

District of Columbia State Innovation Model (SIM) Advisory Committee Key Discussion Topics from the State Health Innovation Plan (SHIP)

The DC SIM Core Team is looking forward to your attendance at this Wednesday's, March 9, 2016 Advisory Committee meeting. At this meeting, the SIM Core Team will facilitate a discussion intended to solicit your policy guidance to further inform the direction of the SIM initiative, and ultimately the District's State Health Innovation Plan (SHIP).

We've agreed that through this SIM initiative we aim to improve health outcomes, experience of care, and value in health care spending for high-cost, high-need District residents, by organizing our work under four primary categories or 'Primary Drivers':

- Support value-based payment models that reward quality, improved health & efficiency.
- Invest in capacity building infrastructure & supports to assist providers as they change their business model and workflows.
- Strengthen data exchange infrastructure to inform clinical and social services, measure performance, & engage patients.
- Improve and integrate coordination of health care & social services with an enhanced focus on high-need patients

The discussions of the SIM Work Groups are ultimately focused on these four Primary Drivers, from the lens of health care and social service integration; payment incentives; new care coordination Medicaid benefits; metrics to help us measure progress; and electronically getting data to service providers and payers to facilitate better health outcomes. As consensus around certain policy is being achieved through the Work Groups and being documented within the DC's SHIP, we realize that there are key aspects of the SHIP that we need a collective discussion on within the Advisory Group setting—to initiate further discussion in the Work Groups. The following pages provide an update on each Work Group's progress to-date and below are Key Discussion Topics to help facilitate our conversation during Wednesday's meeting.

Key Discussion Topics

✿ **District Priorities:** From the environmental scan findings and your stakeholder perspective, what are the specific dimensions of disparities that the District should consider as its top priority/ies?

✿ **Evaluation and Monitoring:** How will the District know that it has made meaningful and measureable progress on reducing disparities?

✿ **Capacity Building:** Based on the answers from the above questions, what should the District's workforce look like in the future? What investments need to be made to transform today's workforce?

Community Linkages Addressing Social Determinants of Health

Background

Social determinants of health are constructs in the environment that have an impact on health status. The District has approximately 8,000 homeless residents, 80% of which are single adults, making housing a key social determinant. According to the DC Fiscal Policy Institute, 25% of Black, and 22% of Hispanic residents in DC lived below the poverty line in 2012¹. The same report revealed that one of every four children living in DC is poor. Stable and supportive housing mitigates environmental hazards and is correlated with increased medication adherence for those who are chronically ill, increased school attendance for children, and higher attendance rates at physicians' appointments. Policy and payment methods that support the integration of clinical and social services needed by these cohorts of the District's population may address health disparities that exist in the District.

Status Update

The SIM Community Linkages Work Group (CLWG) has brought together social services and healthcare providers to develop tangible methods that will connect a person's non-medical needs—such as housing, food insecurity, employment and others—with their medical needs. The goal is to ultimately achieve a whole-person care delivery model. To-date, the CLWG has primarily focused on supporting the design of a new Medicaid Health Home benefit (HH2) that will be used to integrate the health and social needs—specifically housing, of individuals with physical chronic health conditions. Mainly spearheaded by the SIM Care Delivery Work Group (discussed later), the CLWG has leveraged the expertise of its social services provider membership to explore how to establish a systematic partnership between primary care clinicians and more socially-focused providers that deliver services to Medicaid beneficiaries enrolled the District's Permanent Supportive Housing (PSH) Program. PSH is a District-funded program that pays for the health-related, community-based support needed by people with recent housing instability, along with rent, to successfully keep individuals off the streets.

Care Delivery and Health Homes 2

Background

A major step in care delivery redesign is launching a Medicaid Health Home benefit (HH2) in FY2017. HH2 will serve individuals with two or more chronic conditions, or who have one chronic condition and matched with the District's Permanent Supportive Housing (PSH) program. HH2 will provide enrollees with integrated and coordinated primary, acute, mental and behavioral health, and long-term care services. The model will also integrate primary care with community and social services and supports,

¹ Found at: <http://www.dcfpi.org/poverty-rates-remain-high-for-some-groups-of-dc-residents>

including the PSH program. CMS provides a 90% enhanced Federal Medical Assistance Percentage (FMAP) to the District for the first eight quarters of this benefit's implementation.

Status Update

The SIM Care Delivery Work Group has engaged health and social service providers, Medicaid health plans and government leaders to develop the District's second Medicaid Health Home benefit (HH2). Under this model, the HH2 entity would take responsibility for a patient's "whole" health:

- Patients would receive Team-Based Care, which includes clinical aspects of care, such as primary, acute, specialty, post-acute, behavioral, and pharmacy care needs.
- The HH2 care team would be responsible for linking the patient to appropriate Community Linkages, including housing, transportation, food security, job training, and physical safety resources, addressing social determinants of health.

