



Provider Rate Setting Process

Provider Reimbursement Interim Study

August 17th, 2016

June 27 Meeting Follow Up

Follow up with providers regarding cost reporting process.

1. Do you have recommendations for efficiencies/changes related to the cost report process?
2. What alternative format or tool would you recommend DSS establish its rates with?
3. If alternatives are identified, identify the impact that tool would have if any on the rate methodology currently used.

June 27 Meeting Follow Up

Feedback:

- Majority of providers prepare cost reports for other payers (Medicare, etc.) or to internally establish costs of service provision.
 - Hospitals
 - Nursing Homes
 - Behavioral Health
 - Residential Treatment (PRTF/Group Care)
- Will continue to work with these groups to identify methods of streamlining the cost report.

June 27 Meeting Follow Up

- Other provider groups – In-Home Services (homemaker/nursing), Assisted Living
 - Don't typically report costs for other payers.
 - Difficult to allocate nursing/homemaker in a larger organization.
- Discussing alternative approaches for these groups:
 - Salary and Wage Survey
 - Establish rates relational to other payers
- Next Steps:
 - Continue working with hospitals, nursing homes, behavioral health etc. to streamline cost reports.
 - Further discuss alternatives with provider groups/stakeholders.

Health Homes

- Health Homes provide enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses to improve health outcomes and reduce costs related to uncoordinated care.
- By providing the Six Core Services, cost of providing care decreases and health outcomes improve.
- Program design and implementation developed using Health Home Implementation Workgroup - a broad stakeholder group of health home providers.

Six Health Home Core Services

- Comprehensive Care Management
 - Comprehensive Care Management is the **development** of an individualized care plan with active participation from the recipient and health home team members.
- Care Coordination
 - Care coordination is the **implementation** of the individualized care plan that coordinates appropriate linkages, referrals, and follow-up to needed services and supports.
- Health Promotion
 - Health promotion services **support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self manage their health.

Six Health Home Core Services

- Comprehensive Transitional Care
 - Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community. Especially after an ER Visit or Hospital Stay (72 hour follow-up).
- Recipient and Family Support Services
 - Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes.
- Referrals to Community and Social Support Services
 - Referrals to community and social **support services** provide recipients with referrals to support services to help overcome access or service barriers, increase self management skills and improve overall health.

Provider Capacity as of July 1, 2016

- Current Number of Health Homes – 119 serving 122 locations
 - FQHCs = 25
 - Indian Health Service Units = 11
 - CMHCs = 9
 - Other Clinics = 74
- Current number of designated providers - 584

Recipient Participation as of Payment Dates

- Recipients are placed into 1 of 4 tiers
 - Tier 2-4 are automatically assigned if health home is available.
 - 75-80% of the highest cost/need recipients who have a health home in their area are participating.
- As of July 26, 2016, there were 5,681 recipients in Health Homes.

Type HH	Tier 1	Tier2	Tier 3	Tier 4	Total
CMHC	21	195	405	121	742
IHS	10	1,064	606	240	1,920
Other Clinics	66	1,741	837	375	3,019
Total	97	3,000	1,848	736	5,681

PMPM Reimbursement

- Providers are reimbursed for core services on a per member per month basis.
 - FY16 total expenditures: \$3.6 million (\$1.0 M general)
- Non-core services are reimbursed separately based on DSS fee schedules.
- Core Services were new and no historical cost information available when the program began in August of 2013.

PMPM Reimbursement

- Working with the Implementation Workgroup core services payment methodology was established for per member per month reimbursement rates using the average cost of uncoordinated care for individuals within the Medicaid program.
- Implementation Workgroup recommended gathering cost information to validate PMPM costs.
- Isolating core services within larger clinic practices and providers identified as a challenge in submitting cost reports.
- In 2015 a subgroup of the larger Implementation workgroup was formed to develop method to gather cost information regarding core services provision and validate PMPM costs relative to PMPM rates.

Health Home PMPM rates

- Cost Report Subgroup met several times, developed hybrid cost report that targeted personnel costs and common method of developing operating costs.
- Analysis indicated that PMPM payments in the aggregate were commensurate with actual costs. However, adjustments of PMPM rates within tiers was necessary.
- 2016 PMPM payment schedule

CMHC	Payment	PCP	Payment
Tier 1	\$9.00	Tier 1	\$9.00
Tier 2	\$33.00	Tier 2	\$29.00
Tier 3	\$48.00	Tier 3	\$49.00
Tier 4	\$160.00	Tier 4	\$250.00

Preliminary Outcomes

- Population health and care management programs include a very small subset of the larger population. Longitudinal data collected over time is necessary to identify both clinical outcomes and cost effectiveness.
- National studies suggest that outcomes and cost of care for health home programs are challenging with smaller numbers of health home participants.
- Minnesota implemented their program in 2008, published outcomes and cost study in 2015.
 - Did not include first two year's of the program.

Preliminary Outcomes

- Health Homes reports 43 data elements which make up 31 outcome measures. Each of the types of Health Homes also report a set a patient experience questions. Outcome for the program years FY14-FY15 showed improvement on 11 outcome measures.
 - Remaining measures require 2-3 years to establish a baseline.
- A detailed summary of clinical outcomes for 2014-2015 can be found at: <http://legisonenote.sdlegislature.gov/Web/default.aspx?id=300>.
- As the program matures, anticipate improvements in consistency in reporting outcome measures. Revisions to certain measures were implemented for SFY2016.
- Clinical outcome data for FY2016 will be submitted in the fall of 2016.

Preliminary Outcomes

- Preliminary cost analysis for 2014-2015 included analysis of primarily utilization.
- Modified interrupted time series regression to establish correlation between health home core services and utilization.
- Analysis focused on individuals in a health home at least six months during the first two years of the program.

Preliminary Outcomes

- First two years of the program shows an average decrease of 1.2 claims per recipient.
 - Decreased inpatient and outpatient (ED)
- Annual cost avoidance of \$2.5 - \$2.7 million.
- Results are promising – need more program experience to fully assess savings.
- FY16 claims data will yield another year of historical expenditure data. Analysis will be conducted over the course of the next several months. Continuing to isolate individuals that have been enrolled in a health home at least 6-12 months and further refining utilization data.