Department of Social Services

Initiatives:
Money Follows the Person
Health Homes

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Medicaid Solutions Workgroup Initiatives

- The Medicaid Solutions Workgroup was established by Governor Daugaard during the 2011 Legislative Session.
- Solicited key stakeholder input to develop strategies to contain and control Medicaid costs while maintaining quality services for recipients.
- Two key initiatives identified for implementation:
  - Money Follows the Person
  - Health Homes

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What is MFP?

- Department of Health and Human Services Demonstration Grant, with transitions through December 2018
- Designed to assist states to balance long-term care systems and help Medicaid enrollees transition from institutions to community
- MFP demonstration services were authorized by Congress in the Deficit Reduction Act of 2005; and extended by the Affordable Care Act of 2010

SD MFP Eligibility

- Is a South Dakota resident and 18 years or older;
- Has been residing in a nursing facility, ICF/ID or other qualifying institution for more than 90 consecutive days;
- Meets Medicaid level of care and financial eligibility criteria at least one day prior to transition;
- Has at least one paid Medicaid day in a qualified institution;
- Will reside in qualified housing upon transition;
- Is willing to enroll in and can be supported in the community through the provision of an existing 1915(c)HCBS waiver; and
- Expresses a desire to live and receive services in a home and community based setting.

SD MFP Benchmarks

- Five MFP Benchmarks
  - Projected number of eligible transitions
  - Increase in Home and Community Based Service expenditures
  - Maintain transitions for at least one year
  - Participants treated how they want to be treated
  - Home and Community Based Services and Long Term Care workforce services receive training

MFP Roles

- **MFP Program Coordinator – Sara Spisak**
  - Overall oversight of the MFP Program
- **MFP Transition Coordinator**
  - Point person on transitions
- **MFP Participant**
  - Engaged in every step of the process
- **Transition Team**
  - Group of people who support the participant before, during and after transition

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MFP Roles

- **Aging and Disability Resource Connections**
  - Intake and referral
- **HCBS Waiver staff**
  - Crucial part of Transition Team and build continuity of care for post-MFP
- **LTC Ombudsman**
  - Outreach/training to long term care facilities
- **Community Development Specialists**
  - Community based experts engaged to support individual transitions

SD MFP Services

- MFP participant would receive services as authorized by the appropriate HCBS 1915(c) waiver
  - ADLS Waiver
  - ASA Waiver
  - CHOICES Waiver
  - Family Support

- Participant would also be eligible to receive MFP demonstration services as assessed by Transition Team

SD MFP Demonstration Services

- Transition Services
- Non-Medical Transportation
- Assistive Technology
- Consumer Preparation
- Behavior Crisis Intervention

Transition Stages of SD MFP

- Assessment Stage
- Planning Stage
- Moving Stage
- At Home Stage

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Assessment Stage

- Referral
- Initial Interview with Transition Coordinator
  - Meet eligibility requirements
  - Interested in transitioning
    (Wants/Needs and Behavioral Assessments)
  - Viable transition options
- Informed Consent
- Identify Transition Team members

Planning Stage

- Transition Care Plan
  - Participant working with Transition Coordinator and Transition Team to develop plan
  - Identify all needs and the potential risks
- Identify qualified housing
- Create Risk Plan, including 24/7 Back up Plan
- Assess for services needed in the community through providers of services

Moving Stage

- Complete MFP Quality of Life Survey prior to transition
- Discharge plan
- Assure actual transition proceeds smoothly

At Home Stage

- Follow up contacts
  - 2 days, 2 weeks, and 2 months or as needed
- Review care plan and service authorizations to confirm services are meeting recipient's needs
- Quality of Life surveys
  - Completed again at 11 and 24 months

Health Homes

Health Homes provide enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses to increase health outcomes and reduce costs related to uncoordinated care.

Health Homes

Medicaid Solutions Work Group

- Established during 2011 Legislative Session
- Goal to develop recommendations to contain and control Medicaid costs
- Maintain quality services
- Health Homes- established by the Affordable Care Act
  - 2 year demonstration opportunity with enhanced FMAP
- First recommendation of Medicaid Solutions Work Group
- DSS developed Health Home stakeholder planning workgroup to determine how to implement Health Homes in South Dakota

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Health Homes

A Health Home is NOT

- Health home is not home health
- In-home care
- A place where people live and receive care
- Patient Centered Medical Home

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Health Homes

What is a Health Home?

