for this population today – need care management services for this population
- Need for integration with the 211 System and the City's EMS program – for integrated care

Some small faith-based organizations provide essential services to this population today, often without a funding source.

- Need funding for service expansion
- Need funding for emergency medicines etc.
- Need a formalized approach to refer patients for needed specialty care (funding)

Community Care Program Overview – Future State



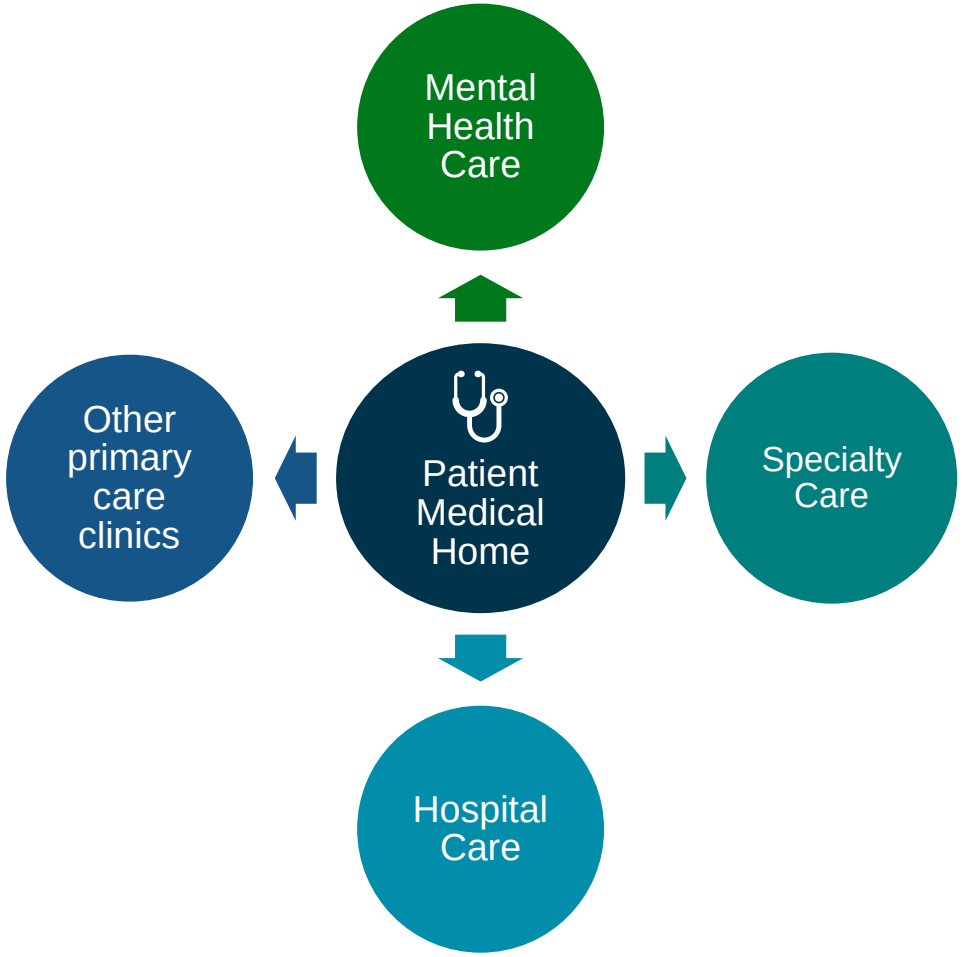
Fund Distribution Model Concepts

- **Program Administration**
  - Community Care Program Administrator
  - TPA services – manage eligibility and simple “billing” process for providers/reporting requirements for cost and quality
  - Possible care management coordination
  - Reserve management - consider a withhold of XX% of funding to allow for variable spending

- **Inmate**
  - Fee for service model at Medicaid-type rates like current process for services
  - Post release, formerly incarcerated persons would move to the underserved pool for 90 days

