Health Home Implementation Workgroup

March 14, 2017

10:00 AM – 2:00 PM Central Time

Drifter’s Ft. Pierre

Call in Number 1.866.410.8397

9961957110

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Health Home Implementation Workgroup

1. Introduction and Roll Call

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2. General Update

Provider Capacity as of January 1, 2017

- Current Number of Health Homes – 119 serving 122 locations
  - FQHCs = 25
  - Indian Health Service Units = 11
  - CMHCs = 9
  - Other Clinics = 74
- Health Home changes –
  - New Health Homes for 01.01.2017
    - Bennett County Community Health Center – RHC
  - Health Home that ceased on 12.31.2016
    - Avera St Benedict Tripp - RHC

Increasing Capacity

- Priority focus on expanding capacity for those eligible in tiers 2-4.

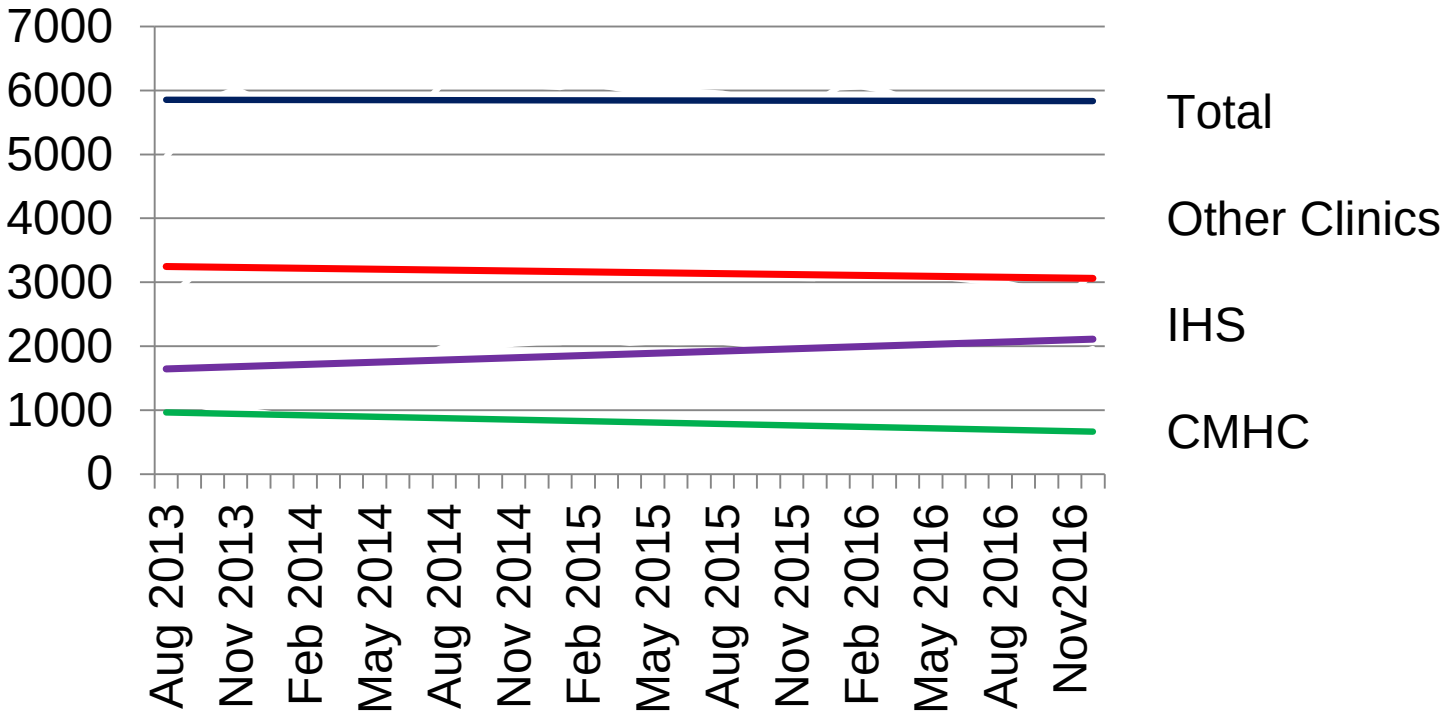
- Missing clinics in key areas. Suggestions for method to increase capacity?
  - Mobridge Regional Clinic and associated West River Health Clinics
  - Huron Regional Medical Clinic Medical Clinic
  - Center for Family Medicine in Sioux Falls
  - Madison Community Hospital
  - Most Regional Clinics
  - Avera Medical Group Mitchell
  - Winner Regional Medical Clinic

Recipient Participation as of Payment Dates

- There were 5,862 recipients in Health Homes as of December 27, 2016. **FY 2016 average participation was 5806 recipients**.