Health Homes provide person-centered care to achieve improved outcomes and reduced costs

Who's eligible?

- Medicaid recipients
- Two chronic conditions or
- One chronic condition and at-risk for second or
- Behavioral health conditions
- Up to 35,000 people on Medicaid

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Health Homes

Chronic Conditions- examples

- Asthma
- COPD
- Diabetes
- Heart Disease
- Hypertension
- Obesity
- Musculoskeletal and Neck and Back Disorders

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HH Population Disease Prevalence

	ADHD	Anxiety	Arthritis	Asthma	Bipolar	CAD	Cancer	CHF	COPD	Depression	Diabetes	Epilepsy	GERD	Hyperlipidemia	Hypertension	Lowback	Migraine	MuscSkel	Obesity	PeriphVasc	Schizophrenia	Sleep	SubAbuse
ADHD	14.9%	1.0%	0.0%	0.7%	0.9%	0.0%	0.0%	0.0%	0.0%	1.7%	0.1%	0.2%	0.2%	0.1%	0.1%	0.7%	0.2%	1.7%	0.1%	0.0%	0.1%	0.4%	0.3%
Anxiety		9.1%	0.5%	0.6%	1.0%	0.2%	0.2%	0.2%	0.4%	3.1%	0.9%	0.4%	0.6%	0.5%	1.0%	2.1%	0.4%	2.6%	0.2%	0.1%	0.5%	0.7%	0.4%
Arthritis			5.5%	0.5%	0.3%	0.6%	0.4%	0.5%	0.7%	1.0%	1.7%	0.2%	0.6%	0.7%	2.3%	2.3%	0.2%	3.7%	0.2%	0.2%	0.4%	0.6%	0.1%
Asthma				6.7%	0.5%	0.2%	0.2%	0.3%	1.1%	1.1%	1.1%	0.2%	0.5%	0.4%	0.9%	1.6%	0.3%	2.4%	0.2%	0.1%	0.3%	0.5%	0.1%
Bipolar					5.8%	0.1%	0.1%	0.1%	0.3%	1.8%	0.6%	0.2%	0.3%	0.4%	0.5%	1.2%	0.3%	1.7%	0.1%	0.1%	0.6%	0.5%	0.3%
CAD						3.2%	0.3%	0.7%	0.7%	0.4%	1.5%	0.1%	0.3%	0.7%	1.5%	1.0%	0.0%	1.2%	0.0%	0.3%	0.3%	0.3%	0.1%
Cancer							3.1%	0.3%	0.6%	0.4%	0.8%	0.1%	0.2%	0.3%	0.9%	0.8%	0.1%	1.1%	0.0%	0.2%	0.2%	0.2%	0.1%
CHF								3.1%	0.9%	0.4%	1.2%	0.1%	0.2%	0.3%	1.3%	0.7%	0.0%	1.1%	0.1%	0.3%	0.2%	0.3%	0.1%
COPD									4.8%	0.9%	1.6%	0.1%	0.4%	0.5%	1.5%	1.5%	0.1%	1.8%	0.1%	0.3%	0.5%	0.7%	0.2%
Depression										18.3%	2.1%	0.7%	0.9%	1.0%	2.0%	3.7%	0.7%	5.0%	0.4%	0.4%	0.9%	1.3%	1.1%
Diabetes											11.9%	0.3%	0.9%	2.1%	4.8%	3.1%	0.2%	4.6%	0.4%	0.7%	1.1%	1.2%	0.2%
Epilepsy												2.7%	0.2%	0.2%	0.5%	0.5%	0.1%	0.8%	0.0%	0.1%	0.3%	0.3%	0.1%
GERD													3.8%	0.5%	1.1%	1.3%	0.2%	1.6%	0.1%	0.1%	0.3%	0.4%	0.1%
Hyperlipidemia														5.2%	2.3%	1.5%	0.2%	2.1%	0.2%	0.2%	0.5%	0.5%	0.1%
Hypertension															14.6%	3.6%	0.3%	5.0%	0.3%	0.7%	1.0%	1.1%	0.3%
Lowback																17.2%	1.0%	8.8%	0.5%	0.4%	0.9%	1.5%	0.5%
Migraine																	2.2%	1.1%	0.1%	0.0%	0.1%	0.3%	0.1%
MuscSkel																		24.3%	0.6%	0.8%	1.3%	1.8%	0.7%
Obesity																			1.5%	0.0%	0.1%	0.3%	0.0%
PeriphVasc																				1.7%	0.2%	0.1%	0.0%
Schizophrenia																					5.1%	0.4%	0.2%
Sleep																						4.3%	0.1%
SubAbuse																							2.9%

