FY 2016 Health Home Performance Results Summary

Success Defined

- Success of the Health Home program is defined by answering two different questions.

  1. Did the Health Home program decrease uncoordinated care costs (UCC) and thus helping Medicaid to avoid costs?
     - Decrease inappropriate utilization of the ER
     - Decrease inappropriate admissions and readmissions
     - Increase the use of the primary care provider and team to ensure that recipients are getting the care where and when they need it.

  2. Did the Health Home program improve Health Outcomes for recipients who are participating?

- The answer is yes to both of these questions.

Health Home Performance History

- Initial analysis done completed for FY 2015. Small numbers made it very challenging to do a great deal of analysis.
  - Findings previously released indicate a reduction of 1.2 claims per member per month.

- In FY 2016 two types of financial analysis were completed to provide confirmation that the Health Home Program was successful at avoiding Medicaid costs:
  1. Analysis comparing where we were at program implementation to where we are now. The results of this analysis are seen on the next set of slides as well as some of our key outcome indicators.
  2. Matched analyses over the same time period comparing costs of those enrolled in Health Home with cost of similar individuals who were not enrolled in Health Home.

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Cost Avoidance Estimates for FY 2016

- The per member per month (PMPM) cost of around $4 million dollars must be removed from these numbers to get the net cost avoided amount.

- Analytic Method 1: $8.244 million avoided annually by reducing the costs for HH enrollees. (Net: $4.2 million)

- Analytic Method 2: $9.605 million avoided annually by reducing the costs for HH enrollees. (Net: $5.6 million)

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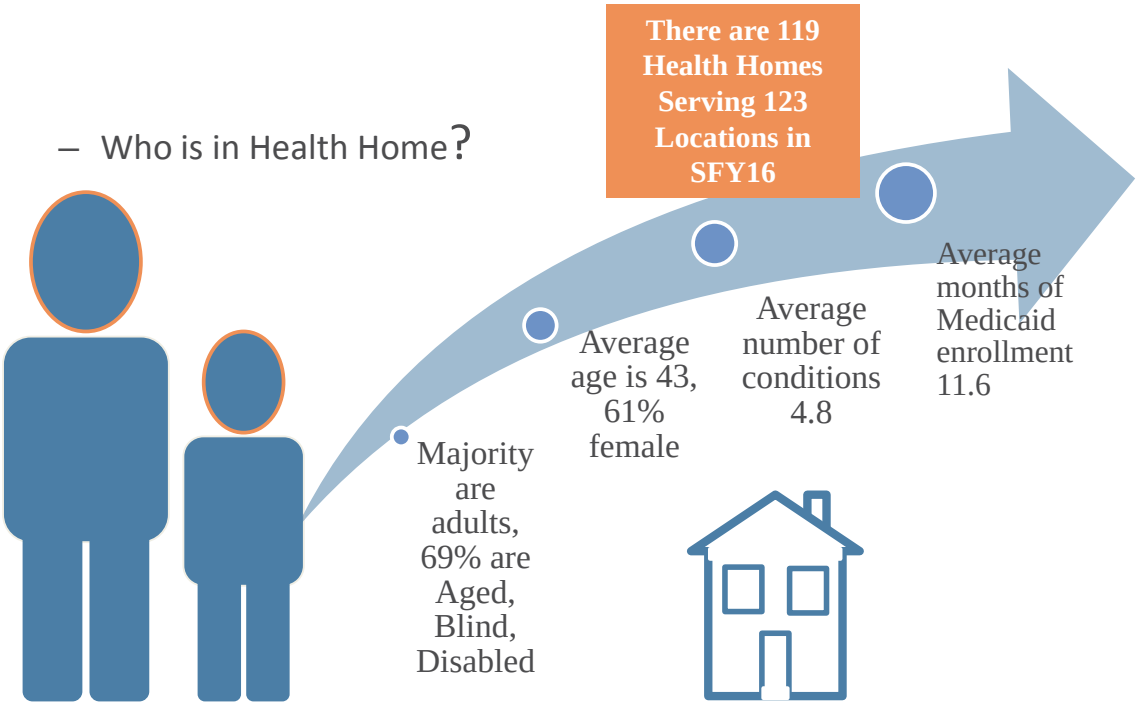
Health Management: Caring for People in the Most Cost-Effective Manner

- Who is in Health Home?



Health Management: Caring for People in the Most Cost-Effective Manner

- **Health Homes Outcomes FY 2014 – FY 2016**
  - Health Homes report every 6 months on a number of performance measures with multiple measures for some conditions , e.g., asthma, diabetes, behavioral health patient demographics, coordination of care, process and utilization of services. New measures for 2017 include substance abuse screenings as well as 72-hour follow-up for hospitalization due to COPD.