Type HH	Tier 1	Tier2	Tier 3	Tier 4	Total
CMHC	16	214	402	121	753
IHS	10	1,110	592	249	1,961
Other Clinics	57	1,852	848	391	3,148
Total	83	3,176	1,842	761	5,862

Trends in Recipient Participation



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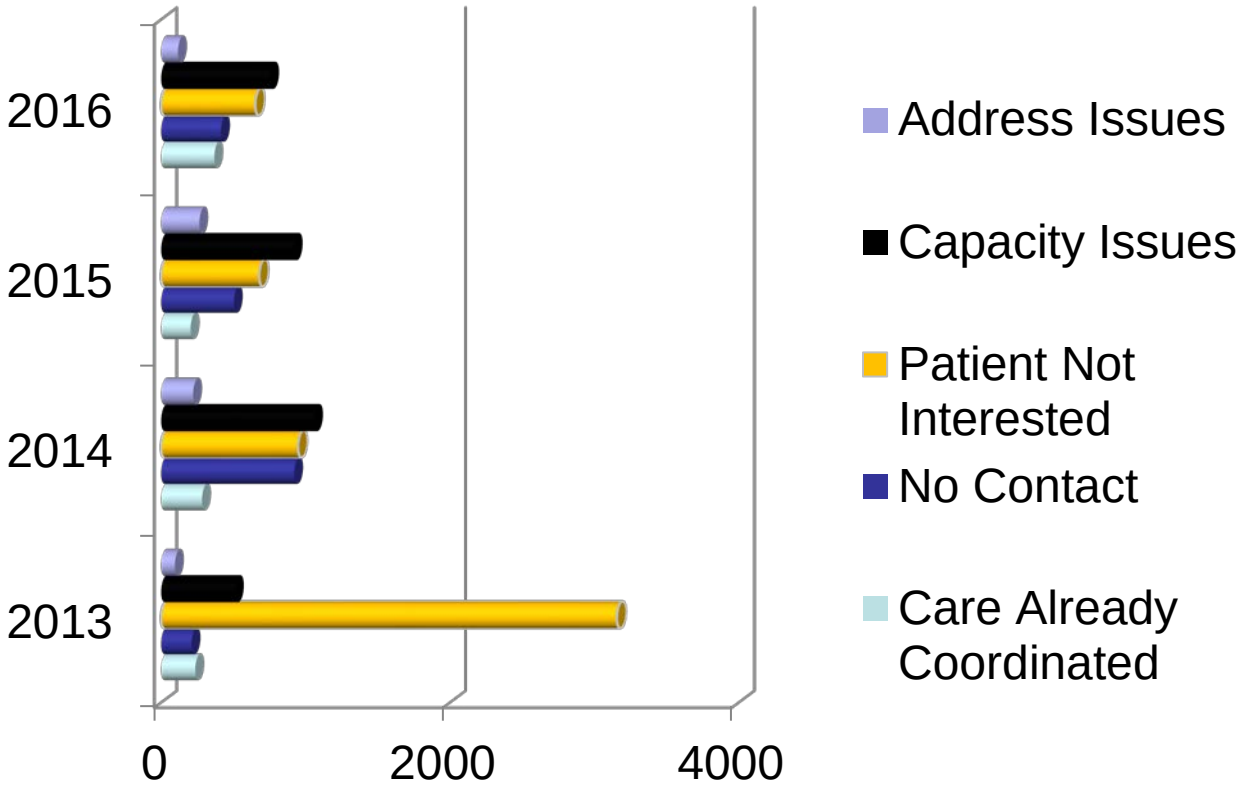
Opt out Reasons

- Background
  - Information is a snapshot in time.
  - Data on opt out reasons fluctuates on a daily basis.
  - True tracking of opt out reason was not completed and or standardized until the beginning of 2014.
  - Most opt outs in 2013 are categorized as Recipient choice or Patient Not Interested.