- **Underserved**
  - Establish various pools: Primary Care, Mental Health, Specialty Care, Hospital Care, and Ancillary Care
  - Consider Medicaid-type rates for services and possibly per member per month (PMPM) for primary care coordination in the future
  - Consider a withhold of *XX%* of funding to allow for variable spending

Care Delivery Model Concepts – Potential Future State



- **Medical Home Concept:**
  - Redesign the care model to support well coordinated primary and preventative care and behavioral care needs under a **patient medical home model** for more community residents qualifying for the program.
    - Several providers are of a size to support this care model along with another primary care/mobile unit.
  - The **primary care team** assigned to patients (family units) will be responsible for **directing care** to other providers including behavioral health care, specialty care and hospital care as needed.
  - Reimbursement rates to align with **Medicaid rates** in the state. Consider PMPM payment for patient medical home care coordination services in the future.

Program administration oversight functions

Recommendations

Administrative Distribution Model Recommendation

Services Covered	Method	Method Amount
Program Administration		
Community Care Program Administrator	Cost-Based	$XXX
Care Management	Cost-Based	
Patient Eligibility Determination	PMPM	
TPA Services – Claim Payments	PMPM	
Reserve Management	To Be Determined by the City	
Direct Funding		
Columbus Fire/EMS (Columbus Correct Care)	Cost-Based	$XXX

Initial Provider Network Recommendation

Initial Provider Network [2,3]	Include in Network	Referred to PYA [1]	PYA Interviewed the Provider	Provider would be considered and committed to the Medical Home Concept
Primary Care – Medical Home				
MercyMed of Columbus	Yes	A	X	X
Piedmont Indigent Care Program Clinic	Yes	A	X	X
St. Francis-Emory Healthcare	Yes	A	X	X
Valley Healthcare - FQHC	Yes	A	X	X
Mental Health				
New Horizons Behavioral Healthcare	Yes	A	X	X
The Bradley Center of St. Francis-Emory Healthcare	Yes	A	X	
Specialists				
Community Specialty Physicians and Clinics	Yes	B		
Piedmont Columbus Regional - Specialists	Yes	A	X	
St. Francis-Emory Healthcare - Specialists	Yes	A	X	
Hospitals				
Piedmont Columbus Regional	Yes	A	X	
St. Francis-Emory Healthcare	Yes	A	X	
Ancillary Services				
Diagnostic Radiology (TBD)	Yes	B		
Labs (TBD)	Yes	B		

1. "A" denotes providers PYA was referred to by either City Manager Isaiah Hugley or Deputy City Manager of Finance, Planning, and Development Pam Hodge. "B" denotes providers whom PYA was referred to by another provider.
2. “Covered Medical Services” include, but are not limited to, limited acute inpatient care, outpatient care, x-ray, laboratory, primary medical care, and mental/behavioral health services for the uninsured person and medically underserved and incarcerated persons in Muscogee County Jail (the Covered Medical Services).
3. Funding is to be determined by Columbus Consolidated Government based on available funds (Funding).

Reimbursement Model Recommendation

Initial Provider Network [1,2]	Reimbursement Method
Primary Care – Medical Home	
MercyMed of Columbus	FFS (Medicaid Rates)
Piedmont Indigent Care Program Clinic	FFS (Medicaid Rates)
St. Francis-Emory Healthcare	FFS (Medicaid Rates)
Valley Healthcare – FQHC[3]	FFS (Medicaid Rates)
Mental Health	
New Horizons Behavioral Healthcare	FFS (Medicaid Rates)
The Bradley Center of St. Francis-Emory Healthcare	FFS (Medicaid Rates)
Specialists	
Community Specialty Physicians and Clinics	FFS (Medicaid Rates)
Piedmont Columbus Regional - Specialists	FFS (Medicaid Rates)
St. Francis-Emory Healthcare - Specialists	FFS (Medicaid Rates)
Hospitals	
Piedmont Columbus Regional	FFS (Medicaid Rates)
St. Francis-Emory Healthcare	FFS (Medicaid Rates)
Ancillary Services	
Diagnostic Radiology (TBD)	FFS (Medicaid Rates)
Labs (TBD)	FFS (Medicaid Rates)

