

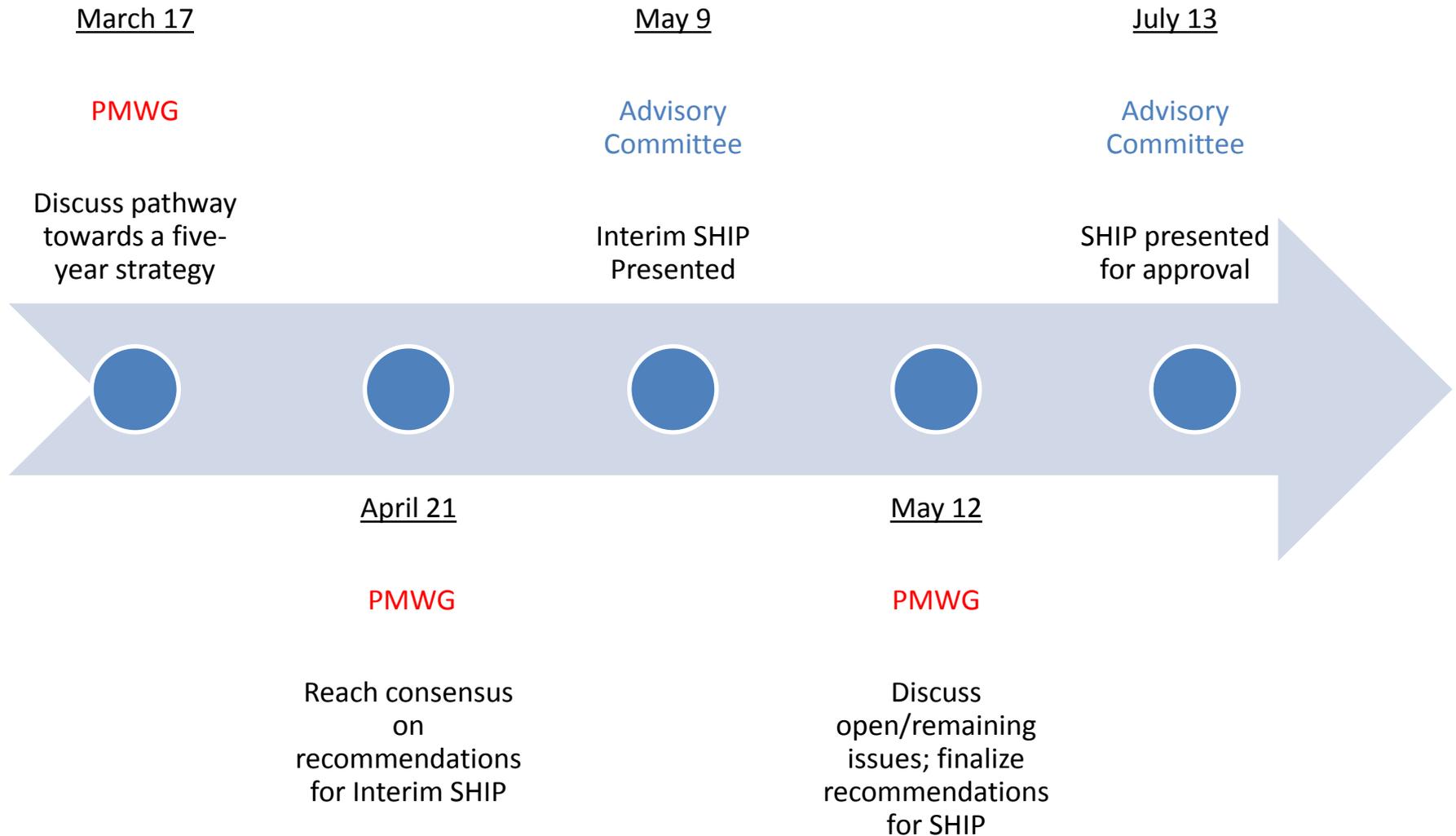


# Payment Model Work Group

(Only Two Meetings Left!)