Opt out Information

- Address issues
  - Letter came back to DSS or recipient moved out of state.
- Capacity Issues
  - Health Home not available or their provider not a Health Home
- Patient Not interested
  - Includes not interested, Patient thinks they do not need, patient currently exempt from referrals
- No Contact
  - Facility unable to make contact
- Care Already Coordinated
  - Includes Boarding in School, Child Protective Services, Long Term Care, Psychiatric Residential Treatment Facility, and Department of Correction/Incarceration.

Opt out Reasons Snapshot in time



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Increasing Participation

- Increase Capacity
- Continue to improve engagement strategies
- DSS proposing to strategically remove opt outs on certain recipients.
  - Recommend removing opt outs as follows:
    - Recipients with Address issues opt outs
    - Recipients with Patient Not Interested opt outs from 2013, 2014 and 2015, in counties where capacity exists.
    - Thoughts about removing opt outs due to no contact?

HIE and Online Provider Portal

- HIE Event Notification Update
  - Kevin Dewald
- Online Provider Portal
  - Portal is live for the following Health Home items
    - Caseload reports
    - Remits
  - Forthcoming will be the
    - Paid Claims reports
    - Core Services Reports
  - Will be moving away from Clinic Ids when these two pieces are complete. BNPI will be come a way to determine groups.

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3. Patient Engagement Strategies

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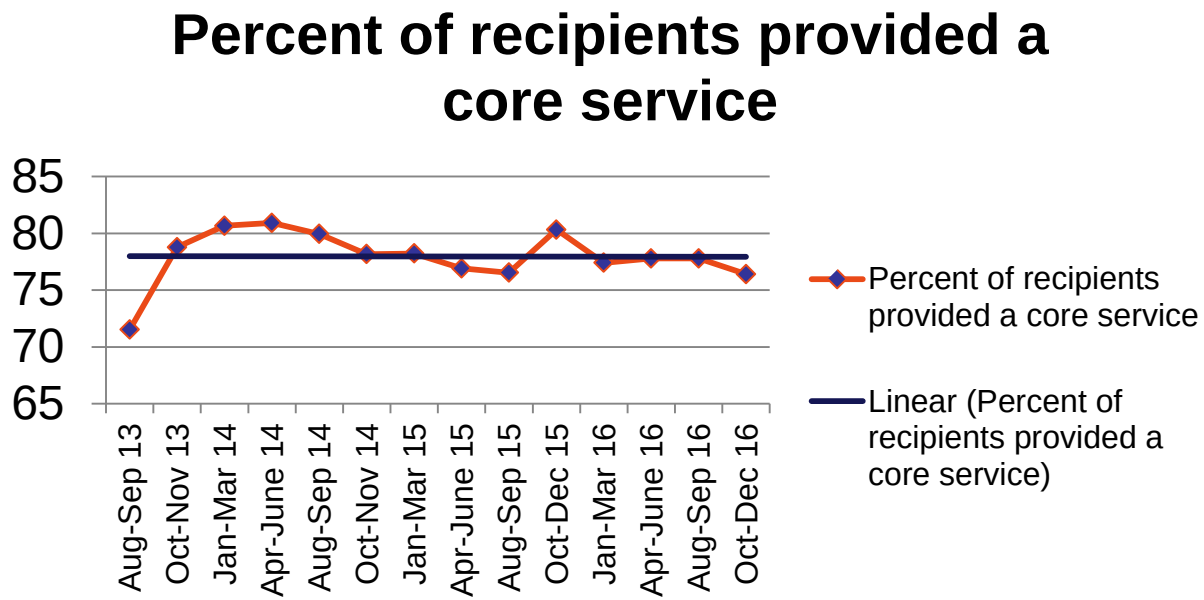
Trend in Core Service Provision by quarter

- Percent of Health Home recipients provided a core service by quarter.



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Brainstorming Engagement Strategies

- Previously indicated that policy requiring three attempts to contact using two different methods over 45 days led to a lower rate of core service provision.
  - Recommendations on this policy?
  - What else could be done to encourage more attempts to engage recipients?

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4. Health Home Training Needs

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Health Home Training Needs

- Training on the new outcome measures was provided in July of 2016. The data continues to improve.
- Provided Online Portal Training and worked with group to help test the portal.
- Four Health Home Sharing Sessions were conducted in Sept of 2016. The feedback in the evaluations was very positive. Plan to do similar sessions this fall.
- Need to query Care Coordinators again on trainings they might find helpful.
- All training web resources found at http://dss.sd.gov/healthhome/training.aspx.

