Health Home Update 2022

September 2022

South Dakota Department of Social Services

Purpose of the Health Home Sharing Session

- Cover some of the basics of Health Homes and learn what has changed.
- Get to know the other clinics and coordinators in your area, so if you need to ask them “how to” questions you feel comfortable.
- Learn how to solve problems.
- Learn more about resources available to you.

Challenge Questions

Health Home Challenge Questions

Challenge Questions

What are the goals of the Health Home Program?

What are the three main criteria of the Health Home Program?

What are the four basic requirements for a core service?

What are the six core services?

What is the goal of the Health Home Program?

- Coordinate the care of Medicaid Recipients who have high cost and high needs.
  - Reduce the Cost of care for these recipients.
  - Improve the health outcomes of these recipients.

Health Home Challenge Questions

Challenge Questions

What are the goals of the Health Home Program?

What are the three main criteria of the Health Home Program?

What are the four basic requirements for a core service?

What are the six core services?

What are the three Main criteria that make a recipient eligible for the Health Home Program?

- Any Medicaid recipient who has:
  - ***Two or more chronic conditions OR***
  - ***One chronic and at risk for another (Defined separately):***
    - **Chronic conditions:** Mental illness, substance abuse, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal, and neck and back disorders.
    - **At risk conditions:** 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.***

Health Home Challenge Questions

Challenge Questions

What are the goals of the Health Home Program?

What are the three main criteria of the Health Home Program?

What are the four basic requirements for a core service?

What are the six core services?

What are the four Basic criteria of a Core Service?

- Health Home minimum requirement is to provide one of the Core Services to each recipient every quarter:
  - Recipient should be engaged by the action – not simply provider care conference.
  - Core Services are actions that are specific to the patient, tied to their care plan.
  - Documented in the Electronic Health Record.
  - Not a services previously billed to Medicaid using a Fee for Service, Daily or Encounter rate

Health Home Challenge Questions

Challenge Questions

What are the goals of the Health Home Program

What are the three main criteria of the Health Home Program?

What are the basic requirements for a core service?

What are the six core services?

What are the Six Core Services?

The Six Core Services for the Health Home Program include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Recipient and Family Support Services
- Referrals to Community and Social Support Services

Health Home Update

Health Home Capacity

Number of Health Homes has increased by 4 since last year. As of July 1, 2022, we had 139 Health Homes serving 143 locations.

- FQHCs = 30
- Indian Health Service/Tribal 638 = 12
- CMHCs = 9
- Other Clinics = 88

New Health Homes

- **January 2021**
  - Bon Homme Family Practice Avon
  - Bon Homme Family Practice Tyndall
- **April 2022**
  - Access Health - Murdo
- **July 1, 2022**
  - Avera Medical Group Yankton

Participation Cont.

- Participation is currently at an all time high due to continuous enrollment requirement of the Public Health Emergency(PHE) remains ongoing.
  - All recipients except, for CHIP (78 and 79), are required to be left on the program unless the recipient:
    - Dies;
    - Moves out of state;
    - Requests that their caseload be closed; or
    - Convicted of fraud or abuse.
    - They can also request to be removed.
  - Examples of recipients whose eligibility may end when the PHE expires include:
    - Pregnant women;
    - Non-disabled recipients who turn 19; and
    - Recipients whose Transitional Medical Benefit (TMB) has expired.
  - The unwinding will be a year long process where every recipient will be reevaluated.

Participation Numbers

Year	Monthly Average
FY2019	5,954
FY2020	5,864
FY2021	6,581
FY2022	7,015

Recent Participation Numbers

Type	Tier 1	Tier 2	Tier 3	Tier 4	Total
CMHC	9	179	322	103	613
IHS	14	1,565	574	206	2,359
Other	61	2,569	1,097	462	4,189
Total	84	4,313	1,993	771	7,161

Tier Update

History

Original plan in 2013, was to update the Tier of recipients ever 6 months.

When the first 6-month update arrived, DSS evaluated the results of the update and found that Tiers go up and down each month as well as changes that could not be explained.

Did not feel that we could implement the update based on the most recent month.

After consulting with the Implementation Workgroup, we decided to postpone the planned update and introduced the manual tiering process as an option to add recipients or adjust the Tiers of recipients.

To date the only Tiers that have been adjusted are those through the Manual Tier process which typically is a request to add or increase.

Tiers have also been adjusted both up and down, when we add new clinics based on the most recent file. Also remove opt outs for these recipients.

Goals

01

The goal was to find a way to smooth out the highs and lows of the Tiers as they come in each month.

02

Find a way to drop people off the program as their claims indicate there the program is no longer needed.

03

Allow providers a way to have a discussion with recipient who drop to a Tier 1 to determine if there is a still a need.

04

Find a way to inform providers of all changes when the update happens.

Why Now?

An independent review placed this as one of the priorities that need to be completed. To make sure that providers were being paid the appropriately for the recipients.

DSS needs a consistent way to update the Tiers as recipient move up and down the Tier scale and fall off the program when they no longer need care management.

