South Dakota Health Home Implementation Work Group Meeting Minutes
March 14, 2017
Drifters – Ft. Pierre
10:00-2:00 CT

Work group Members in Attendance: Dr. Mary Carpenter, Vanessa Sweeney, Sandy Crisp, Terry Dosch, Mark East, Joan Friedrichsen, Nancy Haugen, Mary Beth McLellan, Kathi Mueller, Kelsey Raml, Colette Hesla, Sarah Aker, Senator Alan Solano, Brenda Tidball-Zeltinger, Johanna Barraza-Cannon, Amy Iversen-Pollreisz

Others in attendance: Dalene Beetem, Jean Foos, Kevin Dewald, Mandi Atkins, Stacie Davis, Alicia Collura and Vonita Gardner.

The members of the South Dakota Health Home Implementation workgroup convened on March 14th in Pierre. While the meeting was in person, several members joined by phone.

After a round of introductions, Brenda Tidball-Zeltinger introduced Johanna Barraza-Cannon, who is currently serving as the Interim Medicaid Director. Johanna shared a bit of her background with the group.

General Update – Provider Capacity:

Kathi Mueller provided the general update to the group. Currently, the number of Health Homes is 119 serving 122 locations. Bennett County Community Health started effective 01.01.2017 and Avera St. Benedict Tripp ceased operation as a Health Home on 12.31.2016 due to the small number of attributions. Both were RHC's which left the numbers at 119. The recipients who were at Tripp were transferred to Parkston and continue to receive services there.

Increasing participation in the health home program requires expanded capacity especially for individuals in Tiers 2-4. She outlined missing clinics in key areas: 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 and Yankton Medical Clinic.

Kathi sought ideas from the group on how to expand capacity. The group suggested the biggest barrier to the program was the data extraction from different EHRs. Another barrier is additional staffing to effectively provide the core service. One suggestion was to develop a list of established clinics that are willing to mentor new clinics. Joan shared how this concept worked well with Coteau des Prairie hospital. The group suggested that because of the barrier of data extraction, DSS should try to match new clinics to mentors who have the same Electronic Health Records. Alicia Collura and Mary Beth McClellan agreed to try to reach out to the Center for Family Medicine the residency clinic in Sioux Falls. Additionally, Sandy Crisp gave and update on the status of Avera Medical Group in Mitchell. Kathi will reach out again to Mobridge, Huron and Yankton and follow-up with Mark Wheeler on the status of Winner Regional Medical Clinic.

Recipient Participation:

Participation as of the end of 2016 was 5,862 recipients with an average participation throughout FY 2016 of 5,806 recipients. There was an issue with the attribution programming as a result of the implementation of ICD-10. The issue created an abnormally low attribution throughout the year, but was identified and fixed in October resulting in a very large attribution for the month of December 2016.

Kathi shared a chart which contained the most recent participation by Tier by type and a graph with the average trend line of recipients by type of Health of Home since the program's inception in July of 2013.

Kathi shared a bar graph of individuals who had opted out with the following caveats. 1) The information provided is a snapshot in time; 2)the data on opt out reasons fluctuates on a daily basis; 3) true tracking of opt out reasons was not completed or standardized until the beginning of 2014; and 4) most opt out in 2013 are categorized as Recipient Choice of Patient Not Interested. Kathi then discussed how the different opt outs were categorized on Page 9 of the Power Point and shared the bar graph of a snapshot in time found on Page 10 of the Power Point.

The group discussed ways to increase participation. The biggest way to increase participation is to increase the capacity as discussed above there was also discussion about how to improve engagement strategies. There was discussion around the letters and brochure DSS uses to engage recipients and all agreed that it was time to re-evaluate the marketing of the program. DSS will formulate new drafts and pull together the group for review.

It was suggested that recipients may be better attributed by a physician rather than the DSS. Kathi shared the original discussion held in the Health Home work group used to design the program. The group agreed the use of a physician attribution process would allow clinics to cherry pick the easiest recipients to manage rather than work with the sickest and most challenging personalities. Kathi reminded the group of the manual tier option. Those who had used the manual tier process indicated it was working well.

Sarah Aker raised a discussion about working with the systems to help train ER personnel about the Health Home program so they can refer recipients to existing Health Homes. DSS will continue to flesh out this idea.

Collette Hesla indicated there may be confusion about the different programs offered at the FQHCs around the state.

There were several suggestions about how to improve the information around Health Homes. DSS will review the suggestions as part of the letter and brochure review above. And bring back the results to a smaller group of individuals for review and approval.

Health Information Exchange Update:

Kevin Dewald provided a general update about the Health Information Exchange (HIE). See accompanying Power Point and materials for more specific information.

Mandi Atkins provided an update one the recently completed Notify product through the HIE. She shared the fee stricter of $25 per member per year. This fee is not for a specific recipient and the recipients could be interchanged as the recipients moved in and out of the program. The group asked several clarifying questions about the Event Notification Module of the HIE. The group agreed HIE usage should be a regular metric for the Health Home program.