March 17, 2016

# PMWG/SHIP Development Timeline



# Data Informing HH1 and HH2

FY11 Data Informing HH1*	All individuals	Individuals w/ MH Condition	Individuals w/o MH Condition
Both	7,713	5,224	2,489
FFS Only	36,410	16,960	19,450
MCO Only	36,059	5,537	30,522
Grand Total	80,182	27,721 (73% SMI)	52,461

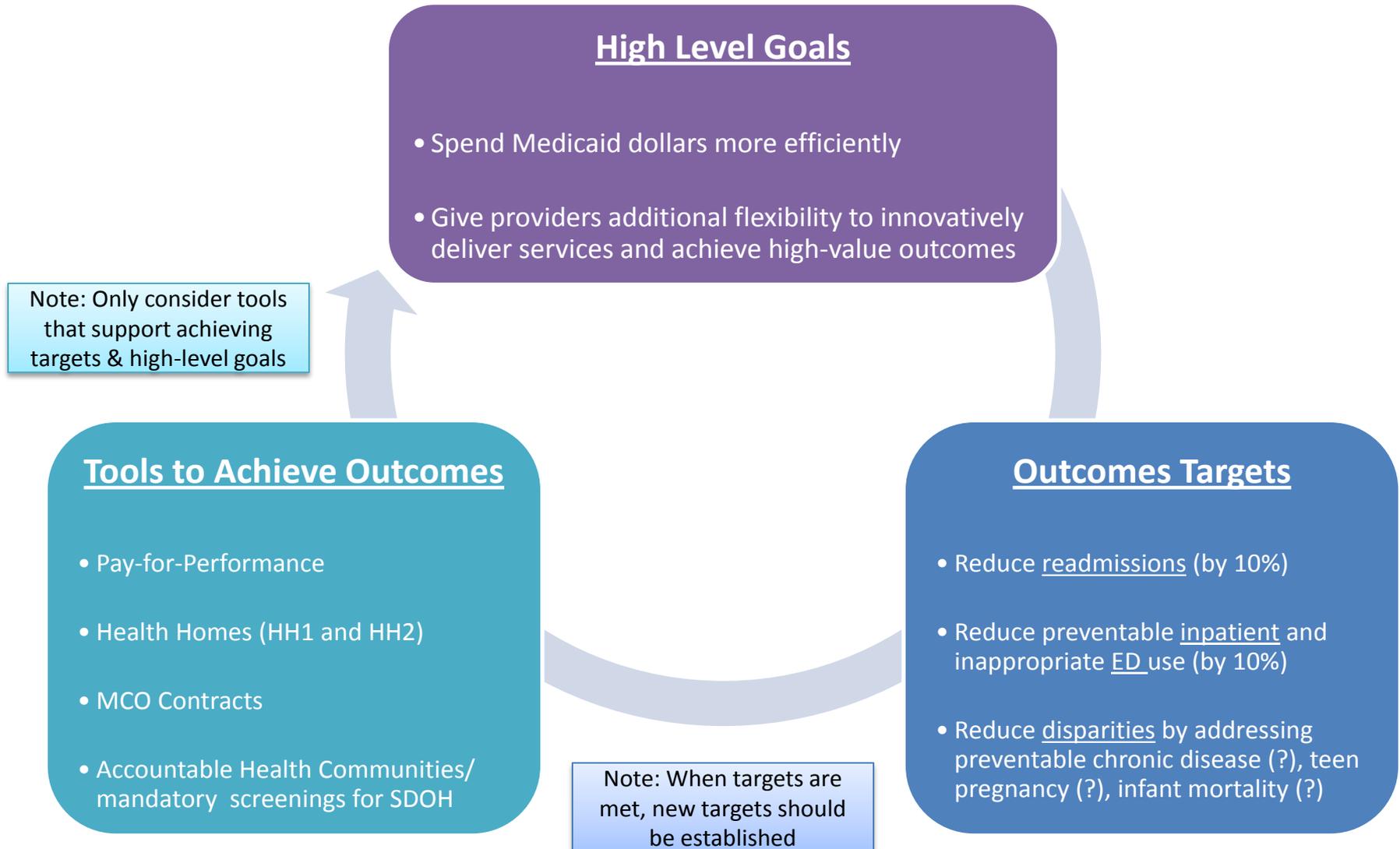
## FY14 Data Informing HH2\*\*

- **ED Visits:** 70,649 MCO beneficiaries had an ED visit (42% of MCO as compared to 23% of FFS)
- **IP Visits:** 12,987 FFS beneficiaries had an IP visit (22% of FFS as compared to 9% of MCO)
- **Proportion of Spending (FFS and MCO):**
  - Top 1 percentile: 2,339 beneficiaries make up 27% of total Medicaid spending
