SIM Advisory Committee

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D.C. Department of Health

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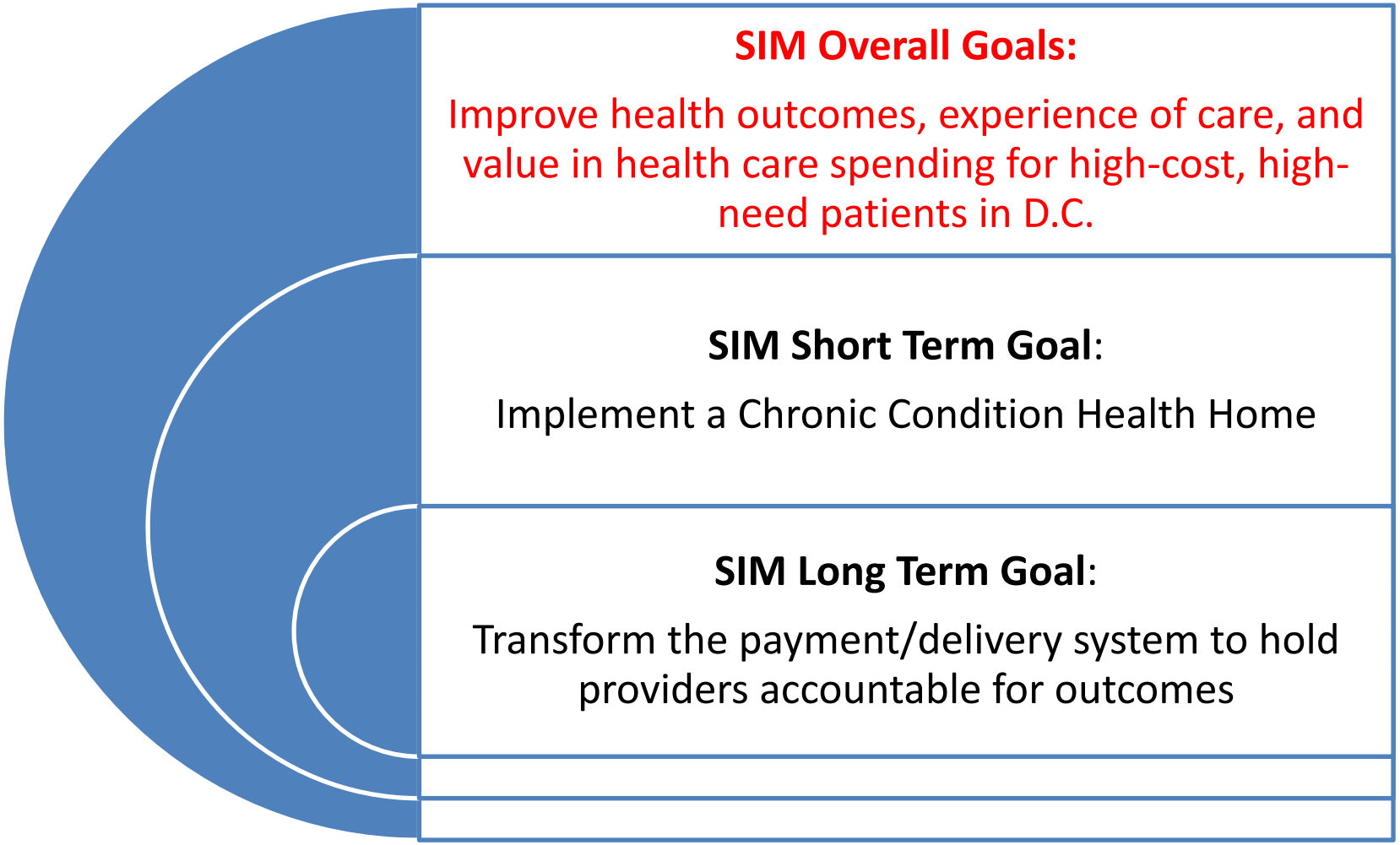
Today's SIM Road Map