n=35,685

Health Homes

At-risk conditions

- Pre-diabetes
- Tobacco use
- Cancer
- Hypercholesterolemia
- Depression
- Multiple-medication use

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Health Homes

Core Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referral to community and support services

There are two types of Health Homes in South Dakota

- Primary Care
- Behavioral Health

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Health Homes

Primary Care

- Primary Care Physicians
- PAs
- Advanced Practice Nurses
  - Federally Qualified Health Center
  - Rural Health Clinic
  - Clinic Group Practice
  - IHS

Behavioral Health

- Mental Health Providers
  - Community Mental Health Centers

Health Care Team

- Care coordinator
- Chiropractor
- Pharmacists
- Support staff
- Health Coach
- Other appropriate services

Health Homes

Health Home Providers

- Must apply to be enrolled as Health Homes
- Must go through orientation training
- May participate in ongoing implementation workgroup
- Will have access to ongoing training opportunities

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Health Homes

Provider Reimbursement

- Per member, per month for 6 core Health Home services
- Eligible Medicaid recipients are placed into one of four tiers, based on their need for services
  - Need for services is based on historical claims and diagnosis information, using a standardized tool normed against the Medicaid population
  - Tier 1- half the population, have average risk of utilization, can opt in to participate
  - Tiers 2-4- have progressively higher risk of health care utilization, can opt out of program
- Non Health Home services are paid on current fee for service basis

Case Studies: 4 Tier Model for Primary Care Provider Health Home

- Tier 1 Member
  - 44-year-old female
  - $4,727 Total Spend
  - $714 Rx spend, 1 Rx/month, 2 chronic drug classes
  - 1 ER Visit
  - 0 IP Admits
  - 4 physicians
  - Hx of substance abuse, smoker, low back
- Tier 2 Member
  - 49-year old male
  - $11,724 Total Spend
  - $4,878 Rx spend, 4.8 Rx/mo, 8 chronic drug classes
  - 1 ER Visit
  - 1 IP Admit, $3,042 IP spend
  - 5 physicians
  - Hx of hypertension, high cholesterol, low back, COPD, asthma
- Tier 3 Member
  - 35-year-old female
  - $18,139 Total Spend
  - $5,580 Rx Spend, 13.3 Rx/mo, 16 chronic drug classes
  - 2 ER Visits
  - 2 IP Admits including 1 readmit, $4,517 IP spend
  - 14 physicians providing E&M services
  - Hx of anxiety, asthma, COPD, depression, high cholesterol, low back, MSK, diabetes
- Tier 4 Member
  - 45-year-old female
  - $49,321 Total Spend
  - $2,359 Rx Spend, 7.3 Rx/mo, 12 chronic drug classes
  - 25 ER Visits
  - 10 IP Admits including 6 readmits, $22,224 IP spend
  - 24 physicians
  - Hx of anxiety, asthma, epilepsy, hypertension, low back, MSK, sleep disorder, substance abuse, smoker, chronic pain, depression