Reduction of 1.2 claims per month – a 14% reduction in average number of monthly claims (inpatient, outpatient, Rx)

Almost a 40% increase in recipients screened for clinical depression

6% increase in people visiting primary care provider in last 6 months

59% increase in the number of counseling sessions with recipients/families to adopt healthy behaviors associated with disease risk factors

38% increase in the number of recipients screened for substance abuse

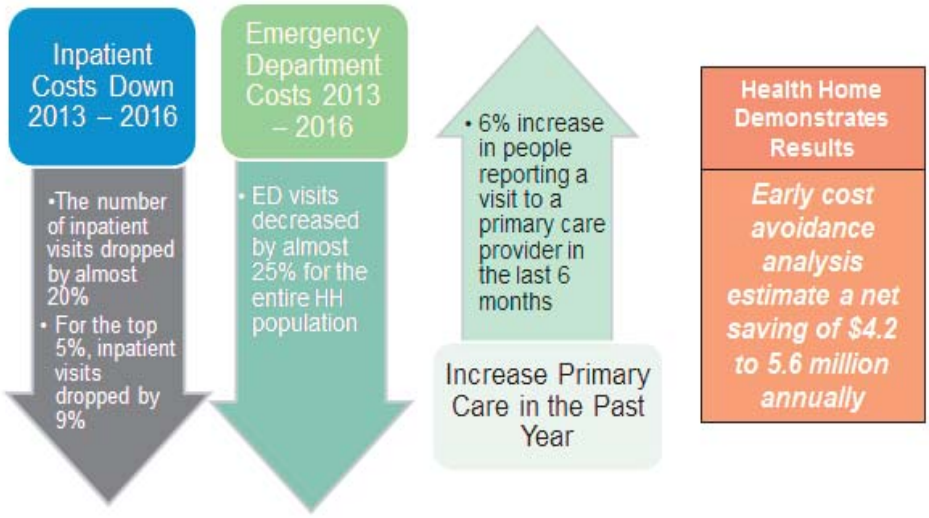
24% increase in medication adherence (prescriptions filled at least 85% of the time) for individuals with severe mental illness.

39% increase in the number of recipients who received a follow-up contact within 72 hour of discharge

Between Period 5 and 6 of SFY 2016 a 49% increase in the number of recipients whose Summary of care was transferred electronically

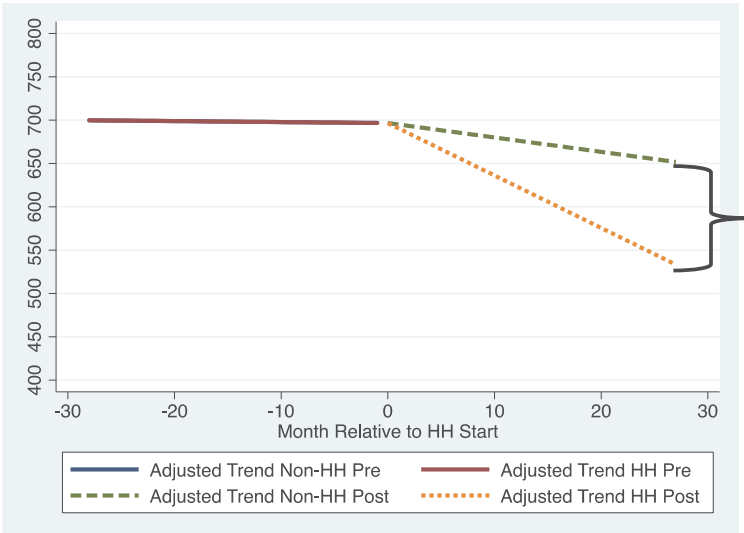
Between Period 5 and 6 of SFY 2016 a 17% increase in recipients with an active care plan

Health Management: Caring for People in the Most Cost-Effective Manner



Health Management: Caring for People in the Most Cost-Effective Manner

- **Health Homes – Estimates of Avoided expenditures**
  - Both analytical methods showed that the Health Home program avoided expenditures for the Medicaid program.



The difference between these two lines is the expenditures avoided by recipients participating in the Health Home program.

Health Management: Caring for People in the Most Cost-Effective Manner

Health Home Program Success Stories

The Health Homes report many success stories resulting from the activities and interventions for patients, for example:

- *A 50-Year-Old recipient enrolled in the Health Home program since December 2013 has improved health significantly as part of participating in the Health Home Program.*
- *Starting weight was 245 with a BMI of 44.7 and she is now down to 129 pounds with a BMI of 23.3. Recipient makes all of her dental and eye appointments as well as her yearly wellness exams. Recipient has reduced cholesterol to the point that they were able to stop one medication. Recipient significantly reduced their smoking and is working toward quitting.*