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

February 3, 2016
3:00 p.m. – 4:30 p.m.

Participants: Joe Weissfeld, Constance Yancy, DaShawn Groves, De Coleman, Dena Hasan, Kandis Driscoll, Chris Botts, Melissa McCarthy, Barbara Ormond, Cyd Campbell, Theresa Silla, Victor Freedman, Gwen Yong, Kimberly Harris, Carmen Hernandez, Ellie Beck, Laura Worby, Janice Llanos, Peter Tuths, Stephanie Hafiz, Jasmine Shih, Alice Weiss, Claudia Schlosberg, Emily Young, Johanna Barraza-Cannon, Daniel Weinstein, Lauren Ratner, Cavella Bishop, Emily Eelman, Christopher King, Corey Mertz, Andem Effiong, Jessica Li, Diane Fields

TOPIC	DISCUSSION

Discussion of Proposed HH2 Provider Enrollment Process	• **Joe Weissfeld presented the Health Home II (HH2) provider standards for enrollment being considered by DHCF. Participants had the following comments and recommendations:**
	
	➢ A minimum capacity standard would be beneficial to ensure that HH2 providers have a sufficient number of staff (e.g. nurse care managers, case managers) to effectively deliver health home services.
	
	    o A lesson learned from Health Homes I, is that on average states require a capacity ratio of around 1:56; Health Homes I requires one case manager to every 60 patients.
	
	    o DHCF proposes to make specific staffing requirements less prescriptive to allow HH2 providers the flexibility necessary to tailor care appropriately.
	
	➢ It is important that the case management models used by HH2 providers meet NCQA standards, especially if these activities are going to be delegated to other providers by the MCOs.
	
	➢ Certified EHR systems should be a required standard for all HH2 providers. In addition,

TOPIC	DISCUSSION
	providers should have access to an organized data tracking system that records a beneficiary's pattern of care. ➢ Appropriate after-hour access to care should be considered as a required standard for HH2 providers, particularly because the expanded access could assist providers in meeting pay-for-performance standards (specifically as it relates to the low-acuity nonemergency visits and potentially avoidable inpatient hospital admission measures). ➢ As a standard, the care coordination plan should require HH2 providers to detail their protocols and processes for connecting beneficiaries to the services necessary for improved health outcomes, including physical, behavioral, and social services.

Discussion of Proposed Opt-Out with Utilization Trigger Process	• **Joe Weissfeld outlined the proposed opt-out with utilization trigger process that is being considered by DHCF for the HH2 program. Participants had the following reactions:**
	
	➢ *Attribution*: The "look-back" process is critical during auto-assignment because it helps protect continuity of care by connecting beneficiaries to previous providers.
	
	    o DHCF will develop appropriate protocols for assigning beneficiaries who have no relationship with a HH2 provider and those that have relationships with multiple HH2 providers.
	
	    o When attributing new beneficiaries to HH2 providers, DHCF should consider running claims data on a quarterly basis.
	
	    o Participants suggested that it might also be useful to assign beneficiaries to HH2 providers that have expertise in managing certain chronic conditions.
	
	➢ *Inactivity*: It is important to clearly define "inactivity" because a beneficiary may become "inactive" due to a lack of personal engagement or a lack of provider engagement.
	
	    o DHCF must determine how a beneficiary can opt back into the HH2 program after being disenrolled due to inactivity. Participants agreed that it should be relatively easy for a

TOPIC	DISCUSSION
	beneficiary to re-enroll into HH2 after being disengaged, and conversely, not relatively easy for a provider to receive payment for services that are not actively delivered. o Participants recommended that after a set period of "inactivity," a beneficiary should be required to have a new assessment when re-enrolling or re-activating their HH2 status. ➤ *Status Change*: DHCF will define a mechanism to determine when (and how frequently) it is appropriate for a beneficiary to move between tiers (e.g. high→low, low→ high). ➤ *Change Providers*: Beneficiaries need to have the ability to change providers or opt-out of the program outside of their HH2 provider. Participants recommended offering a hotline for beneficiaries to call for request about opting-out or provider changes in order for DHCF to help navigate beneficiaries through the process and potentially redirect them to a new HH2 provider.
Next Steps	• The next Care Delivery Work Group meeting is on **Wednesday, February 17th** from 3:00p.m. to 4:30p.m.