Key Data Takeaways (FY14)

Total Medicaid Population

- **Average Per Person Spending:** $10,050
  - FFS: $27,378 (based on 58,034 beneficiaries with a claim in FY14)
  - MCO: $4,014 (based on 166,586 beneficiaries with a claim in FY14)
- **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)
- **Long-Term Care:** Comprises 32% ($757,026,295) of total Medicaid expenditures

High Cost Beneficiaries

- **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
- **Average Per Person Spending within Top 1 Percentile:**
  - FFS: $495,861
  - MCO: $206,125
- **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

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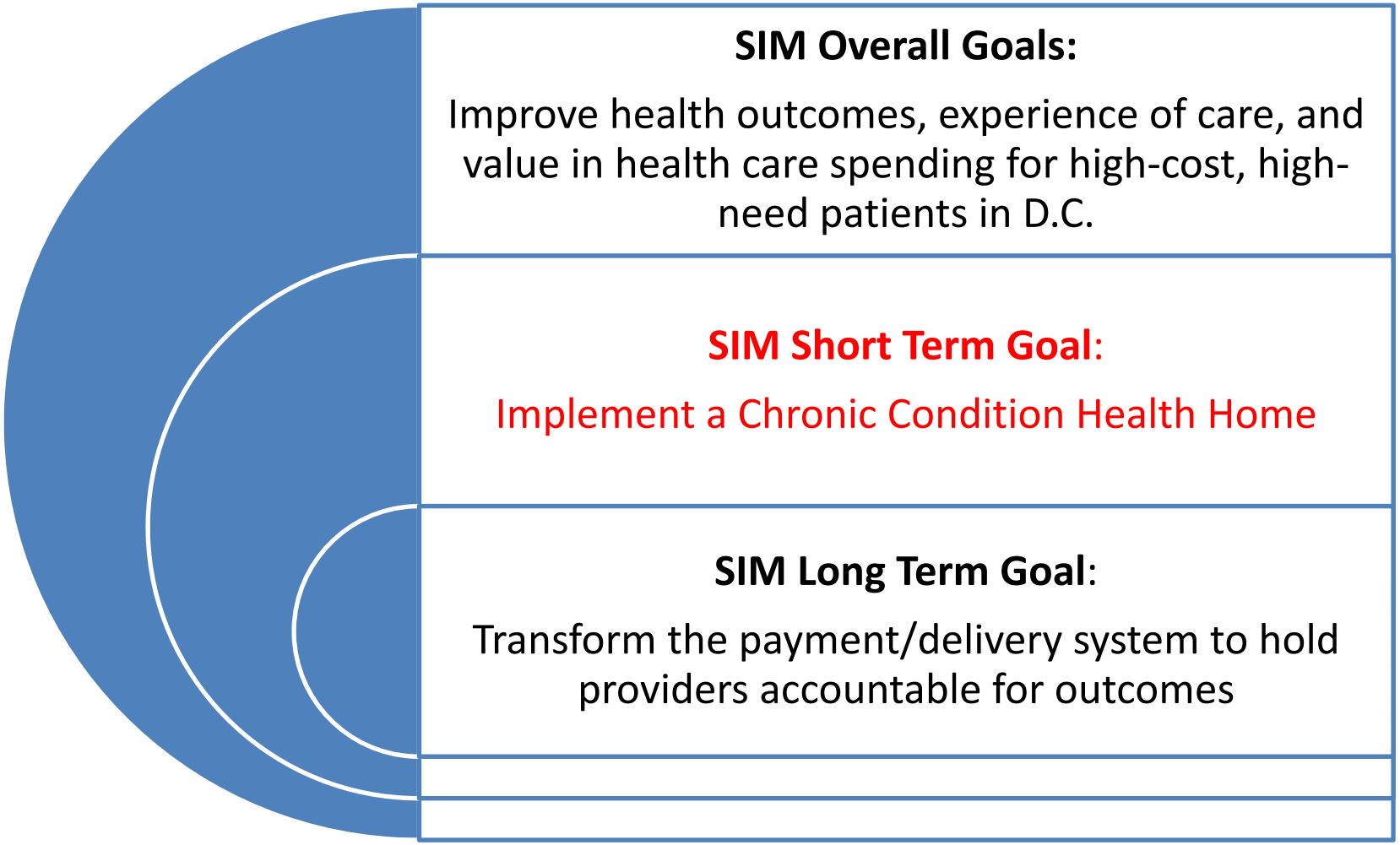

