District of Columbia State Innovation Model
Care Delivery Work Group: Meeting Summary

April 25, 2016
3:00 p.m. – 4:30 p.m.

Participants: Joe Weissfeld, Lisa Fitzpatrick, Kathy Haines, Adam Rocap, Kierstin Quinsland, Sara Cartmill, Christy Respress, DaShawn Groves, Cyd Campbell, Dena Hasan, Constance Yancy, Robert Howard, Carleta Belton, Lisa Truitt, Brede Eschliman, Ellie Beck, Leslie Lyles Smith, Victoria Roberts, Adriana S, Isham H, Victor Freeman, Cavella Bishop, Natasha Miller, Alice Weiss, Hazelyn Marti Henry, Rachel Pierre, Mary Bridge Klinkenbergh, Gwen Young, Felicia Sears, Chris Botts, Melissa McCarthy, Tommy Zarembka, Barbara Ormond, Carrie Thomas, Kia H., Jonathan Perry, Michael Crawford, Mark Weissman, Johanna Barraza-Cannon, Daniel Weinstein

TOPIC	DISCUSSION
Overview of the Most Current Proposed HH2 Policy Framework	**See 4/25 for additional details** **Proposed Eligibility for the District's Health Home 2 (HH2) Program includes:** • *Two or more chronic conditions; or, one chronic condition and a history of chronic homelessness (based on being matched to Permanent Supportive Housing)*: A beneficiary must have at least one physical chronic condition. Specific chronic conditions discussed include: asthma, COPD, diabetes, heart disease, BMI over 35, mental health condition, substance abuse disorder, cerebrovascular disease; chronic renal failure (on dialysis); hepatitis; HIV; hyperlipidemia; hypertension; malignancies; paralysis; peripheral atherosclerosis; and sickle cell anemia. **Tiers within the HH2 Program will be defined as follows:** • *Group 1:* Two or more chronic conditions, with low likelihood of future hospital utilization based on a risk assessment score, or past utilization above a certain threshold.

TOPIC	DISCUSSION
	- *Group 2*: Two or more chronic conditions, with high likelihood of future hospital utilization based on a risk assessment score, or past utilization above a certain threshold. - *Group 3:* At least one chronic condition and receiving services through DC's Permanent Supporting Housing (PSH) program due to a disabling condition and a history of continuous homelessness for 1 year or more, or at least 4 episodes of homelessness within the last 3 years. Implementation of the Health Home benefit for this tier is being delayed slightly to align with Department of Human Services' timelines for PSH provider procurement. With the delay, there will be a transition process for some individuals eligible for low and medium Acuity tiers, but would switch to high Acuity based on their use of PSH. **Proposed Payment Methodology** - The initial approach is a per member, per month (PMPM) rate paid to Health Homes. A pay-for-performance component — based on readmissions, inappropriate emergency department utilization, and preventable inpatient admissions — will likely be incorporated at a later date. - Group 1 = $46 PMPM; Group 2 = $137 PMPM; Group 3 = TBD **Patient Attribution** Patients will be assigned to a HH2 provider through an opt-out with utilization trigger process, and payment will not begin until a HH2 service is delivered. Key components of this opt-out with utilization trigger include: - Attribution: The process will be based on a prior provider/patient relationship (2 year look-back) and geography. Transitions between acuity tiers for enrollees will be guided by a process, as individuals may become eligible for a high acuity tiers while enrolled in a lower acuity tier of HH2. - Payment: A PMPM will be triggered by the delivery of one of the six HH2 services. There will be an inactivity trigger if a HH2 service hasn't been delivered over a certain period of time, including 1 month for medium or high tier beneficiaries, and 3 months for low tier beneficiaries.

TOPIC	DISCUSSION
	• <u>Opt-Out Process</u>**:** Patients will be able to opt-out of the program. If a patient does opt out, it will automatically trigger a call from DHCF staff to explain the program and/or potentially steer them to a new provider.

Open Forum for Stakeholders to Share Thoughts, Suggestions, & Feedback	• A few work group members suggested the following to improve HH2 functionality:
	
	    • Creating an attribution transition plan and process for enrollees who might move between acuity tiers
	
	    • Thinking about ways for PSH providers and other social service providers to become health home providers.
	
	    • The possibility of having two aligned, but separate care plans (one from the HH2 and one from the MCO) for individuals instead of one joint care plan to be used by both.
	
	• Other suggestions included:
	
	    • Providing a forum specific to PSH providers to help gain feedback and adequately structure the high acuity tier which aligns with the District's priorities and varying timeline considerations.

Next Steps	• A meeting for PSH providers to garner more input from them about HH2.