Health Home Implementation Workgroup
Meeting Minutes
January 13, 2016
Via Conference Call

Members in attendance: Sandy Crisp, Terry Dosch, Dr. Mary Carpenter, Kathi Mueller, Brenda Tidball-Zeltinger, Ann Schwartz, Kathy Jedlicka, Mary Beth McClellan, Mark East, Collette Hesla, Nancy Haugen, Kelsey Raml, Joan Friedrichsen, Mark Wheeler and Jean Reed.

Others in attendance: Andrea Heronimus, Jessica Paxton-Deal, Karla Kirkpatrick, Linda Reidt - Kilber, Torrey Sundall, and Vanessa Taylor.

Health Home Performance Analysis
Financial Measures
Brenda Tidball-Zeltinger shared that the Department of Social Services (DSS) has been working diligently with Health Management Associates (HMA) to finalize cost avoidance analysis. DSS has very preliminary utilization results indicating that overall there was a reduction of 1.2 claims per month; a 14% overall reduction in the average number of monthly claims for Health Home recipients. The average monthly claim reductions occurred across multiple services including inpatient hospital services, non-emergency outpatient services, emergency department services, and prescription drugs. DSS will continue to refine the cost impact these results have on program cost effectiveness and individual tiers. Initial results indicate the Health Home program is self- sustaining.

Brenda shared a case study demonstrating the impact of Health Homes on a specific participant.

Outcome Measures
Kathi Mueller presented information on the Health Home Outcome Measures. She provided background information to level-set that Health Homes report outcome measures on all participants who received a core service. These measures are reported to the State bi-annually. PCP Health Homes report data for 33 outcome measures and CMHC Health Homes report data for 35 outcome measures. Data is also collected from both groups to gather satisfaction information.

Kathi reminded the group that after two reporting periods, an Outcomes Subgroup was convened to review issues around definition of the measures and to identify measures that needed to be revised or removed. Substantial changes were made to many of the measures to ensure consistency of data reporting across Health Homes. The revised definitions were effective 07.01.2015. Kathi also indicated that in the summer 2015, DSS procured HMA to assist in data collection and reporting.

Kathi indicated that the outcomes measures being presented include those that had maintained enough consistency across the four reporting periods to provide valid data or focused on those which address the leading chronic conditions within the Health Home population. She reminded the group that the participants in the Health Home program fluctuate on a monthly basis. Every month new recipients join and others become ineligible or choose to no longer participate and that the data provided has not been controlled to measure the same recipients within both time periods.

She then shared information about 15 of the measures selected to present to the group.

Kathi presented data about the demographics of Health Home recipients using a snap shot of recipients from the last quarter payment. The demographic data included information about the age of recipients where she noted that the Health Home population is significantly older than the standard Medicaid population. When reviewing why recipients meet the qualifying criteria she noted that 52%

of recipients became eligible due to a Severe Mental Illness or Severe Emotional Disturbance; number of eligible conditions where it was noted that 48% of the population had 3-6 Chronic Conditions; distribution by Tier where it was noted that 54% of the population were in Tier 3; and the distribution by Health Home Type where other PCP Health Homes serve 53% of the population.

