2024 Health Home Sharing Sessions

The Health Home Sharing Sessions were held in Sioux Falls on September 10, 2024, Watertown on September 11, 2024, Pierre on September 12, 2024, and Rapid City on September 17, 2024. All meetings were held 9-1 at the local time of the location.

Kathi began by explaining the purpose and goals of the three Care Management programs which include:

- **Primary Care Provider Program:** Creates a Medical Home which improves recipients access to Medical Care and improves quality of recipient care. Approximately, 80% of Medicaid recipients are required to be in this program including those recipients who were made eligible through expansion.
- **Health Home Program:** Coordinates the care of Medicaid Recipients who have high cost and high needs which reduces the cost of care for these recipients and improves the health outcomes of the recipients who meet the criteria.
- **BabyReady Program for Pregnant Women:** Improves health outcomes for pregnant women and babies. Targets women who are less than 21 weeks gestation at enrollment.

Kathi then explained that she now has a team of 4 other individuals to help implement these three programs. She is working to transfer her knowledge to the other members of the team as she intends to retire in April of 2025. The other members of the team include:

- **Chris Soukup | Care Management Program Manager** Provides support needed for the Primary Care Provider (PCP) and Health Home (HH) programs during expansion; recommending and implementing enhancements to the PCP program to strengthen the program by implementing components that encourage improved outcomes and cost savings and facilitating policy decisions to make updates; provide technical assistance to providers about PCP/HH policies and procedures.
- **Dawn Schnabel | Care Management Program Assistant** Assist recipients with Primary Care Provider (PCP) and Health Home (HH) provider changes; enroll providers into the PCP/HH Program and update PCP/HH system; provide technical assistance to providers about PCP/HH policies and procedures; and provides support for recipients and providers using PCP/HH online tools.

- **Valerie Kelly | BabyReady Program Manager** Implement and oversee the BabyReady Program. The BabyReady Program seeks to offer enhanced care management services by obstetric care providers to pregnant Medicaid recipients. The program will provide incentives to providers to offer services in accordance with standards of care through quality improvement initiatives to achieve better health outcomes.
- **Sarah Houska | Care Management Program Specialist** Works with the Primary Care Provider (PCP) and Health Home (HH) programs as well as assists the BabyReady Program Manager to implement and run the BabyReady Program. This position helps with the day-to-day functions of the Care Management Programs.

Kathi shared the conditions that make individuals eligible for the Health Home Program. The conditions include the following:

- **Any** Medicaid Recipient who has….
    - Two or more chronic conditions or one chronic and one at risk condition. (Defined separately below)
        - **Chronic Conditions include** Mental Illness, Substance Abuse, Asthma, COPD, Diabetes, Hypertension, Obesity, Musculoskeletal and neck and back disorders.
        - **At Risk Conditions include** Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6 or more classes of drugs)
    - One Severe Mental Illness or Emotional Disturbance.
- Eligibility based on 15 months of claims data based on diagnosis.
- Recipients who meet the eligibility criteria are stratified into four tiers based on the recipient illness severity using the Chronic Illness and Disability Payment System (CDPS).

Kathi also discussed the methods used to place recipients on a providers caseload list, these include:

- Attribution through the Continuity of Care algorithm
- Assignment by a member of the Care Management team
- Recipient selection
- Manual tier request

Kathi also shared that QMB and SLMB Only recipients cannot be a part of the HH Program.

Kathi shared that as of October 1, 2024, NEMHC will discontinue providing Health Home Services leaving the State with 141 Health Homes serving 145 locations.

Kathi shared the average number of recipients in the Health Home Program by State Fiscal Year (SFY). In SFY 2019 there were 5954 to 6908 in SFY 2024. She also noted that the YTD average for CY2024 is 7689. She indicated that the number of recipients in August of 2024 was 8,474. Most of this increase is related to the number of Tier 1 individuals and individuals newly eligible due to Medicaid expansion which happened on 07.01.2023.

Kathi reviewed the tier update on the Health Home population last completed in December of 2023. Recipients went up or down one tier. If their tier changed, a new occurrence was created with the same provider for January 1, 2024. If no change, the occurrence remained the same. A Re-tier Caseload report was made available for all providers so Care Coordinators could determine the changes made to the recipients on their caseload. If the recipient dropped to zero, they were removed from the Health Home Program. Slide13 outlines the change to the Health Home population in the first two years of the tier update process.

