Community Care Program Update

Prepared for **Columbus Consolidated Government**

February 11, 2025

Presented by:

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Introductions

Brian Fuller, MBA

Healthcare Consulting Principal
Strategic & Transaction Solutions

Jane Jerzak, RN, CPA

Healthcare Consulting Principal
Revenue and Compliance Advisory

Bob Paskowski, CPA

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Agenda

1. Project Overview

- Background and Team
- Project Approach and Workstream Structure

2. Project Update

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

3. Estimated Timeline and Milestones

4. Q & A

Project Overview

Project Background

Program Objectives:

1. **Identify** a fair, diverse, and inclusive group of **healthcare organizations** located in or near the City of Columbus (the City) **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 performance indicators (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: Indigent 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?

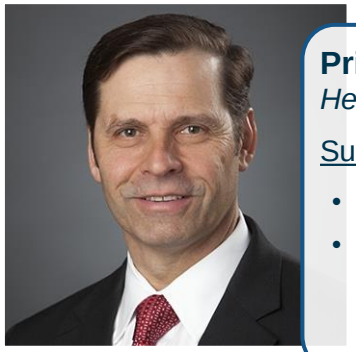
1. **Inmate:** incarcerated persons in the Muscogee County Jail and for the 3-month period following discharge.
2. **Indigent:** (1) must be a resident of Muscogee County, (2) not covered under a private or governmental insurance plan, AND (3) meet the income requirements of the Community Health Plan 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?

1. **Services**: including, but not limited to, limited acute inpatient care, outpatient care, x-ray, laboratory, primary medical care, and mental/ behavioral health services.
2. **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 indigent.

Project Team

Bob Paskowski, CPA

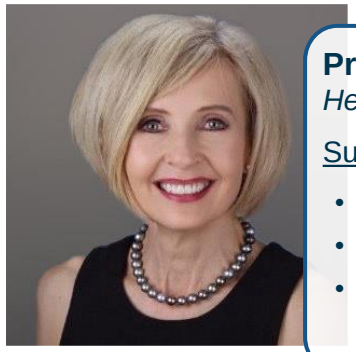


Principal
Healthcare Consulting

Subject Matter Expert

- Population Health
- Network Operations

Jane Jerzak, CPA, RN



Principal
Healthcare Consulting

Subject Matter Expert

- Population Health
- Value-Based Care
- RN

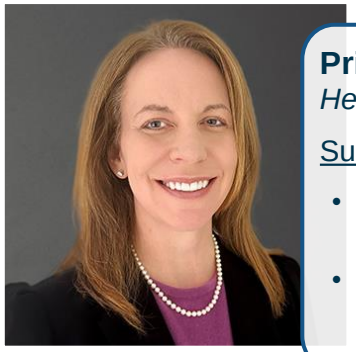
Brian Fuller, MBA

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

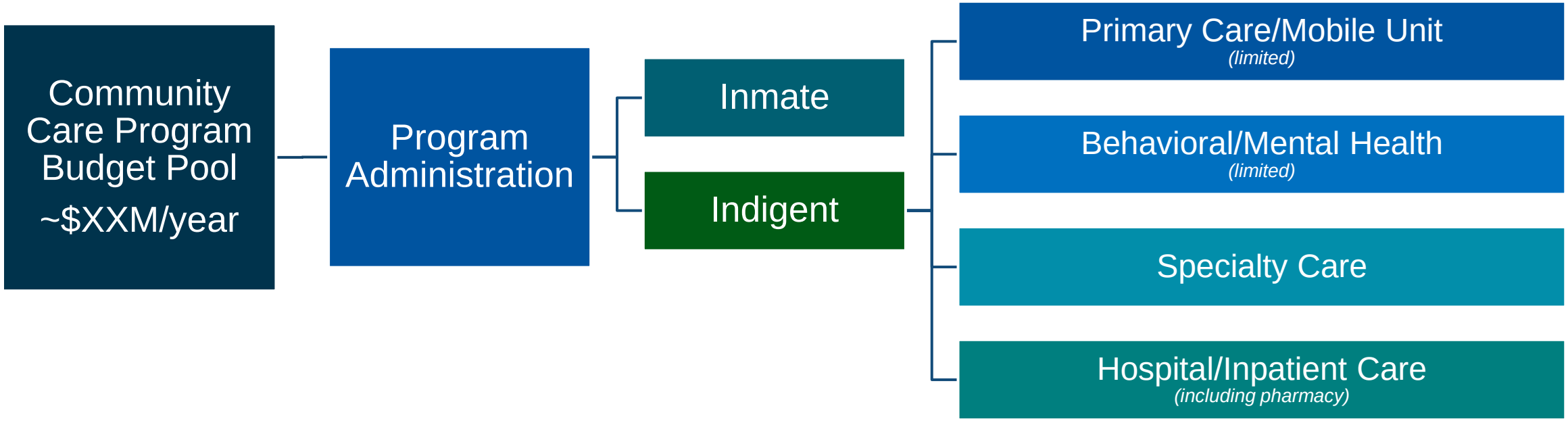
PYA: Bob Paskowski

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

Project Update

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.