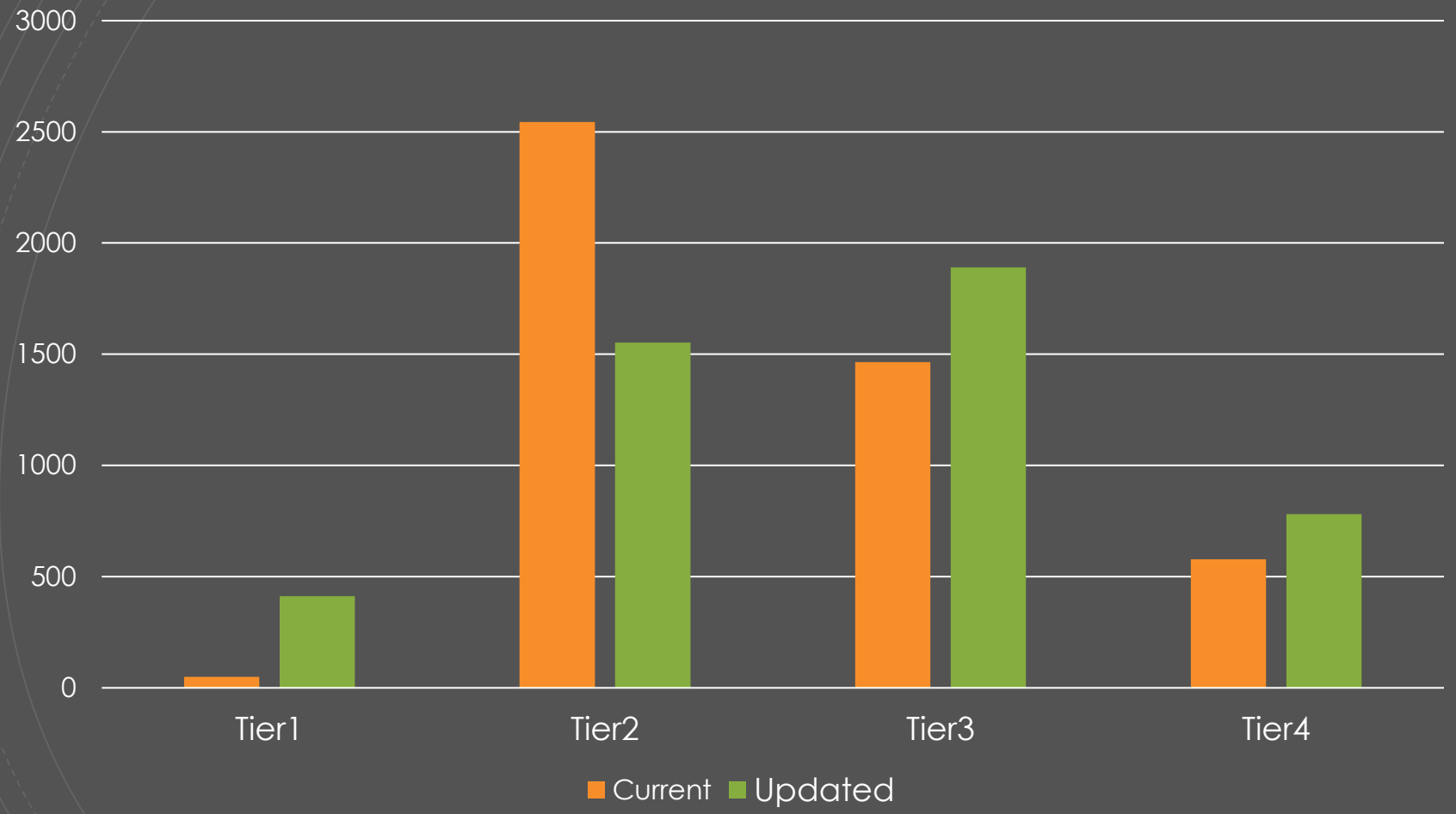
Research Parameters

- Vendor provided a sample file that provided six-month average Tier for each recipient eligible for the Health Home program.
- If recipients had an active provider, they remained as part of the analysis.
- If recipients were provided a core service one of the last 4 quarters, they remained in the sample.
- Final sample for evaluation was 4,653 recipients.
- Tiers were moved 1 up and 1 down.

Tier Update

- Attribution Vendor will deliver a Tier update file in the month of December. File will be an average of Tiers for each recipient in the previous 6 files.
- The goal is to update tiers on 01.01.CCYY of each year. If not the beginning of this year, it would be the beginning of a quarter.
- Active recipients will remain with the same provider and their tier will be increased or decreased according to the file. Tiers will only go up one and down one.
- DSS will make a list of changes available to the coordinators like a caseload report.
- If no change is made, recipient will remain as is.
- If recipient is no longer eligible, their occurrence will be ended on 12.31.CCYY or the end of the quarters and they will be dropped from the program. If provider feels a need for the recipient to remain on the program, a manual tier form can be completed.
- If recipient falls to a Tier 1, provider can discuss with the recipient/caregiver, the purpose of the program and determine if the recipient should remain on the program.