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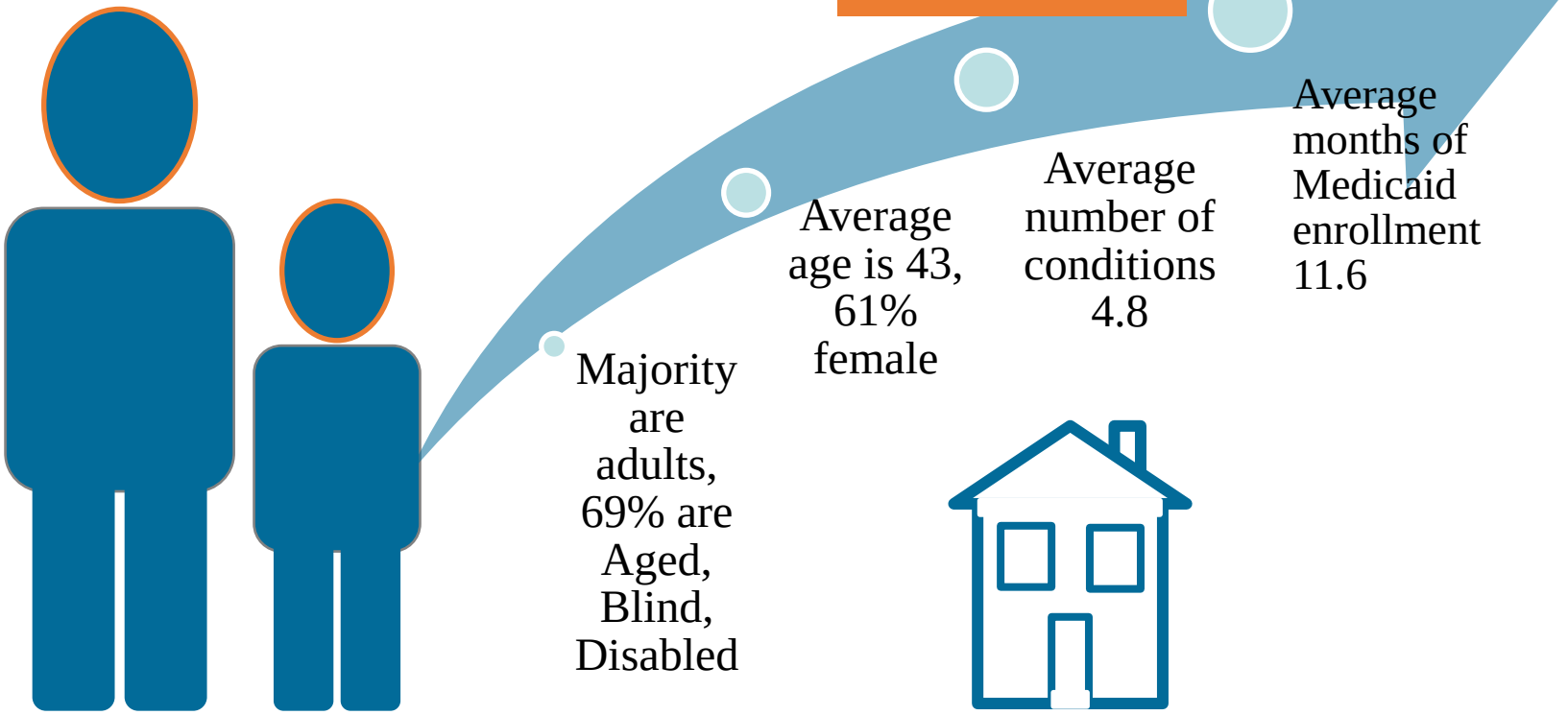
5. Health Home Performance Analysis

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 released at our last meeting included a reduction of 1.2 claims per member per month.
- Population further expanded for FY 2016 analysis.
  - Worked on one page 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.
- Currently, working with HMA on a new methodology to do a comparison group analysis.
  - First time conducting this type of analysis. Working with HMA to refine the results.