Chronic Condition Management Initiatives

Medicaid Health Home

- Program Summary: Pays providers to integrate and coordinate primary, acute, behavioral health, and long-term services and supports to treat the whole person

- Patient Eligibility:
  - Have 2 or more chronic conditions
  - Have 1 chronic condition and are at-risk for a 2nd
  - Have 1 serious & persistent mental health condition

- Mandatory Services:
  - Comprehensive care management
  - Care coordination
  - Comprehensive transitional care/follow-up
  - Health promotion
  - Patient & family support
  - Referral to community & social support services

- Eligible Providers:
  - Designated provider (e.g. physician, group practice, clinic)
  - Team of health professionals (e.g. physicians, nurse care coordinators, nutritionists, social workers)
  - Health team (e.g. specialists, nurses, pharmacists, nutritionists, dieticians, social workers)

Medicare Chronic Care Management (CCM)

- Program Summary: Pays physicians ~$40 PMPM for care management (outside of face-to-face visits) that includes at least 20 minutes of clinical staff time

- Patient Eligibility:
  - Patients with 2 or more chronic conditions lasting at least a year

- Mandatory Services:
  - 24/7 care management services
  - Continuity of care via a designated practitioner
  - Care transition management
  - Creation of an electronic patient-centered care plan
  - Enhanced chances to communicate with provider
  - Home and community-based services coordination
  - EHR utilization for structured recording of clinical data

- Eligible Providers:
  - Physicians and non-physician practitioners (Certified Nurse Midwives; Clinical Nurse Specialists; NPs; and PAs) may bill the CCM code
  - Clinical staff can provide the CCM service incident to the services of the billing physician under general supervision of a physician

Chronic Conditions Health Home

- Target Population
  - FFS & MCO individuals with 2 or more chronic conditions, or 1 chronic condition and at risk of another
  - One risk factor could be chronically homeless

- Payment Tiers:
  - Low Acuity = 2+ Chronic Conditions and/or 1 Chronic Condition + Risk Factor
  - High Acuity = High-cost/High-need