Kathi indicated that in the upcoming year, they will transition the opt out removal process to a 36-month cycle to alleviate the workload on the Care Management team, as the current process generates a high volume of phone calls.

Kathi asked for feedback on the number of Tier 1 individuals in the program. Initially, DSS has asked the Care Coordinators to outreach the recipients who fell to a Tier 1 to determine if they needed the program. Due to larger caseloads, this activity has been a problem. There was a consensus in all 4 sessions that DSS should automatically remove recipients when they fall to a Tier 1.

Chris Soukup walked attendees through the QIP. Details can be found on Slides 16-19 in the PowerPoint. During this section, there was a question as to why the QIP did not consider the Substance Use questions. This is because we no longer collect that measure.

Kathi shared that the South Dakota Foundation for Medical Care (SDFMC) completed the review for Period 10.01.2023-12.31.2023. They reviewed 370 charts for 133 clinics. Initial results of the results can be found on Slides 22-24.

The team walked through the Online Resources available to Care Coordinators. Those can be found in slides 27-30.

Sarah Houska introduced the BabyReady Program to attendees. This is a new DSS program created to improve outcomes for pregnant women and babies. See slides 32-34 for additional information.

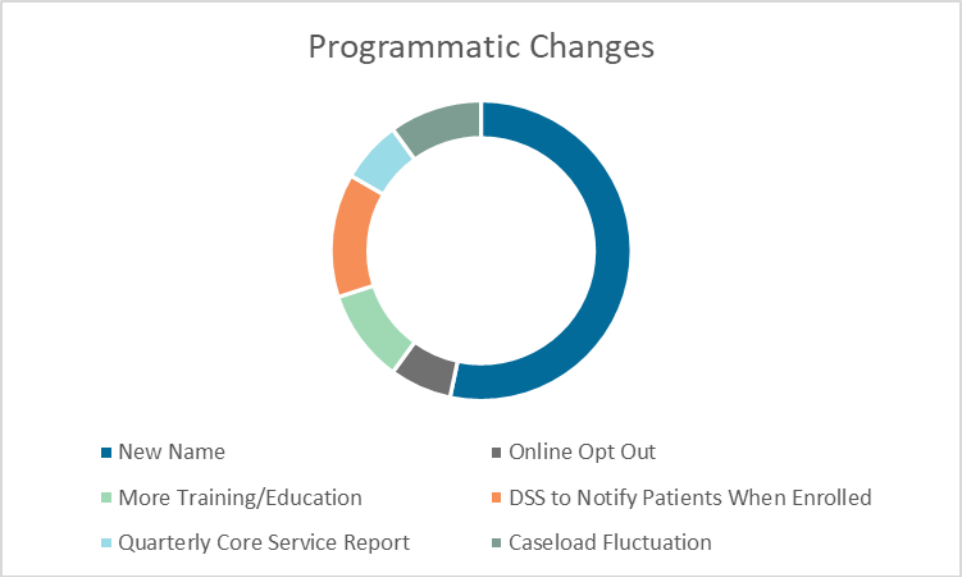
The team walked through reminders to make sure they are connected to the Health Home Listserv and to the Medical Services Listserv. See slide 36 for links.

Finally, the team expressed the importance of keeping us in the loop when providers leave and arrive, as well as when servicing address changes. Other items to keep DSS in the loop including change in Care Coordinators and/or data contacts, if training is needed, or when you are unable to make a reporting deadline. Attendees were also reminded to notify DSS when you find recipient information that is incorrect. Communication on these items should go to CMforms@state.sd.us.

Open discussions were held on the topics of Core Services, Care Plans, and templates/workflows.

Attendees were asked to provide one word that describes their Health Home. The following word cloud was developed using the words provided.

Attendees were also asked to provide one request for changing the program. The chart below summarizes the most requested changes.


Programmatic Changes
New Name
Online Opt Out
More Training/Education
DSS to Notify Patients When Enrolled
Quarterly Core Service Report
Caseload Fluctuation