1. Funding is to be determined by Columbus Consolidated Government based on available funds (Funding).
2. Covered Medical Services include, but are not limited to, limited acute inpatient care, outpatient care, x-ray, laboratory, primary medical care, and mental/behavioral health services for the uninsured person and medically underserved and incarcerated persons in Muscogee County Jail (the Covered Medical Services).
3. Since Valley Healthcare is an FQHC, its Medicaid rate includes care management services in an inclusive per visit rate based on cost. The Community Care Program rate paid to Valley Healthcare would be at the standard published fee for service Medicaid rate as will be paid to other primary care providers initially.

Sample Key Performance Indicators (KPIs)

Actual KPIs to be established with the input of the clinical task force guided by specific goals related to program performance with minimal administrative burden on providers

	Primary Care	Mental Health	Specialty Care	Hospital Care
Patient Access	1) Number of patients screened for the Program and accepted into the Program for Medical Home management. 2) Appointment availability tracking: wait time for both the next appointment and third available appointment	1) Number of referred patients served	1) Number of referred patients served 2) Appointment availability compared to non-community care eligible participants	
High-Cost Utilization	1) Emergency room visit use for patients on the Program (i.e., the number of visits and %) 2) Inpatient use for patients on the Program (i.e., number of admissions and %)	1) Emergency room visit use for patients on the Program (i.e., the number of visits and %) 2) Inpatient use for patients on the Program (i.e., the number of admissions and %)	1) Authorization process from Medical Home followed for patients on the Program treated (i.e., the number and %)	1) Reporting of eligible patients in the emergency department referred to the Program Administrator for Medical Home assignment and reporting emergency room visits for patients in the Program to the Medical Home (i.e., the number and %) 2) Number and percentage of readmissions on 30 days for patients on the Program.
Care Coordination	1) Patient contact by Medical Home within three days after discharge.	1) Information on patient encounters submitted back to the Medical Home within five days of the encounter (both the number and percentage).	1) Information on patient encounters submitted back to the Medical Home within five days of the encounter (both the number and percentage).	1) Notice of discharge submitted to the Medical Home on the day of the discharge (both the number and %)
Clinical	1) Starting with blood pressure tracking and moving to more clinical measures in the future	*1) To be decided in the future*	*1) To be decided in the future*	1) Typical hospital operating metrics including readmissions specific to the community care population.

Key Milestones Prior to July 1, 2025

1

Clinical Task Force

Patient Assignments, Care Management, Initial KPIs etc.

2

TPA Request for Proposal and Selection

3

Hire a Program Administrator

4

Provider Contracting

Project Estimated Timeline and Milestones

Incomplete Work Product

Project Status Update

Workstream	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
Provider Network Development	Interviews with key stakeholders ✓ **Completed 11/25/24**								
	Draft of objective criteria for selection of network providers ✓ **Completed 3/5/25**								
	Draft list of recommended network providers ✓ **Completed 3/5/25**								
Contracting & Reimbursement Models	Draft of reimbursement methodology ✓ **Completed 1/31/2025**								
	Draft of contracting guidelines with key providers ✓ **Completed 2/12/25**								
	Draft of recommended reimbursement methods ✓ **Completed 3/5/25**								
Measuring Program Effectiveness	Share draft of KPIs with the City ✓ **Completed 3/17/25**								
	Share recommended list of initial KPIs ✓ **Completed 3/31/25**								
Minimum Actuarial Reserves	Share reserve options with the City; City will determine ✓ **Completed 3/5/25**								
Program Implementation							The City will be leading the Implementation Phase of putting the Program in place. **April – June 2025**		

Q & A

Thank you!

Should you have any questions, please do not hesitate to contact me.

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