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 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 Female enrolled in the Health Home program since December 2013 has improved health significantly as part of participating in the Health Home Program.*
- *Her starting weight was 245 with a BMI of 44.7 and she is now down to 129 pounds with a BMI of 23.3. She makes all of her dental and eye appointments as well as her yearly wellness exams and mammograms. She has reduced her cholesterol to the point that she was able to stop one medication. She has significantly reduced her smoking and is working toward quitting.*

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

- **Health Homes Outcomes FY 2015 – 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 children screened for clinical depression

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

Almost double the number of counseling sessions with recipients/families to adopt healthy behaviors associated with disease risk factors

14% increase in use of electronic medical records and almost 50% Increase in notification and records transmission 24 hours from discharge

14.3% increase in medication adherence (prescriptions filled at least 85% of the time) for individuals with severe mental illness.

Hypertension (slight increase in percent of people with blood pressure in control

1% increase in people whose BMI is in control

1% increase in people whose HbA1c is in control (diabetes)

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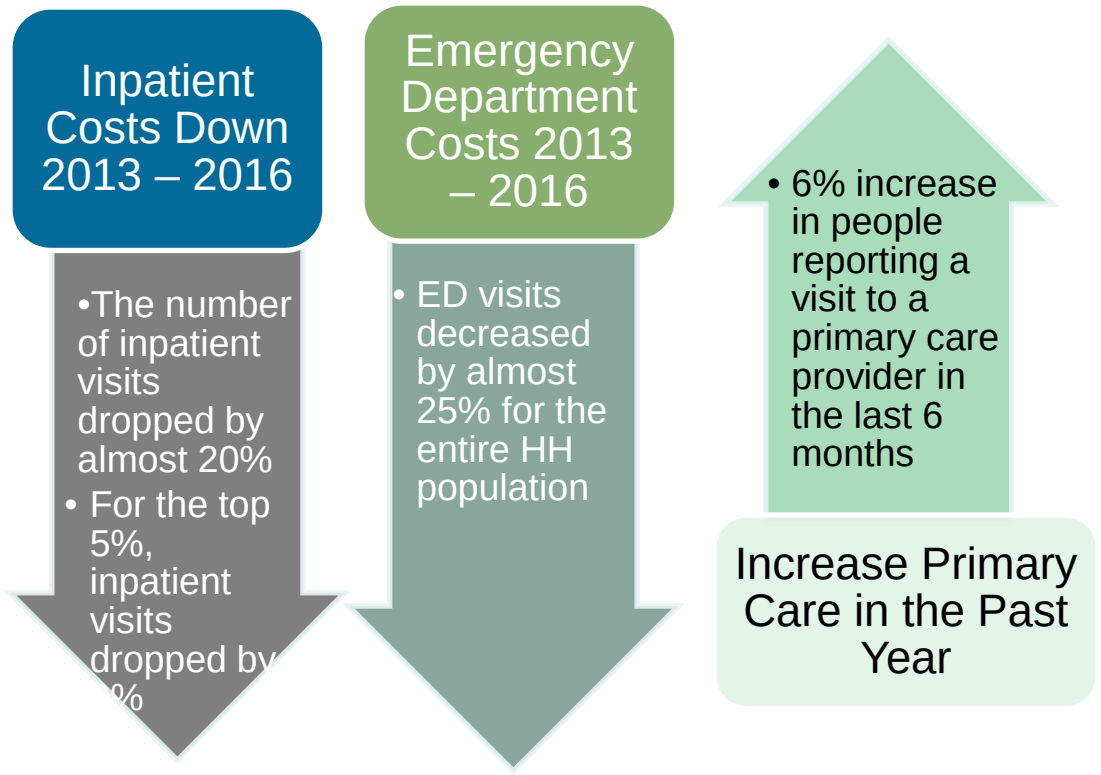
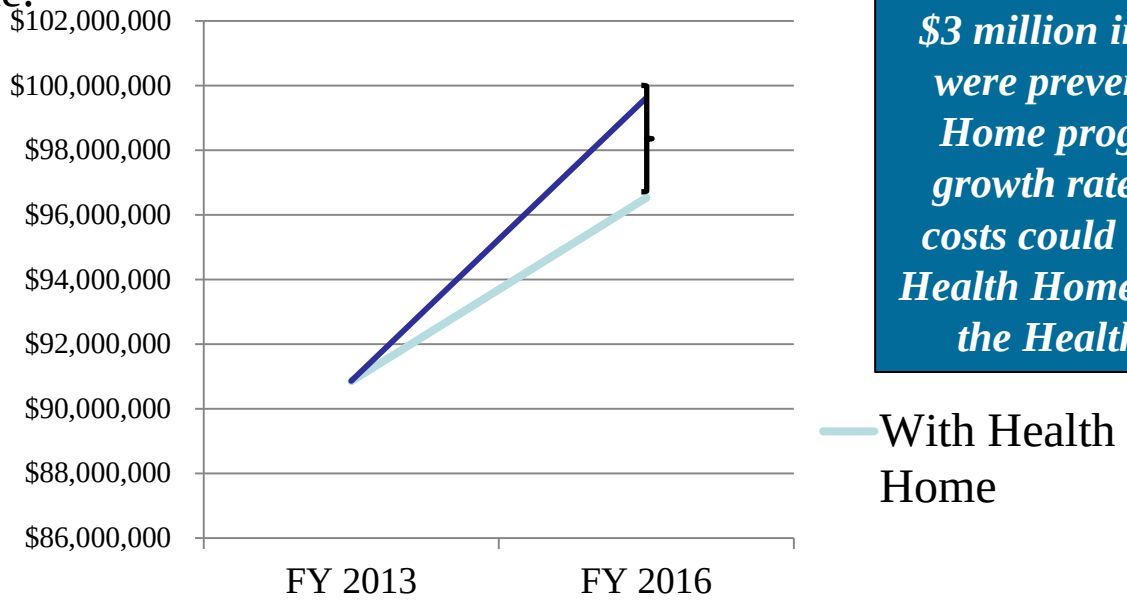