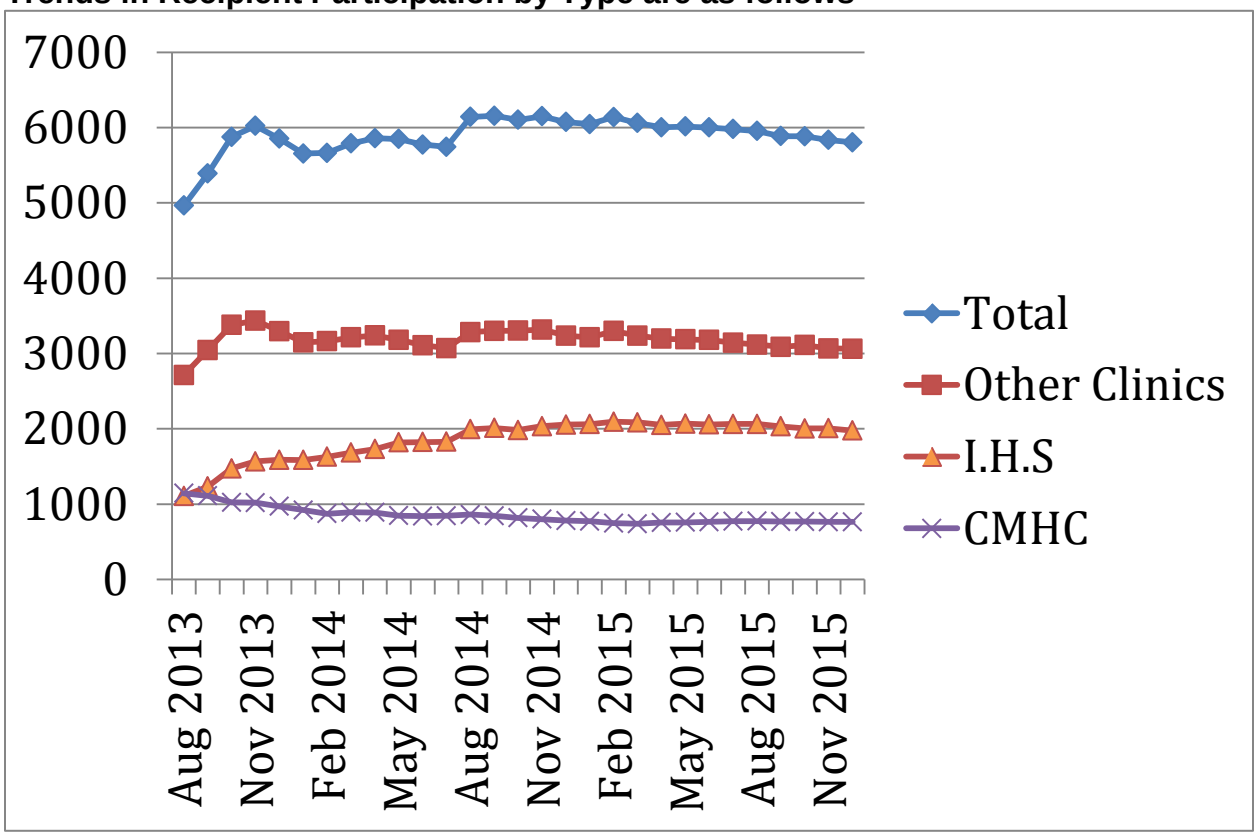
General Update
Provider Capacity
Kathi Mueller provided a general update on provider capacity. As of January 1, 2016, there were 119 Health Homes serving 122 locations. This consists of 25 FQHCs, 11 IHS units, 9 CMHCs, and 74 other clinics. Currently, there are 584 unduplicated designated providers and 637 duplicated designated providers. There were 6 new Health Homes, which began to provide services effective January 1, 2016. These include Avera Aberdeen and Sioux Falls Internal Medicine and the four Rapid City Medical Centers in Rapid City. These 6 clinics greatly expanded the capacity to serve recipients in the Health Home Program.

Kathi shared that they continue to work with Mobridge Regional Hospital, Huron Regional Clinic, and Winner Regional Clinic to explore participation beginning with the April 1, 2016 quarter.

Kathi noted that the number of recipients remains relatively stable at around 6,000. As of December 29, 2015, there were 5,803 Health Home recipients. Kathi did note that while the number has recently dipped, that decline is due to a change to provider records associated with one group of providers. She indicates that this issue was completely resolved by January 1, 2016. The breakdown is as follows.