The District has proposed two parallel ways in which medical and PSH providers may be partner through the HH2 benefit:

Two Parallel HH2 Tracks: Medical Providers and Permanent Supportive Housing Providers

Option 1

One entity-- either a medical provider or a PSH provider-- builds internal capacity to integrate the health and the social services needs of individuals with historical homelessness, to become a Medicaid HH2 provider. This HH2 provider receives funding from the Department of Human Services [DHS] for non-Medicaid allowable services (such as supplemental rent & utilities), and funding from the DHCF Medicaid-allowable services (such as categorical Health Home services, which include health-related PSH services).

Option 2

Partnership: A medical provider becomes a Medicaid HH2 provider alone, only after contractually partnering with a PSH provider to ensure that collectively the health and the social services needs of individuals with historical homelessness are met. DHCF pays the HH2 provider for Medicaid-allowable services (such as categorical Health Home services, which include health-related PSH services), and requires that a portion of the payment tied to health-related PSH services be allocated to pay the partnering PSH provider. DHS pays the PSH provider for non-Medicaid-allowable (such as supplemental rent & utilities).

Drafted design of the Medicaid HH2 benefit includes the following policy decisions:

- Individuals will be auto-assigned to a HH2 provider based on analyses of two years of claims data and provider encounters, connecting beneficiaries to previous providers.
- Enrollees can opt out of HH2 altogether, switch HH2 providers, or move risk tiers based on changes in health status or life events. Mechanisms for making changes, determinations, re-assessments, and re-enrollments are under discussion.
- HH2 providers will be paid a prospective PMPM rate, triggered when the provider first submits an HH2 claim for an attributed patient. HH2 plans to integrate pay for performance

(P4P) by FY18. The Care Delivery Work Group is also discussing eligibility standards for providers wishing to participate in HH2. Current progress in determining provider standards is detailed below:

- A minimum capacity standard would ensure that HH2 providers have sufficient staff capacity to effectively deliver health home services (Health Homes I requires one case manager to every 60 patients).
- Case management models used by HH2 providers would still need to meet NCOA standards, which is especially important for MCOs.
- Certified EHR systems should be a required standard for all HH2 providers. 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.
- Providers should be able to detail their protocols and processes for connecting beneficiaries to the services necessary for improved health outcomes, including physical, behavioral, and social services.

Payment Model Reform

Background

The District's current fee-for-service (FFS) payment structure does not incentivize preventative care, case management, and informational supports to manage and coordinate care. This often leads to inefficient use of care, higher costs and poor health outcomes among high-need populations.

Paying for quality services through value-based alternative payment models (APMs) can address shortcomings of the FFS system by incentivizing providers to take a more holistic approach to treating patients. APMs can include, but are not limited to:

- Payments for care coordination,
- Incentives for integration of social and community supports,
- Shared risk or shared savings arrangements that tie increased provider payments to improved patient outcomes, and
- Payment for initiatives that integrate traditional clinical care with care addressing social determinants of health, such as social and community services and supports.

These models typically serve populations that have certain conditions and care needs and their payment systems incentivize coordinated care delivery to address populations' unique needs. Payment reforms use financial means to incentive providers achieve certain healthcare transformation goals—such as eliminating health inequalities and improving health outcomes.

Status Update

The SIM Payment Model Reform Work Group (PMWG) continues to weigh options for a payment reform strategy that reflects the District’s landscape of provider capacity, District government oversight, upcoming programs that can be used to launch APMs, and the quality metrics that will be linked to the payment. Work group discussions have also centered on determining what payment models are most applicable to the District’s goals for care delivery integration. PMWG members have agreed to recommend value-based payment reforms that:

- Are realistic and quantifiable—especially for health disparity reduction;
- Incentivize coordinated care delivery for targeted populations;
- Scalable to reach broader populations and
- Align with other payers movement towards APMs, including Medicare, which has set aggressive targets for providers to move towards APMs.

Additionally, through discussions on the diversity of health service provider types and relative infrastructure capabilities of each provider practice in the District, the PMWG notes that different providers will need varying amounts of time, support, infrastructure development and capital to institute practice transformation. Thus, when outlining the path for instituting payment model reform in the District, the PMWG ranks provider flexibility as key to successful and sustainable payment model reform uptake.

Health Information Technology and Exchange (HIT / HIE)

Background

Data sharing in the District is inconsistent and fragmented, resulting in limited or absent health information exchanges between and among health and social services providers and payers of these services. Improving HIT interoperability and enhancing connectivity will enable access to real-time healthcare data, and will support care coordination, integrated care delivery, community linkages and population health monitoring.