Comparison between Current and Updated Tier numbers



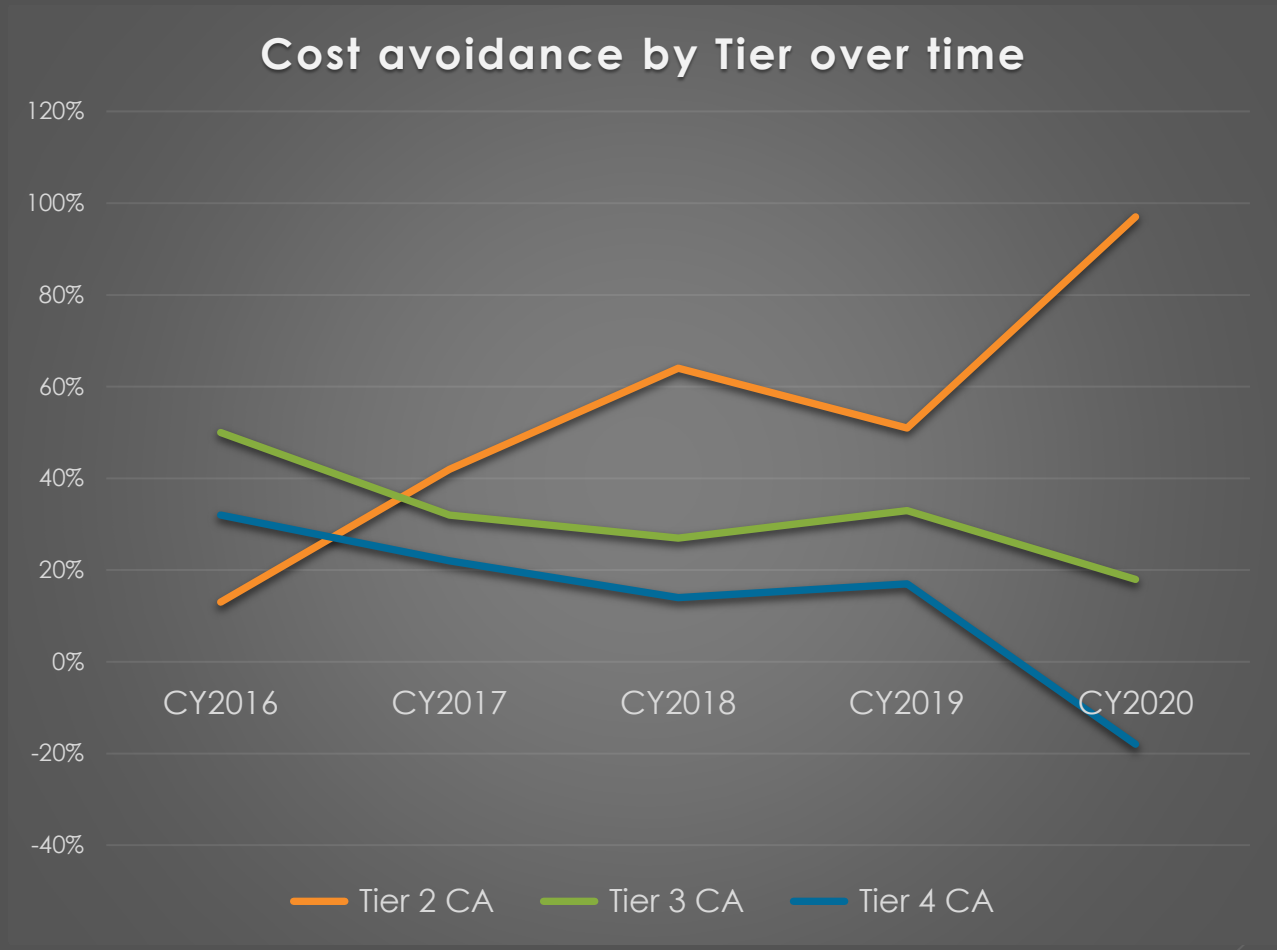
Tier 4 Concerns

Tier 4 Rate Concerns

- Since the inception of the program, the difference between Tier 3 and Tier 4 PMPM payments has been a concern.
- The 2015 Cost Study normalized these rates and brought them closer to the Tier 3 rate.
- As DSS has inflated these rates the disparity between the rates continues to grow.
- No additional work is required as Tiers increase
- The percentage of cost avoidance continues to decrease indicating that a higher Tier rate doesn't really help improve management.
- See Chart next slide.

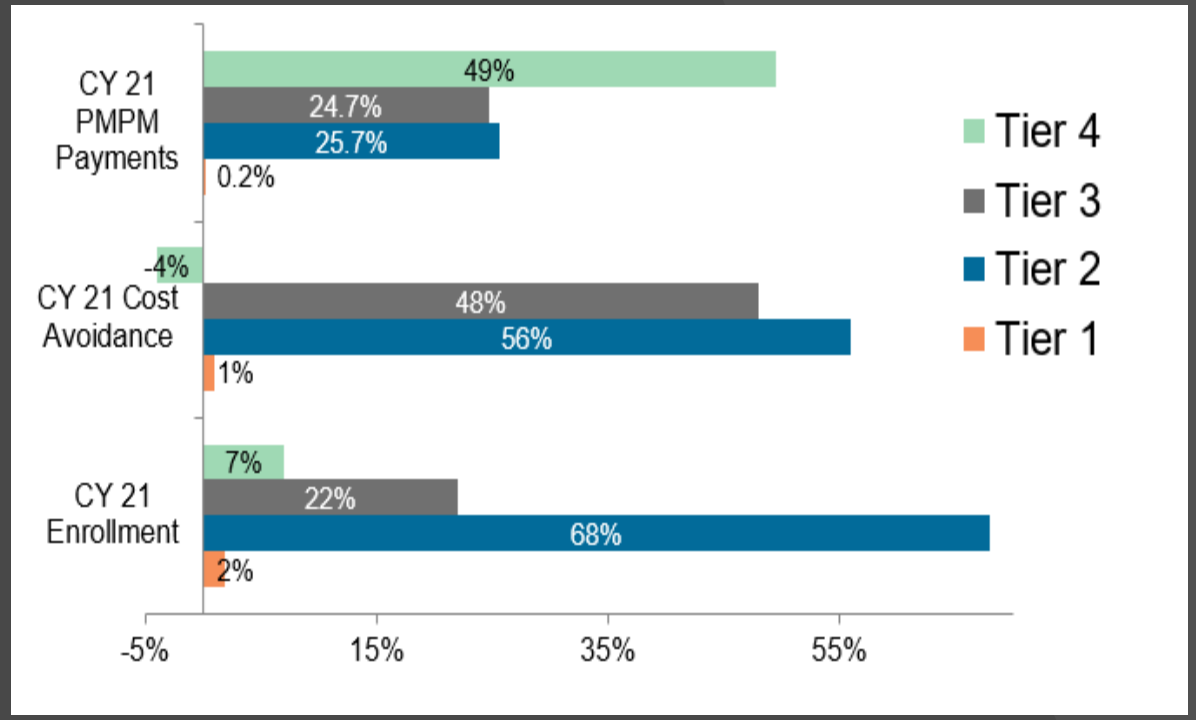
Tier 4 rate cost avoidance continues to decline

*Note: Vendor does not receive the claims for the PMPM to include in the cost avoidance numbers. They are taken off the top of the entire estimated cost avoidance.



Payment, Enrollment and Percentage of Cost Avoidance by Tier

- Tier 1 recipients made up 1% of cost avoidance.
- Tier 2 and 3 made up the remainder of the cost avoidance.
- Tier 4 continues to lose money.



Current Rates

- Rates that took effect in July 2022.