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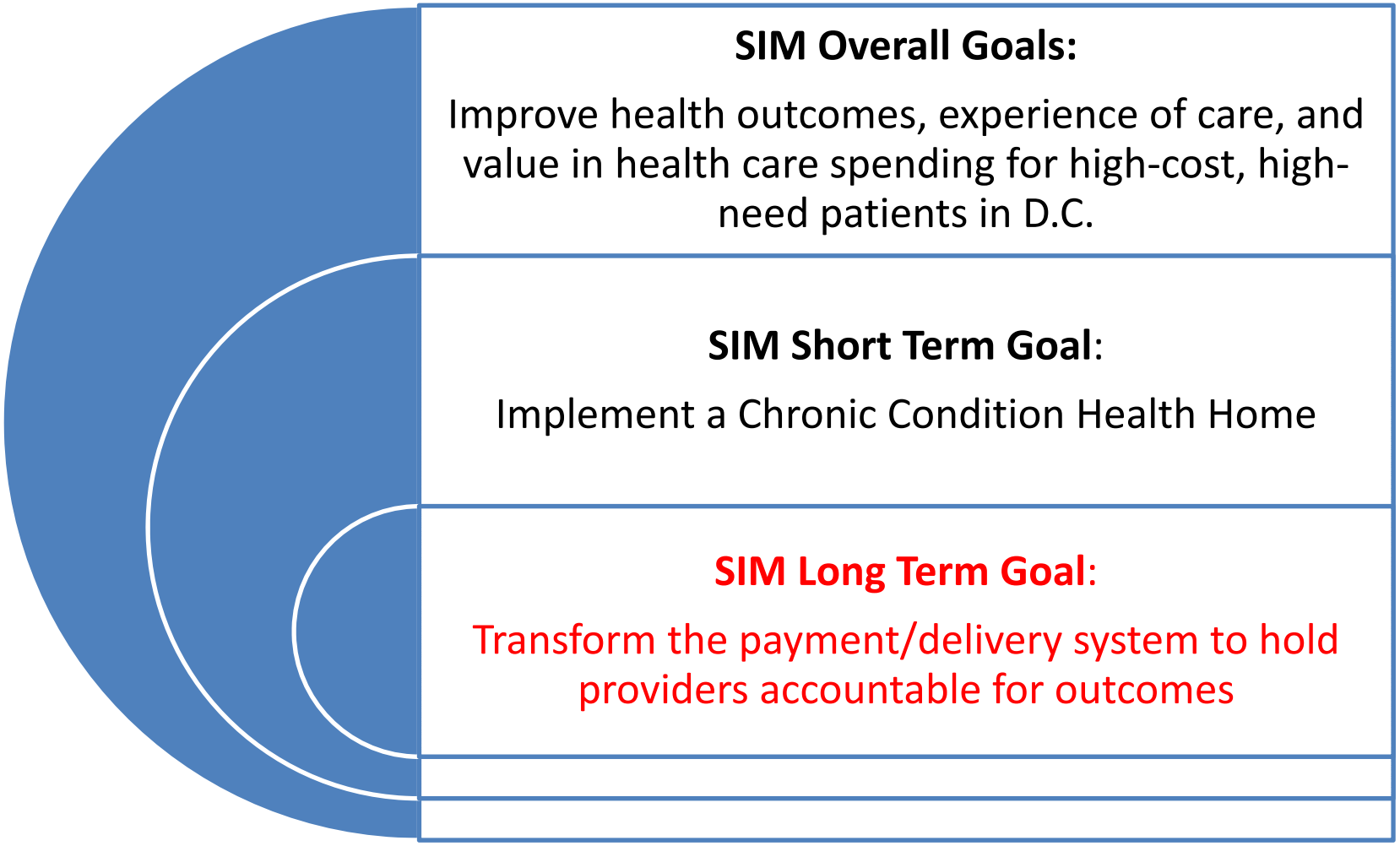

Role of the Advisory Committee

Key Elements of the SHIP	Responsible Work Group(s)	Key Issues to Address
Health System Design and Performance Objectives	Quality Metrics Care Delivery Payment Models	• Agree on and align core set of quality measures • Identify sub-populations in need of targeted interventions • Tie quality measurements to payment
Value-Based Payment and/or Service Delivery Model	Payment Models	• Reduce duplicative care coordination efforts and incorporate social services into intervention • Identify promising payment models and determine level of financial risk and risk-adjustment
Plan for Health Care Delivery System Transformation	Care Delivery	• Identify appropriate staffing models and provider eligibility for Health Homes • Identify policies that build off of Health Homes to increase provider accountability
Plan for Improving Population Health	Care Delivery Community Linkages Quality Metrics	• Identify sub-populations to target for future interventions • Use payment to address social determinants of health • Include population-based quality measures
Health IT Plan	HIE	• Identify and design tools to support provider coordinate care and for future needs as payment/delivery models change
Workforce Development Strategy	Care Delivery Community Linkages	• Identify workforce gaps and propose solutions to support care coordination and future workforce needs as payment/delivery models change