Case Studies: 4 Tier Model for Behavioral Health Health Home

- Tier 1 Member
  - 25 year old female
  - $4642 total spend
  - $113 Rx spend, 1.5 rx/mo, 1 chronic drug group
  - 0 ER Visits
  - O IP Admits
  - 7 physicians
  - History of ADHD, Depression and Low Back Pain.
- Tier 2 Member
  - 43 year old female
  - $18,393 Total Spend
  - $4,493 Rx spend, 6.1Rx/mo, 8 chronic drug classes
  - 2 ER Visit
  - 1 IP Admit, $2,757 IP spend
  - 16 physicians
  - Hx of Bipolar, Depression, High Cholesterol, Low Back Pain, Migraines, Sleep Disorder
- Tier 3 Member
  - 40-year-old male
  - $28,096 Total Spend
  - $4,544 Rx Spend, 4.7 Rx/mo, 7 chronic drug classes
  - 3 ER Visits
  - 1 IP Admits $2,399 IP spend
  - 5 physicians
  - Hx of Bipolar, COPD, Schizophrenia, Smoker, Substance Abuse
- Tier 4 Member
  - 44-year-old female
  - $49,387 total spend
  - $20,195 Rx Spend, 15.7 Rx/mo, 12 chronic drug classes
  - 15 ER Visits
  - 5 IP Admits, $13,863 IP spend
  - 27 physicians
  - Hx of Bipolar, Chronic Pain, Low Back Pain, Musculoskeletal disorder, obesity, pre-diabetes, Schizophrenia, Sleep Disorder, Smoker and Substance Abuse.

Health Homes

Outcome measures

- Developed by workgroup with providers
- Will be shared with CMS and used for program evaluation purposes
- Two Sets
  - Primary Care Providers
  - Community Mental Health Centers

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Health Homes

Outcome measures –Primary Care Providers

- 38 outcome measures
- Primary goals
  - Improving health of Medicaid Health Home recipients
  - Providing cost-effective, high-quality care
  - Transforming primary care delivery system
- Use standardized measures and tools already in use by providers

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Health Homes

Outcome measures –Primary Care Providers

- Improving health of Medicaid Health Home recipients
  - Number screened for depression
  - Number identified with asthma who have remained on meds
  - Hemoglobin and blood pressure rates for diabetics
  - Percent screened for breast cancer
- Providing cost-effective, high-quality care
  - Resource utilization
  - Emergency room utilization
  - Hospital readmissions
- Transforming primary care delivery system
  - Resource referrals
  - Individual care plans
  - Transfer of care plans

Health Homes

Outcome measures –Community Mental Health Centers

- 44 outcome measures
- Primary goals
  - Improving health of Medicaid Health Home recipients
  - Providing cost-effective, high-quality care
  - Transforming primary care delivery system
- Use standardized measures and tools already in use by providers

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Health Homes

Outcome measures –Community Mental Health Centers

- Improving health of Medicaid Health Home recipients
  - Medication management
  - Screening for co-occurring conditions
  - Use of pro-active patient management
- Providing cost-effective, high-quality care
  - Appropriate levels of care
  - Reduction of hospitalizations
  - Use of follow-up care
- Transforming primary care delivery system
  - Self-management
  - Care plan development
  - Patient follow-up

Health Home Numbers

- Current number of Health Homes – 113 serving 118 locations
  - FQHCs = 23
  - Indian Health Service Units = 11
  - CMHCs = 10
  - Other Clinics = 69
- Current Number of Designated Providers = 574

Recipient Participation

- There were 5664 recipients in Health Homes as of the February 26, 2014.

Type HH	Tier 1	Tier2	Tier 3	Tier 4	Total
CMHC	6	349	427	90	872
IHS	5	826	526	272	1,629
Other Clinics	81	1764	920	398	3,163
Total	92	2,929	1,873	760	5,664