Tier	CMHC	PCP
1	$11.77	$11.77
2	$43.12	$37.90
3	$62.72	$64.03
4	$197.24	$308.18

Plan Approved by Implementation Work Group

- Tier update should be close to budget neutral.
- Tier 4 payment needs to be addressed to make the update budget neutral.
- When the Tier update happens, the Tier 4 will be reverted to 2015 Cost Study rate in order to move back to a more reasonable difference.
  - PCP $250
  - CMHC $160
- DSS only inflated Tiers 1-3 as part of the July 2022 inflation.
- A subgroup has been developed and had their first meeting in August to make recommendations on how to differentiate the requirement by Tier in order to achieve better management of the Tier 3 and 4 recipients.
- Even with this adjustment **84% of clinics or clinic system will earn more on the PMPM.**

Subgroup Work

2022/23 Subgroup Work

Created a group to review the cost avoidance associated with Tier 4

- Review the work required by Tier to find a way to bring additional cost savings to Tier 4.
- Subgroup reviewing options.
- Will implement recommended option on January1, 2023.

Ongoing work on how to decrease the amount of work to collect the outcome measures

- How can we use claims to gather the data we need.
- What would need to change in the submission of claims process.

Quality Incentive Payment

Example Calculation

- DSS worked with our vendor to calculate a Composite Score for each Clinic.
- Improvement is any improvement.
- Attainment is greater than or equal to the target.
- Clinic must have provided 50% or more of the recipients on their caseload a core service.

Health Home Composite Scoring*					
	Weight**	Improvement***	Attainment****	Caseload Severity	Score
Depression Follow-Up Plan Documented	10	0.5		20.75	93.375
Substance Abuse Positive Referred	10		1	20.75	311.25
Chronic Pain Follow-up	10	0		20.75	0
Care Transition F/U	15		1	20.75	311.25
Active Care Plan	15		1	20.75	311.25
Recipients with Self Mgmt. Ability who use Tools	8	0.5		20.75	93.375
					0
BMI in Control	8	0.5		20.75	72.625
Mammogram up to date	8	0.5		20.75	72.625
Colonoscopy up to date	8		1	20.75	145.25
Blood Pressure in Control	8	0		20.75	0
					0
TOTAL	100.00				1411

Example Distribution

Pool Funding		$500,000
Small Clinic Pay		$75,000
Incentive Pool		$425,000
	Points	Incentive Dollars
HH #1	1000	$60,619
HH #2	1411	$85,533
HH #3	1700	$103,052
HH #4	1500	$90,929
HH #5	1400	$84,867
TOTAL	7011	$425,000
Incentive dollars per point		$60.62

- Each qualifying clinic will receive a portion of the funds based on their composite score. The higher the score the more money received.
- As the number of clinics increases, the incentive dollars per point decreases.

Quality Incentive Payment

More information about the Quality Incentive Payment can be found on our website at https://dss.sd.gov/healthhome/paymentinformation.aspx

Quality Incentive Payments

DSS has made Quality Incentive Payments based on CY2019 and CY2020 data to the following clinic locations based on the results of their outcomes data.

Clinic Payments CY2019 | CY2020

The methodology used to calculate these payments is summarized in the documents below.

Methodology CY2019 | CY2020

Information about this payment can also be found on Health Home Quality Incentive Payments.

Fee Schedule CY2019 | CY2020

Quality Assurance Review

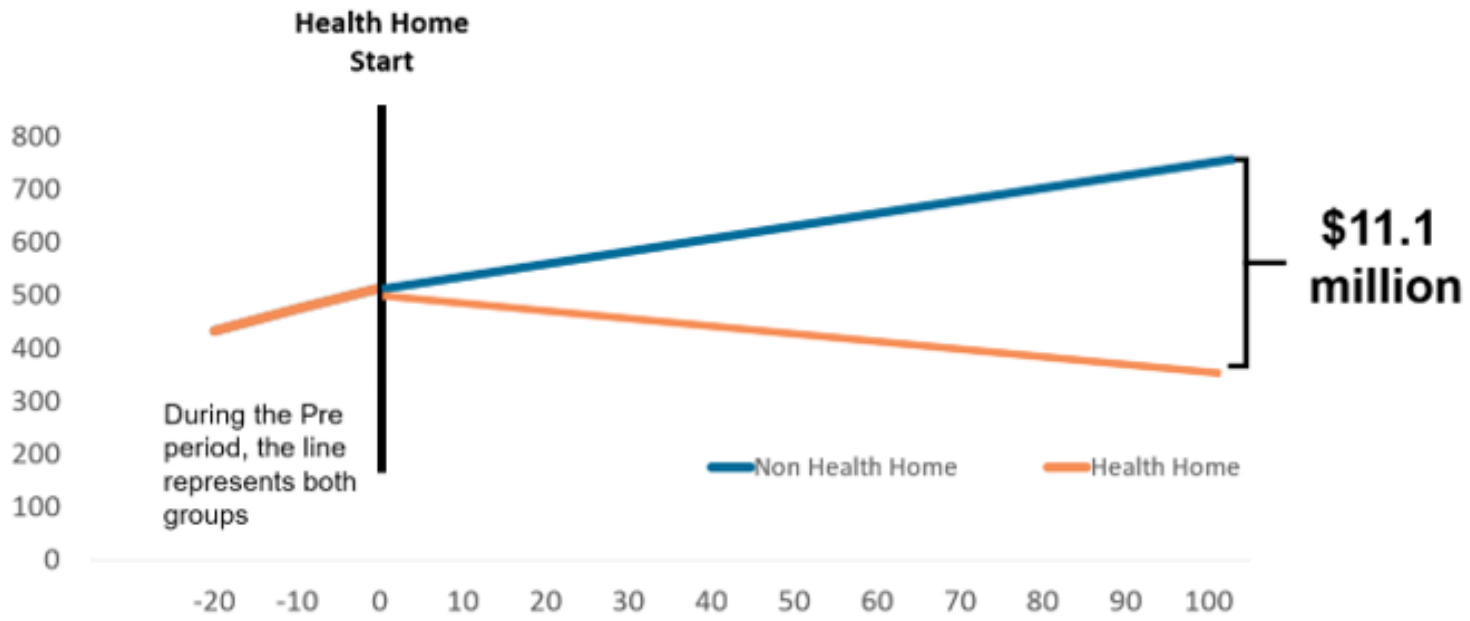
Quality Assurance Review

- The Quality Assurance Review is currently in progress.
- DSS has hired South Dakota Foundation for Medical Care to conduct the Quality Assurance review for the CY2021 year. We currently have a 3-year contract.
- A briefing was offered on August 16th. It was recorded and can be found at link https://dss.sd.gov/healthhome/training.aspx.