Status Update

Currently, there are five ‘HIE entities that operated in the District: Capitol Partners in Care, Children’s IQ Network, CRISP, the Department of Behavioral Health’s iCAMS, and the public health integration system housed in the Department of Health. As noted by the District’s HIE Policy Board and in the District’s HIE Road Map, many of these HIEs fail to seamlessly integrate with one another, although CRISP is now connected to Capitol Partners in Care, which is in the process of linking to iCAMS. Additionally, each HIE is governed independently and have varying standards for data flows, interoperability and functionality. These differences hinder the bidirectional exchange of data from one HIE to the next—especially the contrasting aspects in interoperability. The Road Map also notes that HIE capabilities do not seamlessly integrate ambulatory and visit history information for Medicaid patients. To help address these challenges, DHCF, with guidance from the HIE Policy Board and the SIM HIE Work Groups (and other Work Groups), is undertaking or planning the following activities:

- 1) Compiling a comprehensive District-wide data map detailing the flows of key information among and between HIE systems and users, and identifying current gaps in HIE access, data elements and data flows. By first understanding the HIE landscape, we can devise the most appropriate next steps for addressing identified gaps and improving connectivity.
- 2) Developing an HIE designation process and associated HIE eligibility criteria to elevate the standards and requirements to which District HIEs are held. This proposal involves creating minimum threshold criteria for HIEs that will help align connectivity and interoperability across the District.
- 3) Increasing the capacities and capabilities of the District's centralized data warehouse, from which claims, health outcomes, quality metrics and administrative data can be pulled using the existing HIEs. This will alleviate some of the current disconnect between HIE systems as it will provide a centralized storage point from and into which HIEs can pull or populate data.
- 4) Creating and sharing dynamic care profiles, an aggregation of clinical, pharmacy and social service data in a single document, to support care coordination. Dynamic care profiles will allow data to follow the patient, transmitting data so that portions of care history are not left out.
- 5) Using IAPD funds to enhance HIE functionality to support ambulatory HIE connectivity, electronic clinical quality measurement, surveillance of prenatal health outcomes, and patient population health monitoring and analytics. This will increase the scope of data captured, reducing gaps in care histories and other critical patient data points that are not currently collected.

These activities will enable the infrastructure needed for providers, payers and other stakeholders to track and report performance metrics, utilization and real-time use of services across the healthcare system, and support the District's aims to improve health outcomes, experience of care, and value in health care spending.

Measuring Quality

Background

As healthcare payment moves toward a more value-based system, there is increasing need for alignment among public and private payers on quality measures to support new patient-centered payment and delivery system reforms. Private and public payers are interested in changing the way that they pay for health benefits by moving from a volume-based fee-for-service system to a system that pays for value. Fundamental to value-based payment systems are performance measures that can be used to assess progress toward improved health care quality, reduced disparities and lowered costs.

Status Update

The SIM Quality Metrics Work Group (QMWG) has discussed current measures and quality reporting activities in the District for Medicaid health plans and providers (e.g. Health Homes, FQHCs); public health tracking (e.g. listed in Health People 2020); Electronic Health Record Meaningful Use attestations;

private insurance payer initiatives (i.e. CareFirst’s Person-centered Medical Home) and Medicare’s Quality Initiatives. This work group has been able to catalog over 100 unique quality measures that are in use in the District and identified the ones that are most frequently used in programs.

To support the Medicaid HH2 benefit, the QMWG discussed the adding additional measures to those mandated by CMS. These included three hospital and ER based utilization measures (All-cause 30-day Readmission, Potentially Preventable Hospital Admissions and Low Acuity Non-Emergent Emergency Department Visits), in addition to two additional clinical measures: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence and Hospital-based Inpatient Psychiatric Setting Admission Screening. Due to the lack of accessible data, the follow-up measure was withdrawn from consideration. The screening measure was suggested to be part of the Health Home assessment instead of as an additional measure. The group also considered measure for PSH providers, but the group decided to use those measures for program evaluation efforts.

Drawing from CMS’ Core Quality Measures Collaborative, the QMWG is developing a District-wide quality strategy with a specific focus on the Medicaid program, to accomplish the following:

- Promotion of measurement that is evidence-based and generates valuable information for quality improvement,
- Consumer decision-making,
- Value-based payment and purchasing,
- Reduction in the variability in measure selection, and
- Decreased provider’s collection burden and cost.

Over the next three months, the QMWG will leverage CMS’ Core Quality Measure set and make recommendations on which should be included in the District’s quality strategy, and if additional measures are needed that align with the District’s priorities. The core sets focus on the following areas:

<ul style="list-style-type: none"> • Accountable Care Organizations (ACOs)/Patient Centered Medical Homes (PCMH)/Primary Care (<i>Quality Metrics recommends more focus on prevention</i>) • Cardiology • Gastroenterology • HIV/Hepatitis C 	<ul style="list-style-type: none"> • Medical Oncology • Orthopedics • Obstetrics and Gynecology • End Stage Renal Disease (Quality Metrics added) • Autoimmune Diseases – Sickle Cell Anemia (<i>Quality Metrics added</i>)
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Lastly, the QMWG will discuss the infrastructure needed to promote more coordinated and streamline reporting.