Stacie Davis provided information about the clinical engagement services provided by Health Point to their members. Clinical Engagement allows Health Point to work with clinic staff to indicate how the HIE can better be used in their day to day work flows.

The group discussed the HIE export from the new Online Provider Portal. Kathi indicated there were several issues with the addresses provided in the export. Kevin Dewald suggested users were better off creating their own export than using the one provided by DSS. This would allow fields like SSN to be populated. SSN is a field currently not readily available on the recipient screen.

Vanessa Sweeney, Falls Community Health, raised an issue about having the address as one of the matching criteria. She indicated her clinic serves a vulnerable population who move around a lot and using the address as one of the matching criteria was not an effective way to match.

Online Provider Portal:

Kathi provided an update on the new DSS online Provider Portal. The DSS Online Provider Portal is live for caseload reports and remits; and forthcoming will be paid claims report and core services reports. The Core Services report for 01.01.2017-03.31.2017 would still be completed in Launch pad, but would eventually move to the portal as well. When the core service reports were moved to the online portal, DSS would start to group clinics by BNPI rather than creating a separate clinic number.

Patient Engagement Strategies:

Kathi shared a line graph of the percent of recipients in the health home program who were receiving a core service by quarter. While the trend line seems to increase, the quarter to quarter results are very volatile. (See Power Point on page 14). In previous work group discussions identified that the inability to provide a core service is in large part due to the challenge in making the first contact with the recipient. A policy created by the work group requires coordinators to contact the recipient no less than three times over 45 days using two different methods, before they can be removed from the caseload list as “no contact”. The requirement of 45 days automatically creates a 1 month stay in health homes. If they are unable to engage within the time period they can be removed at the end of the previous month, but no core service is provided.

The group discussed removing the occurrence in its entirety if there was no core service, but decided on improving the marketing and creating new benefits for individuals who use the program. DSS also agreed to explore the possibility of an engagement PMPM and other benefits such as lower copays or no copays which may create an incentive for individuals to participate.

Health Home Training Needs:

Kathi shared information about the training provided to health homes during 2016. This included training on outcome measures, the online provider portal and the four Health Home Sharing Sessions. Kathi indicated she needed to query the care coordinators again on the type of training needed and all training web resources can be found at http://dss.sd.gov/healthhome/training.aspx.

Members of the work group suggested more about the HIE, statistics and core services. Kathi will integrate these ideas into those submitted through the query done to all care coordinators.

Health Home Performance History:

Johanna reviewed the Health Home Performance History with the work group. She provided history of our performance analysis. An initial analysis was completed for the FY 2015 Legislative Session. Small numbers made it very challenging to do a great deal of analysis. Findings released at the January 2015 meeting included a reduction of 1.2 claims per member per month.

With a larger population in FY 2106 the Department took a new approach, which compared the cost of the top 5% recipients between 2013 and 2016. DSS is currently working with HMA to refine a comparison group methodology.

Johanna presented a set of slides shared with the legislature as part of the budget process. These slides can be found and reviewed in the Power Point on slides 20-24.

Other discussion

Explore shared savings:

Johanna walked the group through a set of slides which discussed other shared savings programs done by the Federal Government and outlined for the group the 5 steps for calculating shared savings. There was considerable discussion around shared savings with the group concluding that a subgroup should be appointed to look more closely at this issue. DSS will move forward at looking at this issue this upcoming year.

PMPM rate inflation:

Brenda Tidball–Zeltinger shared with the group the budget proposal included inflation for the PMPM payment made to Health Homes to provide the core service. She also indicated the final budget provided 0.3% inflation of provider rates. This is how rates will be increased in the future. Brenda also took some time to inform the group about federal Medicaid reform initiatives that may change the landscape of Medicaid in the future and DSS will look for opportunities to make changes in the Health Home program model as opportunities arise.

Alignment with MN Health Care Homes and MACRA:

Kathi indicated she had a request from Bonnie LaPlante, the Director of the MN Health Care Home Program to align our program with their program in the area of core services and outcome measures. MN Health Care Homes is not an approved Health Home program through the Affordable Care Act. It was done as part of Minnesota's Health Care Reform and encompasses a certification 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). There were several groups who expressed concern about moving to new measures.

Public Facing Health Home Metrics

As a high profile program, DSS proposes to add new data as it is available to the website to promote transparency. DSS will start by adding the number of recipients participating on a monthly basis and move to posting aggregate outcome measures on a bi-yearly basis with more emphasis on process measures vs clinical measures. Finally, when it becomes available the financial information will be added as well.

Senator Alan Solano expressed his concern about the financial burden of EHR programming required every time DSS and the Quality subgroup change the health home outcome measures. Kathi indicated the recent changes have been associated with measures needing further clarification. DSS will work with the group would try to reduce the number changes made.

Next meeting:
DSS agreed to call the group back together when the results of the comparison group analysis were completed and ready for review. There will be a subgroup formed around the shared savings topic and the additional work done by the existing quality subgroup. DSS will continue to work with the stakeholders as issues arise.