Health Home Demonstrates Results

Recent analysis of Health Home enrollee utilization, claims, and outcomes show significant progress in achieving savings and efficiency. Inpatient and emergency costs are down while primary care is increasing.

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

- **Health Homes – Estimates of Avoided Costs**
- Total costs for Health Home enrollees rose by 12% between 2013 and 2016 compared to the 16% projected increase in costs for the Health Home eligible population prior to implementation. This is a conservative estimate of the impact on costs "with" and "without" the Health Home program. We are continuing to study the effects for recipients who are Health Home eligible but not enrolled in Health Home.



$3 million in expenditures that were prevented by the Health Home program reducing the growth rate compared to how costs could have grown for the Health Home population without the Health Home program

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6. Other Discussion

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Other Discussion – Explore Shared Savings

- There are federal and state models for developing shared savings programs, e.g., the Medicaid Comprehensive Primary Care (CPC) program.
- CMS has developed a methodology to measure savings and share them across providers in particular regions.
- CPC includes primary care along with multi-payer reforms, continuous use of data to drive quality improvement, and meaningful use of health information technology.

Other Discussion – Explore Shared Savings - Methodology

- Five steps for calculating shared savings
  1. CMS calculates shared savings at the regional level
  2. CMS uses claims experience in the region to estimate future expenditures
     - CMS calculates the baseline and future expenditure targets, with and without CPC
  3. If a region spends less than the expenditure target by more than 1% then CMS shares the savings

Other Discussion – Explore Shared Savings – Methodology(Continued)

- Five steps for calculating shared savings (cont)
  4. A practice's share is determined by the relative proportion of care management fees in the region
     - Larger practices have more care management fees therefore get a larger proportion of shared savings
  5. Only practices that maintain or improve quality of care are eligible to share in the savings. Practices are score on following quality metrics:
     - CAHPS patient experience surveys
     - Three regional claims-based quality measures
     - Nine (out of 13) electronic Clinical Quality Metrics from the Meaningful Use program

Other Discussion

- PMPM rate Inflation
- Alignment with MN Health Care Homes and MACRA
  - Request from Bonnie LaPlante of the MN Health Care Homes to align our program with their program.
    - Core Services
    - Outcome Measures – MN measures
  - Items of Note
    - MN Health Care Homes is not an approved Health Home program through the affordable care act. It was done as part of their Health Care Reform.
    - Encompasses a certification process done by the MN Department of Health as a result, it has been approved by CMS as meeting full credit for the Clinical Practice Improvement Activities Performance Category (CPIA)

Other Discussion – Public Facing Health Home Metrics

- High Profile Program with Legislature
- Until now we have shared data with Implementation Workgroup and clinics.
- After three years, DSS needs to add HH metrics on a regular basis to our current Health Home Webpage
  - Number of Recipients participating - monthly basis
  - Aggregate outcome measures – every 6 months
    - Will focus on process improvement measures rather than clinical measures.
  - Financial Analysis – As completed.
  - Other thoughts of metrics to add/concerns?

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Questions and Thank You!

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