  - Top 5 percentile: 13,855 beneficiaries make up 60% of total Medicaid spending
- **Top 10 Chronic Conditions within Top 1 Percentile:** 1) Hypertension; 2) Behavior Problems; 3) Diabetes; 4) Dementia; 5) Paralysis; 6) Cerebrovascular Disease; 7) Chronic Renal Failure; 8) CHF; 9) Hyperlipidima; and 10) Depression

\*FY11 data, based on 80,182 individuals with at least one FFS claim and/or MCO encounter paid with diagnosis codes included in DBH's recognized range of mental illness, and/or diagnosis code for a somatic condition (e.g. asthma; diabetes; heart disease; hypertension; BMI>25; HIV/AIDS)

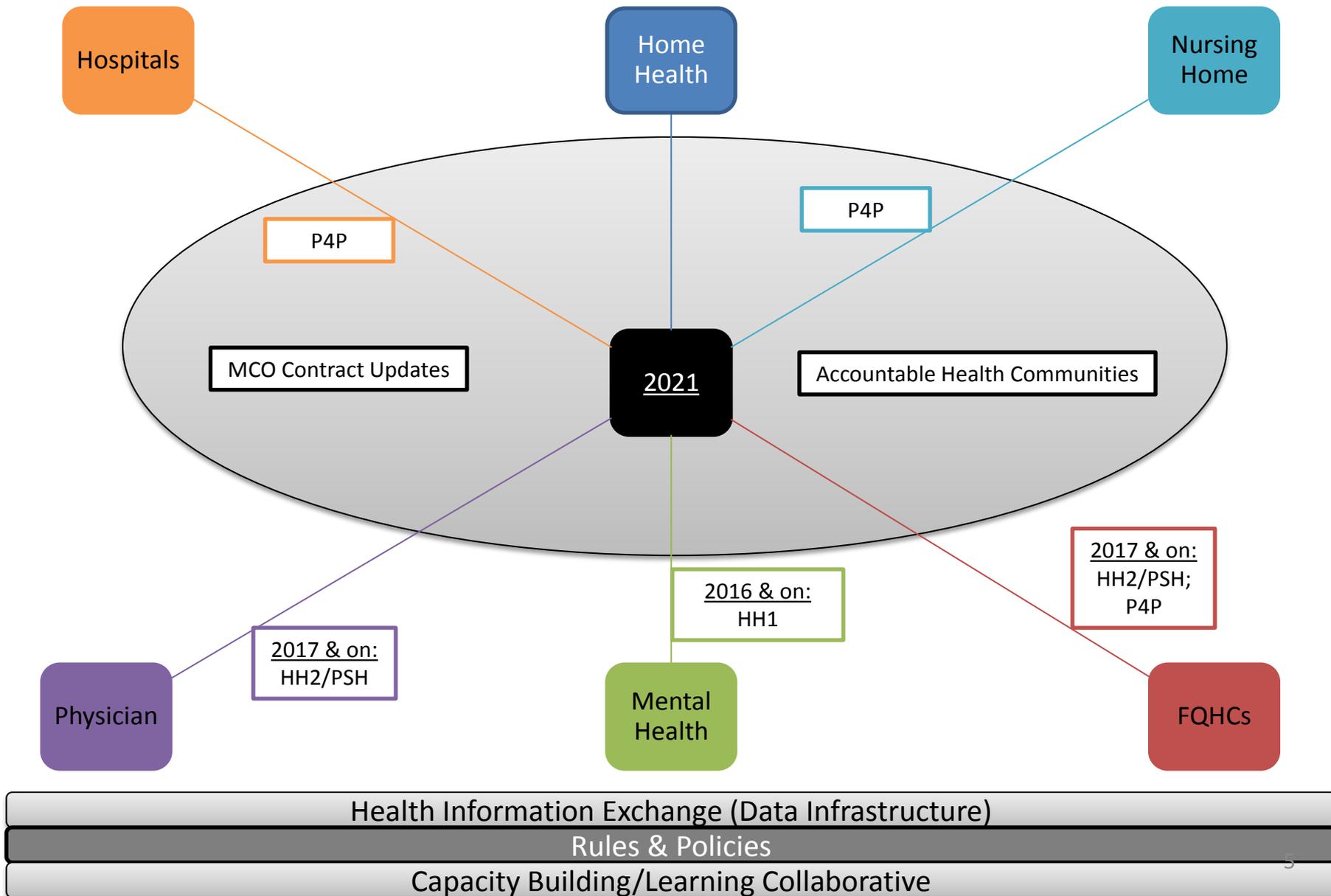
\*\* FY14 data from District's Medicaid Management Information System 2015