CY2021 Program Results

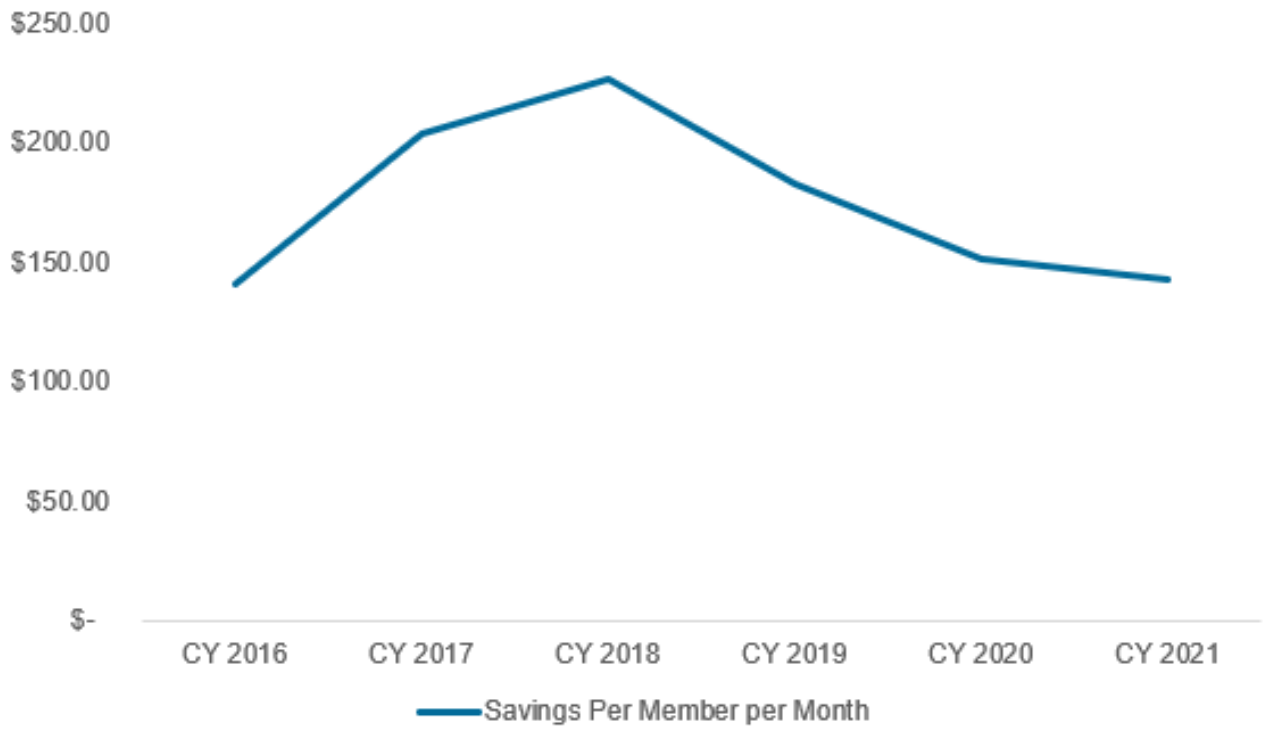
CY 2021 Financial Analysis Results

- Participants in the Health Home Program $143 less per month than recipients with similar demographics and health condition.
- DSS estimates that $11.1 million in cost were avoided in CY 2021 after the payment of $4.2 Million for core services and $500,000 in Quality Incentive Payments.



Cost Avoidance Per Member Per Month (PMPM)

- CY2021 one of the lowest Average PMPM cost avoidance
- Number of the recipients who met the criteria of the evaluation was the largest ever
- Highest number of average member months
- These three items multiplied together to get the overall cost avoidance.



Cost Avoidance by Type of Service

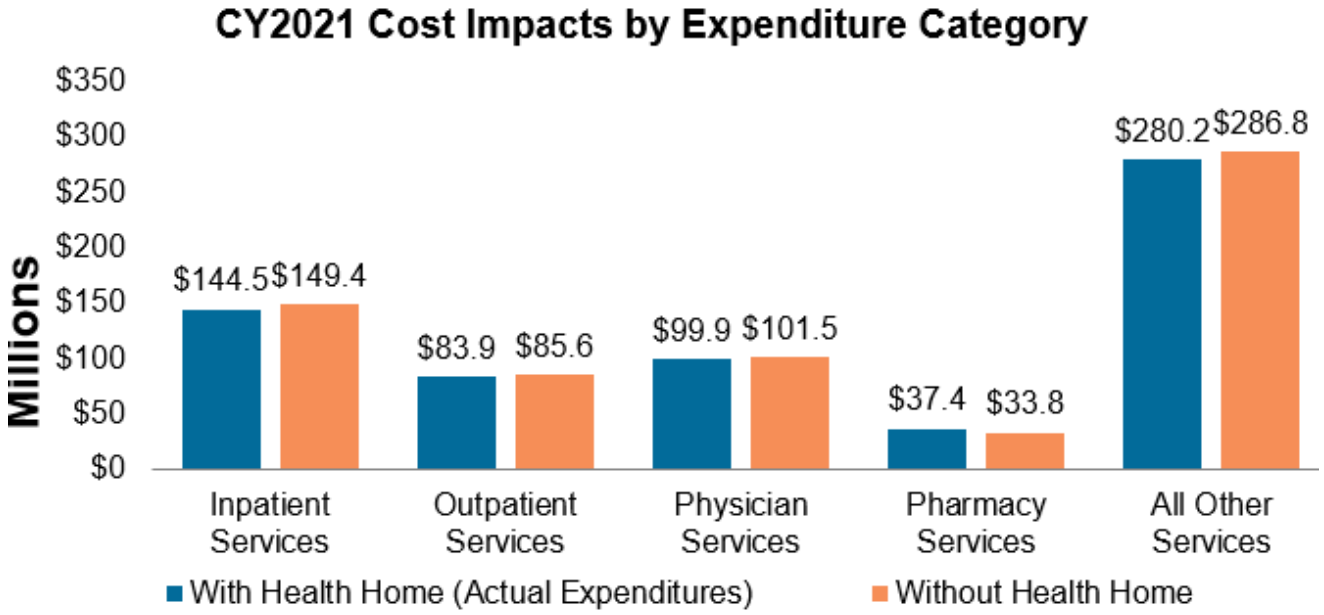


*Chart above depicts the impact to the overall Medicaid Budget.

