Health Home Implementation Workgroup
Meeting minutes for September 30, 2013 meeting
AmericInn, Ft. Pierre, SD

Members in attendance: Barb Smith, Tony Tiefenthaler; Mark Wheeler, Joan Friedrichsen, Sandy Giovannettone, Mary Beth McLellan, Kathy Jodheka, Terry Dosch; Alan Solano, Shawn Nills, Alicia Collura, Kristin Griffith, Sandy Crisp, Nancy Haugen, Dayle Knutson, Kim Malsam-Rysdon, Kathi Mueller; Ann Schwartz; Kirby Stone, Brenda Tidball-Zeltinger, Amy Iverson-Pollreisz, Leah Ahartz, Jean Reed

Others in attendance: Mark Johnston, Byron Okutsu

Meeting Minutes:
The meeting began with introductions and a thank you to all of those who have participated in the Health Home implementation process. Specific acknowledgement was given to the Health Homes who are now providing services to qualified recipients. The Health Home Implementation Workgroup is comprised of members representing the initial Health Home Workgroup and those who are now responsible for Health Home daily operations.

DSS Secretary Kim Malsam-Rysdon provided a general update on the status of the Health Home State Plan Amendment. She indicated that the State Plan Amendment was submitted with comments from the tribe and public to address two specific areas. These include the 72-hour vs. 48-hour follow-up contact after discharge and the licensure requirements of providers and IHS. She also indicated that CMS issued several questions back to DSS and responses to CMS are in process.

An overview of provider capacity was given. There are currently 109 active Health Home locations. The total consists of FQHC's, CMHC's, IHS units and private clinics. The group reviewed a map of the locations. It was noted that DSS is taking steps to increase capacity by outreaching clinics in geographical areas that are underserved. All Health Homes completed the orientation training prior to their start date. The orientation evaluations showed a positive response to the training. Evaluations showed increased knowledge of the Health Home program an average of 1.2 points on a 4-point scale.

The group was informed that small changes have been made to the attribution methodology since implementation. Changes included adding pregnant women if they have the conditions necessary to qualify and including two Assisted Living facilities that target those with mental illness in the standard attribution rather than moving them to Tier 1 with other long-term care facilities. It was noted that DSS is reviewing the attribution of tier 4 kids that are eligible for both a CMHC and clinic Health Home and how the timing of opt outs impact the PMPM payment.

Current attribution numbers were reviewed indicating there are currently 5,391 recipients in a Health Home, 2,879 recipients have opted out and 166 recipients have opted in. Those in attendance indicated that they are willing to outreach recipients who have opted out, but would be assigned to their clinic as a continuity of care recipient to encourage participation.

The next item addressed was the Transition of Care Notification requirements that are currently required. The current requirement is as follows:

> HH must have agreements or a method in place to receive notification when a recipient is admitted to the hospital or seen in an ER within 24 hours as well as any transitions that may occur to ensure information is received from other systems when a recipient is transitioning from one care setting to another or home. HH must contact the recipient within 48 hours after the transition occurs.

It was noted that based on comments, the State Plan Amendment was submitted with a broader 72 hour requirement. DSS is awaiting response from CMS. DSS shared information about other states' approaches for meeting this requirement. Regardless of the timeframe of the requirement (48 hours or 72 hours), there is a need to have a notification system in place that supports the sharing of this formation. This will be needed to support the goal which is to assist individuals in transitioning from one setting to another without a resulting readmission.

DSS noted programming is being developed to allow providers to check Health Home eligibility and provider name via the IVR and card swipe.

The group had extensive conversation regarding methods that would assist Health Homes in providing the transition of care core service. Suggestions included having the Health Home name on the recipients' identification card, which would assist in alerting providers they should communicate with the Health Home. It was also suggested information be reported to DSS who in turn would notify the Health Home. A process currently used in Iowa and North Carolina requires providers notify Medicaid whenever a Medicaid member presents to the ER. This information is then forwarded to the respective Health Homes. It was felt having a list of the transition of care contact at each Health Home would help this process, so each Health Home will be asked to submit the contact person to Kathi Mueller who will compile a list to be posted on the DSS website. The discussion concluded with attendees agreeing to work with one another by using the contact list to share the necessary information.

The process for referrals was discussed. Health Homes were asked to replace the paper referral card with an electronic referral form whenever possible. A new referral form template was provided and reviewed. Health Homes were encouraged to incorporate the new template into their respective electronic health records. It was noted that when a referral is from a CMHC, the referral would include the servicing NPI of the designated provider. It will also include the billing NPI of the CMHC, which should be used for billing purposes.

Next, it was reported that a performance measurement system is being developed and implemented. The intent is to report performance results from the recipient level, disease category, designated provider, health home type, aggregate data and financial information. Implementation will occur in a phased approach starting with baseline performance reports.

During phase I of the performance measurement system, outcome measure reporting will be modified to address reporting issues that have been identified and reported by Health Homes. When this is complete a new file layout will be provided to the Health Homes. The implementation plan will include a testing phase. Health Homes were asked to volunteer to participate in this testing process. Volunteers included Dayle Knudson (IHS), Alan Solano (CMHC), Tony Tiefenthaler (Sanford), Mary Beth McLellan (RCR) and possibly Brown Clinic. Brown Clinic will follow-up with Jean Reed.

The reporting schedule for Health Homes was distributed. The schedule addressed the quarterly core service report and the specific process that will be used. The schedule also addressed the method of reporting for biannual outcome measure data. It is expected that the first set of reports will be available the end of March early April. In addition to collecting the specific outcome data it was suggested that anecdotal, real life stories be captured as a means to communicate the positive impact the program is having on people's lives.

Several next steps were reviewed. This included cost reporting requirements and the evaluation phase that will encompass Health Home performance, utilization trends and shared savings opportunities. Specifics are as follows.

The process for assessing the accuracy of the initial PMPM payments was reviewed. It is expected that analysis will be completed to initially review actual costs at the six-month and nine to twelve month marks. The six-month review is expected to look at implementation costs and ongoing operational costs. DSS will provide the Health Homes with the report to be submitted.

The outcome measures will provide data for the clinical and utilization components of the evaluation. Additionally, DSS will continue to work with Sellers Dorsey to evaluate tier movement, utilization changes, etc.

CMS has recently issued guidance on shared savings. CMS has stated that savings may not be based only on cost savings; but must account for improvements in quality and health outcomes. Shared savings methodologies need to focus on mitigating risk, be able to realize rewards, and be easily replicated by CMS nationally if so desired. Requirements include an actuarial analysis, benchmarked performance against a recognized standard, and compliance with all other Medicaid tenets, which includes free choice of providers. The CMS letter outlining the details of shared savings methodologies was distributed to the group. Shared savings will continue to be an area of focus.

It was suggested that a review of other states' approaches to shared savings be undertaken to inform the future development of a model in South Dakota. .

The group discussed future education needs. This included additional information on outcome data submission, interim cost reporting and updates that address program changes. Time for additional discussion will be included on the next meeting agenda.

In closing, the group was again thanked for their participation and ongoing commitment to Health Homes. The next group meeting will be planned for the next quarter and is expected to be a teleconference.