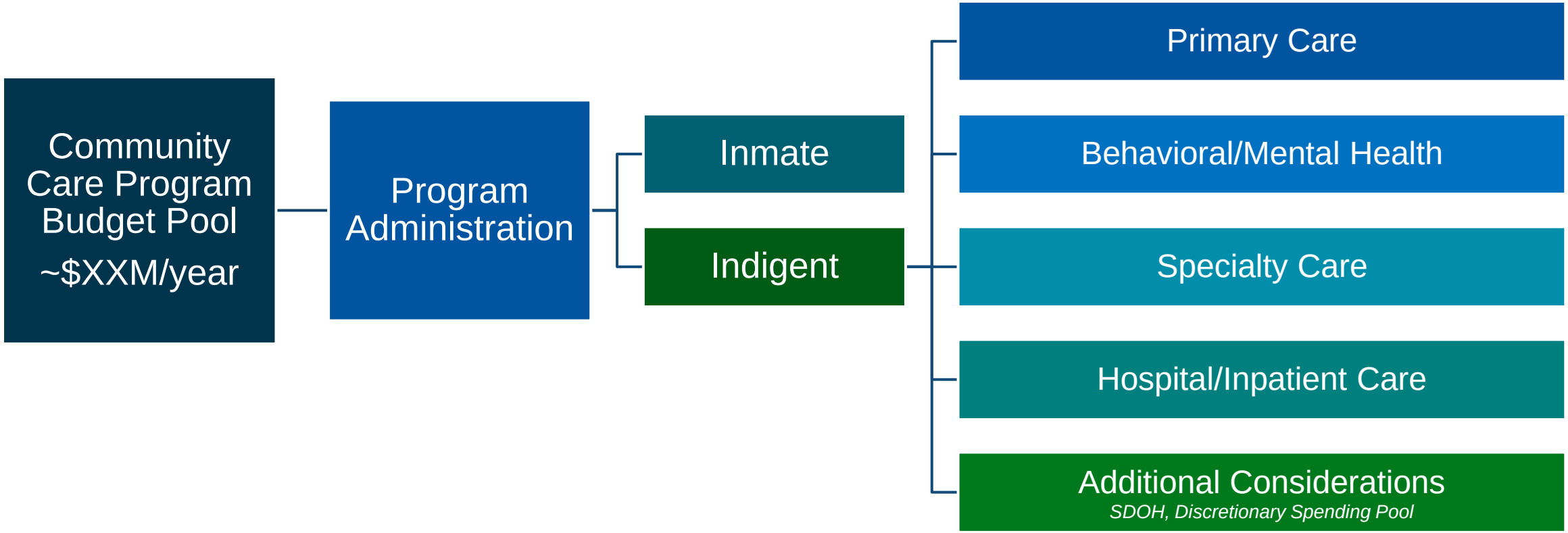
Key Learnings from Interviews – Current State View

1. **Growing number of community members are unhoused.**
   - Increasing the need for healthcare services for the indigent population
   - This population often tied to a substance abuse issue (and need for mental health services)
2. **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
3. **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)
4. **Providers have served this population without City-based reimbursement.**
   - Two 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.