- **Inpatient Stays-**Participants had 1.72 fewer stays per 1,000 members per month or 8% fewer stays that the control. Cost avoidance estimated at $4.89 million.
- **Emergency Department** Participants has 4.8 fewer visits per 1,000 members per month or 5.6% fewer visits than the control group. Cost avoidance estimated at $1.61 million.
- Physician Services and all other services accounted for the remaining decrease.
- Pharmacy Services cost more for recipients who participate in the Health Home program than the control group.

Outcome Measure Comparison

Outcome Measure Comparison

- Every year DSS submits data to CMS for the HH program.
- While we have been reporting for many years, CMS just released results by state for the CY 2018 data in 2020.
- CMS also recently released data for the CY2019, but it only included the national results with the Median, Upper Quartile, and Lower Quartile for each measure. No state-by-state results.
- The slides below also include the data for each measure for CY 2020. This data has not yet been reported to CMS due to a system change for reporting.
- The next set of slides contains the results for each of the measures.
- **NOTE** – Median, Upper Quartile, and Lower Quartile lines are all from the CY2019 data.
- Federal Fiscal Year (FFY) always references the previous calendar year (CY) so FFY2020 means CY 2019.

There are two measures submitted by South Dakota that were not available for performance analysis by CMS, they are detailed below.

Measure 2-CDF-HH: Screening for Clinical Depression and Follow-Up Plan

FFY20	Total	Age 12-17	Age 18-64	Age 65+
Percent Screened	77.3%	56.6%	79.2%	84.8%
FFY20	Total	Age 12-17	Age 18-64	Age 65+
Percent Positive	32.1%	15.2%	36.0%	20.1%
FFY20	Total	Age 12-17	Age 18-64	Age 65+
Percent with Follow-Up	72.2%	69.0%	72.3%	71.7%

Measure 5- CBP-HH: Controlling High Blood Pressure

FFY20	Total	Age 18-64	Age 65-85
Denominator (Number of People with Hypertension)	1,213	796	417
Number of People with Hypertension with Controlled BP	1,116	718	398
Percent with hypertension that is controlled	92.0%	90.2%	95.4%

South Dakota's Performance

Outperformers
Measure 1: Body Mass Index
Measure 3: All-Cause Readmissions Rate
Measure 7: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite
Measure 8: Ambulatory Care - Emergency Department Visits

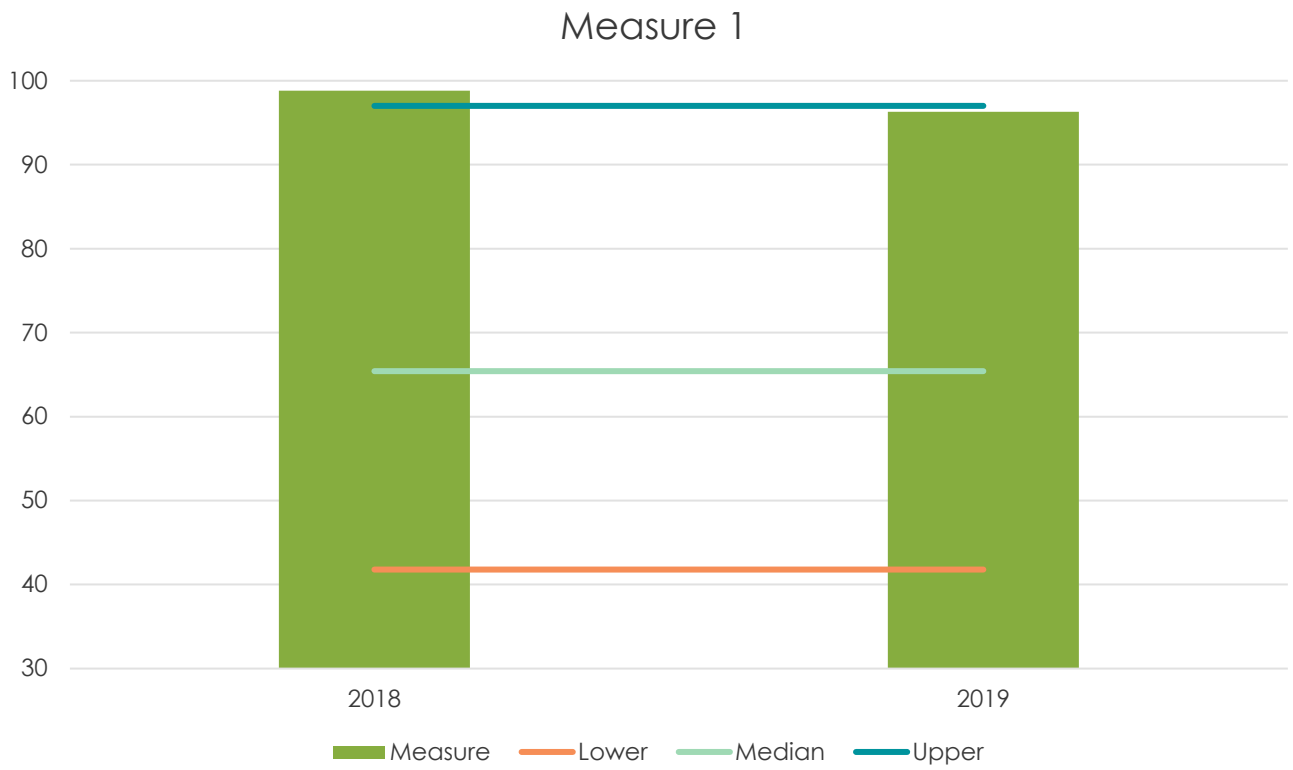
Under Performers
Measure 4: Follow-Up After Hospitalization for Mental Illness
Measure 6: Initiation Engagement of Alcohol and Other Drug Dependence Treatment
Measure 10: Opiate Use Disorder Utilization
Measure 11: Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence