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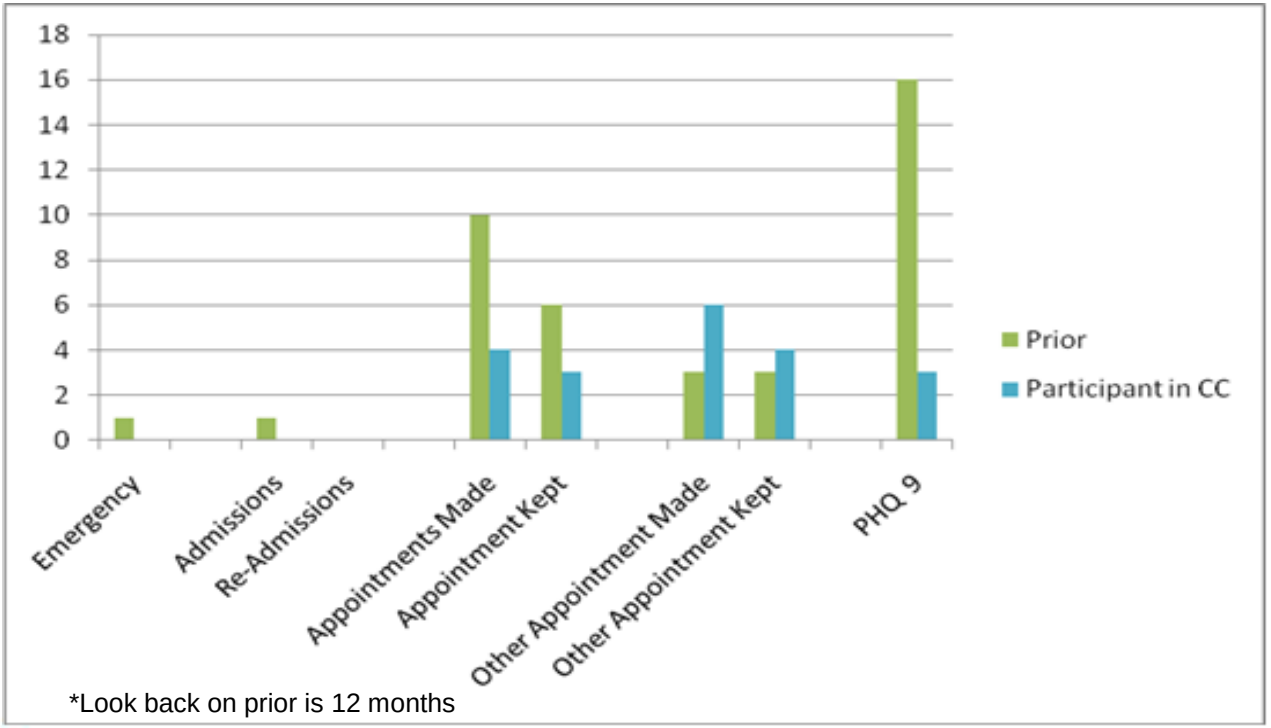
Success Stories

- 73 year old female with a history of Anxiety, Bi Polar, Atrial Fibrillation, Diabetes, Irritable Bowl Syndrome, Coronary Artery Disease, Hyperlipidemia, COPD, and Arthritis.



*Look back on prior is 12 months

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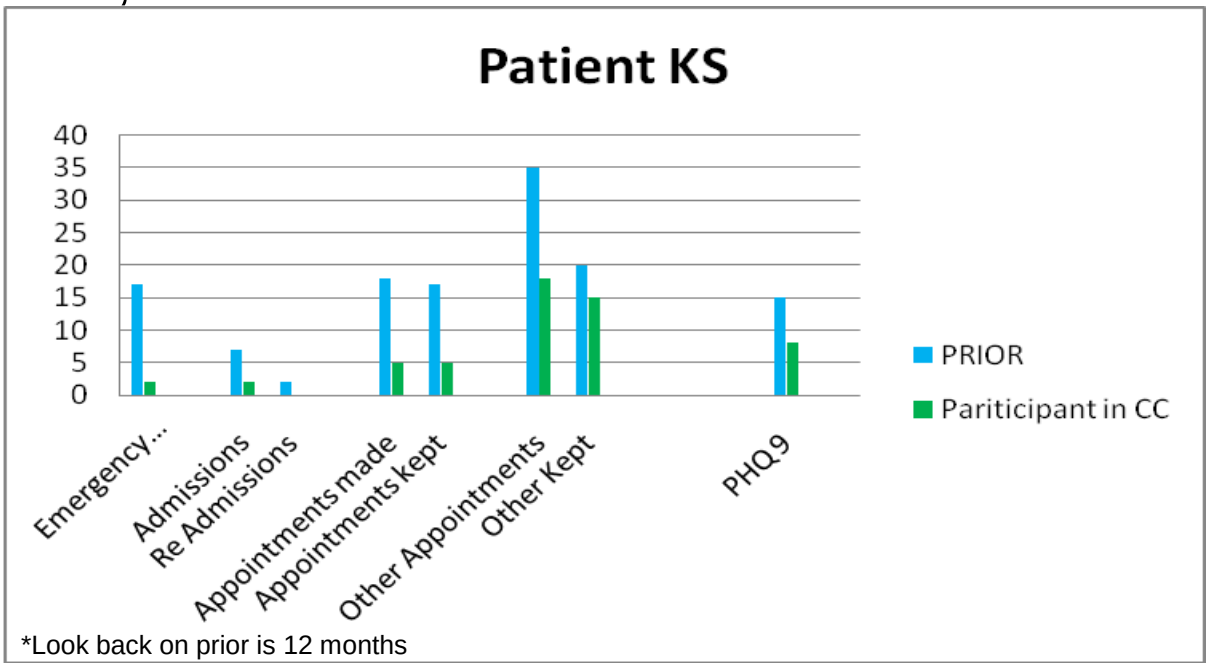
Success Stories