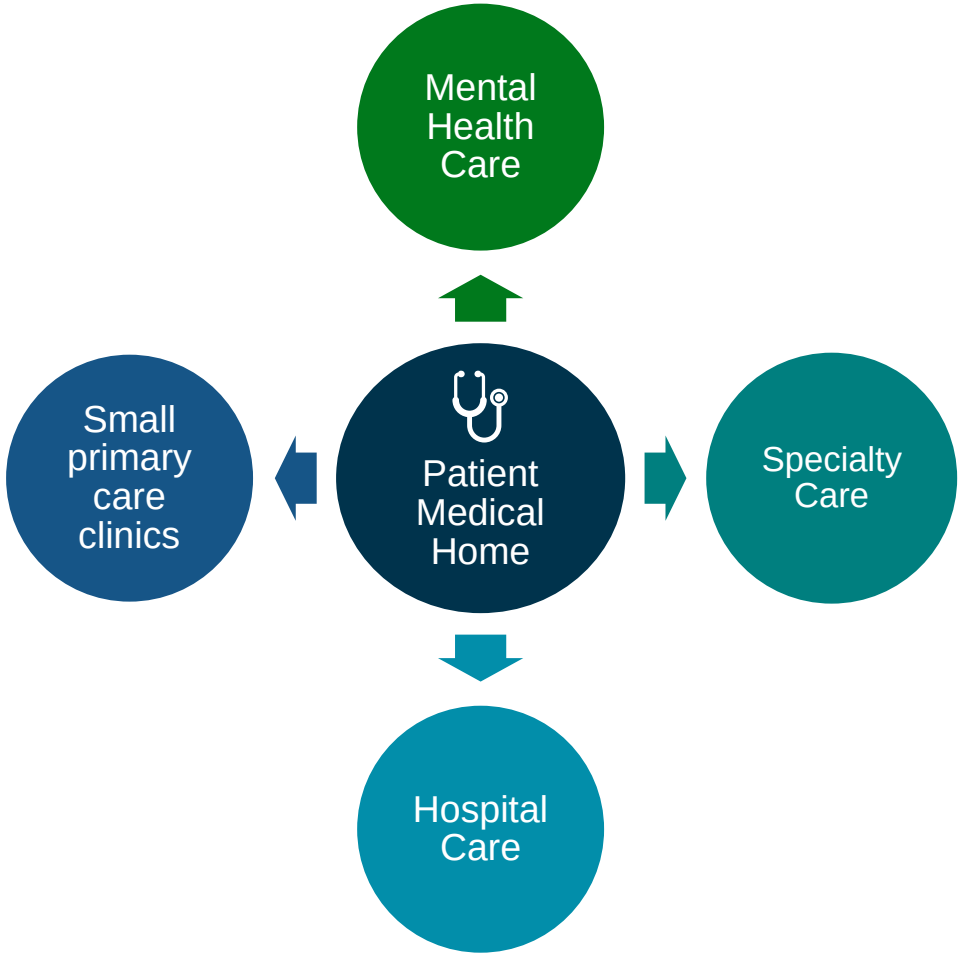
Goals for the Program Redesign Effort

- **Expand the reach** – provide more care to a growing number of indigent 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 indigent population (including small faith-based organizations and organizations providing care management services).
- **Integrate and coordinate care** with local publicly funded resources
  - 211 system, EMS system etc.

Community Care Program Overview – Potential Future State



Care Delivery Model – Potential Future State



Program administration oversight functions

- **Medical Home Concept:**
  - Redesign the care model to support well coordinated primary and preventative care and behavioral care needs for more community residents qualifying for the program.
    - Two 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 per member per month payment for patient medical home care coordination services.
  - Recognizing the value of smaller faith-based and nonprofit clinics in the city, grant funding could support services provided to the qualifying populations.

Fund Distribution Model Concepts

- **Program Administration**
  - Community Care Program Coordinator
  - TPA services – manage simple “billing” process for providers/reporting requirements for cost and quality
  - Care management coordination
  - Possible one-time investment for primary care expansion
  - Consider a withhold of 5% of funding to allow for discretionary spending

- **Inmate**
  - Fee for service model at Medicaid-type rates like current process for services
  - Post discharge, formerly incarcerated persons would move to the indigent pool for three months post incarceration

- **Indigent**
  - Establish various pools: Primary Care, Mental Health, Specialty Care, Hospital Care
  - Consider Medicaid-type rates for services and possibly per member per month for primary care coordination; consider other reimbursement methods for certain providers
  - Consider a withhold of *XX%* of funding to allow for discretionary spending

Project Estimated Timeline and Milestones

Workstream	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025
Provider Network Development	Interviews with key stakeholders **completed 11/25/24**	Draft of objective criteria for selection of network providers ***completed December 2024***	Draft list of recommended network providers **complete by 12/31/24**							
Contracting & Reimbursement Models	Draft of reimbursement methodology **currently in process**	Draft of contracting guidelines with key providers **complete by 3/31/25**								
Measuring Program Effectiveness	Share draft of key performance indicators with the City **complete by 3/31/25** Share the program's key performance indicators tracking tool with the City **complete by 3/31/25**									
Minimum Actuarial Reserves	Determine requirements to establish a claims reserve fund **complete by 3/31/25** Draft policy to outline the management of the claims reserve fund **complete by 3/31/25**									
Program Implementation									The City will be leading the Implementation Phase of putting the Program in place. **May – July 2025**	

Q & A

Thank you!

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

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