*Measure 9 is currently under review by CMS

Measure 1
ABA-HH: Adult Body Mass Index (BMI) Assessment Out Performer

Percentage of Health Home Enrollees Ages 18 to 74 who had an Outpatient Visit and whose Body Mass Index Value was Documented in the Medical Record

Higher is Better



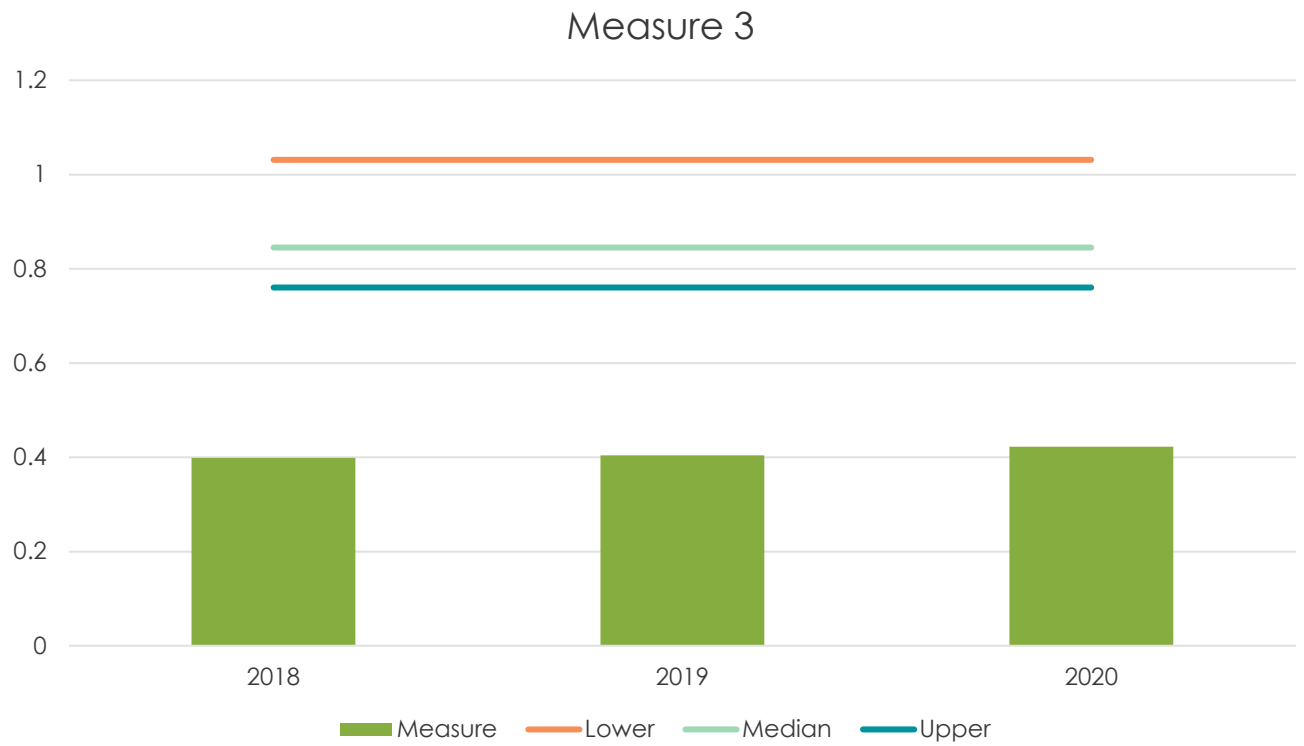
Year	Measure
2018	98.8
2019	96.3
2019 Quartile Data	
Lower	41.8
Median	65.4
Upper	97

*2020 Data Not Available

Measure 3
PCR-HH: Plan All-Cause Readmissions Rate Out Performer

Ratio of Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) among Health Home Enrollees Ages 18 to 64