# Strategy to Reduce Disparities Within the Medicaid Population



# Five Year Plan to Reduce Disparities through Provider Innovation

**NOTE: Illustrative example, for the PMWG. For discussion purposes only.**



# Payment and Care Delivery Transformation Road Map

**NOTE: Illustrative example, for the PMWG. For discussion purposes only.**

	2017	2018	2019	2020	2021
<b>Key Activities</b>	• Baseline year	Year 1 of P4P payments	Menu of Payment Options (P4P, APMs)		
<b>Base Payment</b>	Enhanced FFS		• Enhanced FFS; or		
			• APM (e.g. Shared Savings; Full-Risk)		
<b>Supplemental Payment(s)</b>	<ul style="list-style-type: none"> <li>Care Coordination Payments (HH1, HH2, EPD, DD, MCO)</li> <li>P4P (e.g. bonuses and/or penalties related to readmission rates, preventable IP/ED use, hospital acquired conditions)</li> <li>Other (e.g. partnership with Hospital ACO)</li> </ul>				
<b>Capacity Building</b>	<ul style="list-style-type: none"> <li>Health Information Exchange (e.g. IAPD tools)</li> <li>Health Home 1 and 2 (e.g. flexible PMPM dollars)</li> <li>Accountable Health Communities (e.g. screening/referral resource)</li> <li>Lump Sum Payment for APM/Capacity Building (see Medicare)</li> </ul>				
<b>Outcomes</b>	Set baseline for LANE, Re-admissions, and IP measures	Set reduction targets (%)	<ul style="list-style-type: none"> <li>Reset baseline</li> <li>Add measures based on data/priorities</li> </ul>	Reset baseline	Reset baseline
<b>Non-Traditional FFS Payments</b>	<ul style="list-style-type: none"> <li>0% APM</li> <li>30% tied to value</li> </ul>	<ul style="list-style-type: none"> <li>20% APM</li> <li>50% tied to value</li> </ul>	<ul style="list-style-type: none"> <li>30% APM</li> <li>70% tied to value</li> </ul>	<ul style="list-style-type: none"> <li>50% APM</li> <li>90% tied to value</li> </ul>	
<b>Key Policy Considerations</b>	<ul style="list-style-type: none"> <li><u>Priorities</u>: What payment model(s) are the highest priority to you/your provider type?</li> <li><u>Screening</u>: Should there be universal screenings for SDOH? Based on Accountable Health Communities model?</li> <li><u>Workforce</u>: What does the workforce of the future look like? What are key strategies/priorities for development?</li> <li><u>Reinvest</u>: What are key reinvestment priorities?</li> <li><u>Continuous Learning</u>: How do we scale successful efforts? What are the markers to make sure we on target?</li> </ul>				