



Better Health Together

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

March 2, 2016
3:00 p.m. – 4:30 p.m.

Participants: Joe Weissfeld, Lisa Fitzpatrick, Lauren Ratner, Constance Yancy, DaShawn Groves, Dena Hasan, Kandis Driscoll, Chris Botts, Melissa McCarthy, Tommy Zarembka, Felicia Sears, Cathy Anderton, Emily Eelman, Gwen Young, Carmen Hernandez, Ana Veria, Liza Fues, Wanda Foster, Barbara Ormond, Khalil Hasam, Leslie Lyles Smith, Tiffany Lee, De Coleman, Adil Alaoui, Claudia Schlosberg, Johanna Barraza-Cannon, Daniel Weinstein, Corey Mertz, Andem Effiong

TOPIC	DISCUSSION
<p>Overview of Most Current Proposed HH2 Policy Framework</p>	<p>DC's Health Home 2 (HH2) Eligibility</p> <ul style="list-style-type: none"> • <u>Two or more chronic conditions or one chronic physical health condition and at-risk of developing another (based on being matched to Permanent Supportive Housing):</u> 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. <p>HH2 Tiers</p> <ul style="list-style-type: none"> • <u>Low Acuity:</u> 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. • <u>Medium Acuity:</u> 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. • <u>High Acuity:</u> At least one chronic condition and receiving services through DC's Permanent

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	<p data-bbox="646 224 1854 289">Supporting Housing 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.</p> <p data-bbox="552 329 911 362">Estimated Population Size</p> <ul data-bbox="600 407 1791 548" style="list-style-type: none"> • Based on initial data analysis, it is anticipated that ~25,000 beneficiaries will receive this benefit, with the following estimates in each tier: Low Acuity: ~17,000; Medium Acuity: ~5,000; and High Acuity: ~3,000. <ul style="list-style-type: none"> ○ ~8,000 of the 25,000 beneficiaries are served by an MCO. <p data-bbox="552 589 852 621">Health Home Services</p> <ul data-bbox="600 667 1829 732" style="list-style-type: none"> • Comprehensive care mgmt., care coordination, health promotion, comprehensive transitional care/follow-up, patient & family support, referral to community & social support services. <p data-bbox="552 773 858 805">Payment Methodology</p> <ul data-bbox="600 850 1881 992" style="list-style-type: none"> • The initial approach is a fee-for-service per member, per month (PMPM) rate paid to Health Homes and the payment rates are still under development. A pay-for-performance component — based on readmissions, inappropriate emergency department utilization, and preventable inpatient admissions — will likely be incorporated. <p data-bbox="552 1032 814 1065">Patient Attribution</p> <p data-bbox="552 1105 1869 1170">Patients will be assigned to a HH2 provider through an opt-out process; however, payment will not begin until a HH2 service is delivered. Key components of this opt-out with utilization trigger include:</p> <ul data-bbox="600 1219 1881 1438" style="list-style-type: none"> • <u>Attribution</u>: The process will be based on a prior provider/patient relationship (2 year look-back) and geography • <u>Payment</u>: 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 isn't delivered over a certain time frame (1 month for medium or high tier beneficiaries and 3 months for low tier beneficiaries)

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	<ul style="list-style-type: none"> • Opt-Out Process: Patients will be able to opt-out of the program. If 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. <p>Provider Types and Standards</p> <ul style="list-style-type: none"> • Designated Health Home providers will be primary care providers and/or clinics. Each Health Home must have the capacity to comprehensively coordinate the clinical, long-term care, and social needs of its empaneled population. To ensure that the complex chronic health and social needs of Medicaid beneficiaries are met, DHCF plans to ask providers to demonstrate an ability to successfully deliver HH2 services, such as through Patient Centered Medical Home recognition. Additionally, it is likely that providers will be required to have a certified electronic health record system and offer after-hours access.
<p>Open Forum for Stakeholders to Share Thoughts, Suggestions, & Feedback</p>	<ul style="list-style-type: none"> • A few work group members suggested leveraging the lessons learned from Health Home 1 moving forward. These suggestions included: <ul style="list-style-type: none"> • Be very clear with roles and responsibilities and stay consistent with NCQA delegation requirements • HH1 offered a template where MCO case manager worked in a supportive role, ready to jump in when the HH1 provider needed assistance • Data exchange is hugely important; MCOs suggested improved processes for reporting back to them • Other suggestions included: <ul style="list-style-type: none"> • Ensure that the administrative requirements don't hurt quality, and • Provide consistent re-training for case managers
<p>Next Steps</p>	<ul style="list-style-type: none"> • The next Care Delivery Work Group meeting is on Monday April 25th from 3:00p.m. to 4:30p.m., and will discuss a more robust Health Home 2 policy framework.