- 60 year old female with a history of Depression, Anxiety, Cerebrovascular accident, Short term memory loss, Hypertension, Sleep apnea, Gastric by-pass, Arthritis, Chronic pain, Diabetes, and Anemia.



*Look back on prior is 12 months

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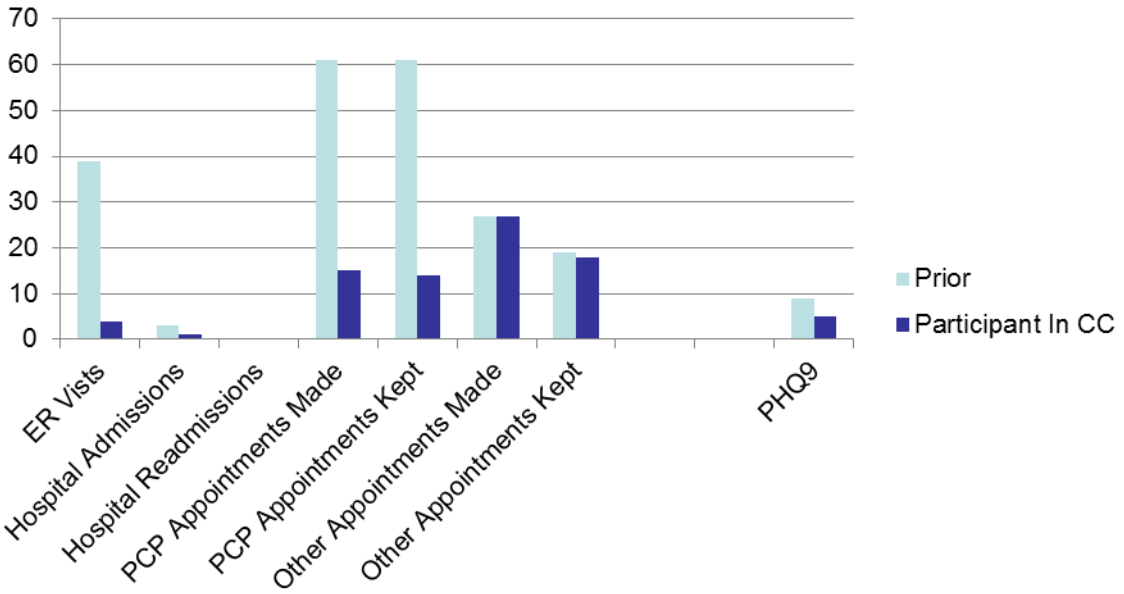
Success Stories

- 40 year old female with a Panic Disorder w agoraphobia, Major Depressive Disorder, Generalized Anxiety Disorder, Bipoloar disorder, Panic Disorder, OCD Pseudotumorcerebri, gastro-esophageal reflux, Headache disorder, Abdominal pain, and Morbid obesity.



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Questions?

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