Background

• During the 2018 Legislative Session, the Legislature provided just under $1 million to incentivize Health Home participation and in recognition for helping SD Medicaid to avoid $7.7 million in CY 2016.
  ▪ 50% of the money went to all Health Homes by increasing PMPM around 16%. Took effect for the January –March 2018 quarter.
  ▪ The remainder of the funds will be used for Health Home Quality Incentive Payments.
  ▪ Quality incentive payments to be paid as a lump sum payment.
Cost Avoidance Drivers

• In CY 2016, 68% of cost avoidance was derived from a decrease in inpatient admissions and emergency room use.
• In CY 2016, tiers 3 and 4 yielded the greatest portion of the cost avoidance.
• Clinic process changes drove outcomes in these areas.

Process

• Convened a subgroup of Health Home representatives to determine a payment methodology for the Quality Incentive Payments.
  ▪ Representatives from all provider systems serving as Health Homes.
  ▪ Group met twice in October to give feedback and recommend a methodology.
What we heard

- DSS Original Proposed Methodology:
  
  \[
  \text{Quality Incentive Payment} = \text{Case Mix} + \text{Clinical Outcome Measures} + \text{Inpatient Utilization} + \text{Emergency Room Utilization}
  \]

- Subgroup Feedback on key elements for the Quality Incentive Payments:
  
  - ER and Inpatient Utilization:
    - Concern about small numbers and the effect of relatively few IP and ED events to drastically impact the rate of utilization.
    - Concerns about small numbers in the outcomes data.
  - Case Mix:
    - Group wants to recognize Tier 2 as well as Tier 3 and 4.
    - Concern about challenges for small/rural programs.
  - Clinical Outcome Measures:
    - Revised the measures removing some and adding others based on previous discussion.
    - Want to recognize highest performing clinics.
    - Payment should reward clinics above statewide average.

Selected Clinical Outcome Measures

- Clinical Outcome Measures:
  - Depression Follow-up Plan
  - Substance Use Positive Referred
  - Ability to Self Manage
  - Uses Self-Management Tools
  - Chronic Pain Follow-up Plan
  - Patient Management (Proactively remind patients of services needed)
  - Care Transitions: Follow up within 72 hours of discharge
  - Patient has an active Care Plan
  - CMCH only – Recipient Prescriptions Refill 85% of the time
  - PCP only - Has seen PCP in the last 6 months
  - Mammogram up to date
  - Colorectal Screening up to date
Revised Methodology

- Revised key elements for payment:
  - **Case Mix** – Removed Case Mix Payment and added as a factor to clinical outcome measures.
  - **Small Clinic Payment** – Recognized clinics with average caseload 15 or fewer participants with a small clinic payment.
  - **Clinical Outcome Measures** – Calculated overall quality score based on clinic’s standard deviation across all outcome measures. Split into two components:
    - Quartile Payment: Recognizes clinics in the top half of the top quartile (clinics above the statewide average) with $2,500 and clinics in the bottom half of the quartile with $1,500.
    - Caseload and Tier Payment: Payment based on caseload size and tier to clinics above the statewide average.
  - **Inpatient/Emergency Room Utilization** – Removed due to data concerns.

Payment Model

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Next Steps

• State will use additional input to finalize the formula.
• Present to the Health Home Implementation Workgroup.
• State Plan Amendment (SPA)
• Payments will be made in lump sum using CY2017 data