Type HH	Tier 1	Tier 2	Tier 3	Tier 4	Total
CMHC	19	225	408	112	764
IHS	10	1,095	614	258	1,977
Other Clinics	69	1,806	826	362	3,062
Total	98	3,126	1,847	732	5,803

Trends in Recipient Participation by Type are as follows



Recipient Eligibility

Kathi reminded the group that people eligible for Health Homes fall into two groups. The first group is Tier 1, which accounts for over half of all eligible recipients. Tier 1 recipients are not automatically enrolled in the program because they are not the high cost/high need people the program is focused on, but per federal requirements must have the ability to opt-in.

The second group is Tiers 2 – 4 recipients. These recipients are automatically enrolled in the program and include the high cost/high need population that will realize the most benefits from the program.

Eligibility Stats are as follows:

- Tier 1 not priority high cost/high need claimants.
  - 98 participating
- Tiers 2-4 – high cost/high need target population
  - 5,743 actively enrolled
  - Automatically enrolled in the program.
  - This group includes the high cost/high need population that will benefit most from management through the Health Home program.
  - 7, 400 of the eligible have a Health Home in their area
  - 75-80% of the highest cost highest need recipient who have a Health Home in their area are participating in the program.

- Increasing the numbers served requires increasing capacity, specifically in the following counties: Beadle, Butte, Custer, Davison, Faulk, Fall River, Lawrence, Lake, Meade, Pennington, Yankton and Walworth.

- Priority is to expand capacity for those with Tiers 2 – 4 eligibility.

Health Home Trainings

Kathi reported that training on the refined outcome measures was provided in early December. After this next data submission, DSS will work with HMA to determine if additional training needs to be provided in this area.

Kathi also shared that all of the Health Home Sharing Sessions were a success and that feedback was very positive. 98% of attendees indicated they would be interested in attending a sharing session again. Because of the response, Kathi indicated that they would most likely do the sharing sessions again in the Fall of 2016.

Patient Engagement
Kathi indicated that 76.53% of recipients enrolled in the program received a core service during the July-September 2015 quarter. This was a decrease from 76.91% in the previous quarter.

Vanessa Taylor and Sandy Crisp indicated that the challenge has been to engage recipients initially and because of the requirement of the 45 days, they showed up on the quarterly core service report and the have to indicate that no core service was provided.

There were no success stories shared at the meeting. Kathi asked that Workgroup members look to their teams and forward any stories directly to her.

Health Information Exchange
Kathi provided an update on the HIE Event Notification. She indicated that per Kevin Dewald, the South Dakota Health Link had completed the contract negotiations for the Event Notification piece of HIE. Development is expected to begin at the end of January and will last approximately 90 days. Once developed, DOH and DSS will work with selected Health Homes to test the product.

Online Caseload Reports
Kathi provided an update on the progress made towards online caseload reports which are currently under development and should be available for the March 2016 caseload reports. She indicated that the reports can be found on the same portal as the Quarterly Core Service report. The individuals with access to the Quarterly Core Service report will also have access to the online caseload report. The online caseload report will be able to be printed and downloaded into an Excel Format.

Upcoming Meeting Dates
Kathi recommended that the Workgroup move to bi-annual frequency in 2016. She indicated that subgroups can be formed to work on challenging issues or new policies and updates will be made to the Health Home Workgroup on a regular basis. She indicated that the Quality Subgroup will need to be reconvened to examine the quality of the data submitted by Health Homes and to establish targets for each measure. This is required in order to propose a future Shared Savings Methodology, which would then be one other possible subgroup to address the topic of Shared Savings.

LivingWell@Home
To close the meeting, Sherrie Petersen from the Good Samaritan Society presented the LivingWell@Home program which helps monitor recipients in their homes. Sandy Crisp commented on how the program was working with some of their coordinated care/Health Home recipients.

Kathi indicated that this would be a program option that Health Homes could pursue, but the payment would need to come out of the PMPM already provided by DSS. There would be no additional payment from DSS. Kathi asked the groups next steps and they indicated that they would handle on their own at the system level.