Lower is Better

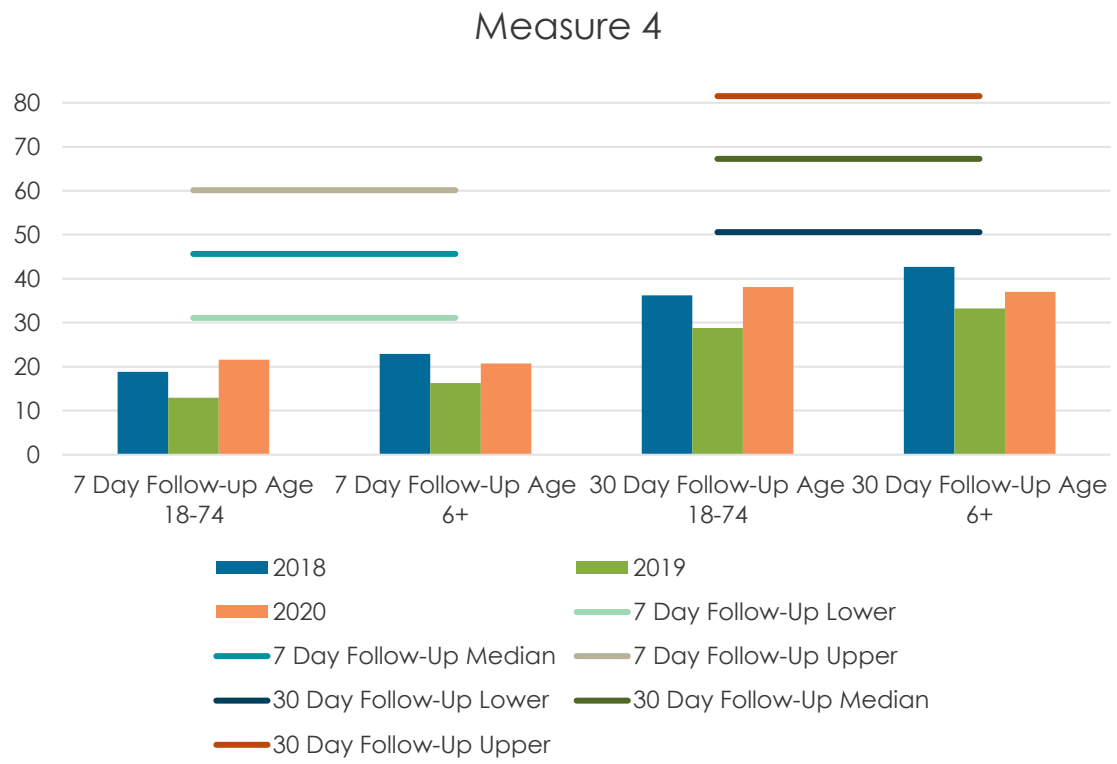


Year	Measure
2018	0.3988
2019	0.4041
2020	0.4223
2019 Quartile Data	
Lower	1.0311
Median	0.4852
Upper	0.7605

Measure 4
FUH-HH: Follow-Up After Hospitalization for Mental Illness
Under Performer

Percentage of Discharges for Health Home Enrollees Age 6 and Older Hospitalized for Treatment of Mental Illness or Intentional Self-Harm with a Follow-Up Visit with a Mental Health Practitioner within 7 and 30 Days After Discharge

Higher is Better

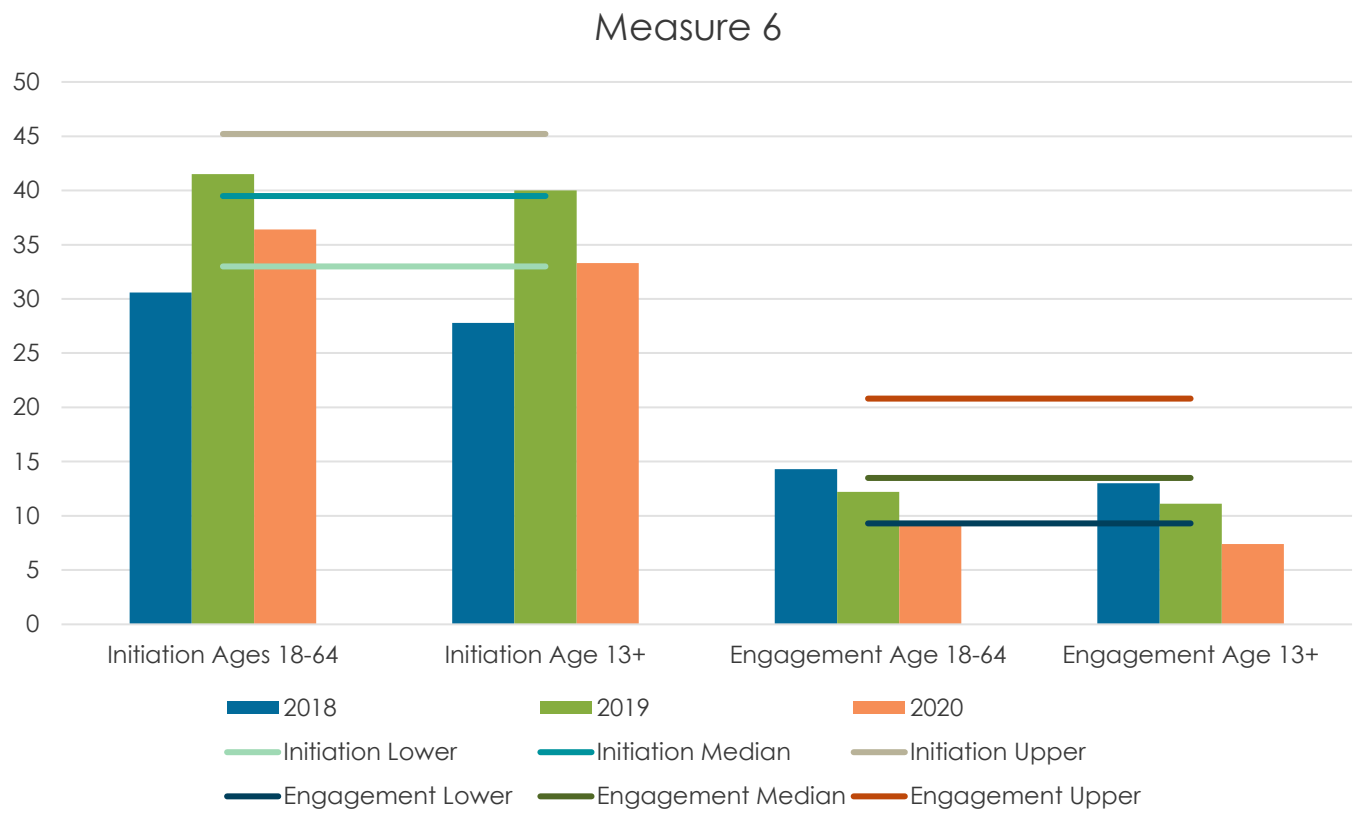


Year	7 Day Follow-up Age 18-74	7 Day Follow-Up Age 6+	30 Day Follow-Up Age 18-74	30 Day Follow-Up Age 6+
2018	18.8	22.9	36.2	42.7
2019	12.9	16.3	28.8	33.2
2020	21.6	20.7	38.1	37
2019 Quartile Data				
Lower	29.8	31.1	44.9	50.6
Median	42.2	45.6	65	67.2
Upper	57.3	60.1	77.9	81.5

Measure 6
IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Under Performer

Percentage of Health Home Enrollees Age 13 and Older with a New Episode of Alcohol or Other Drug Abuse or Dependence, who: (1) Initiated Treatment within 14 Days of the Diagnosis, and (2) Initiated Treatment and Had Two or More Additional Services within 34 Days of the Initiation Visit

Higher is Better

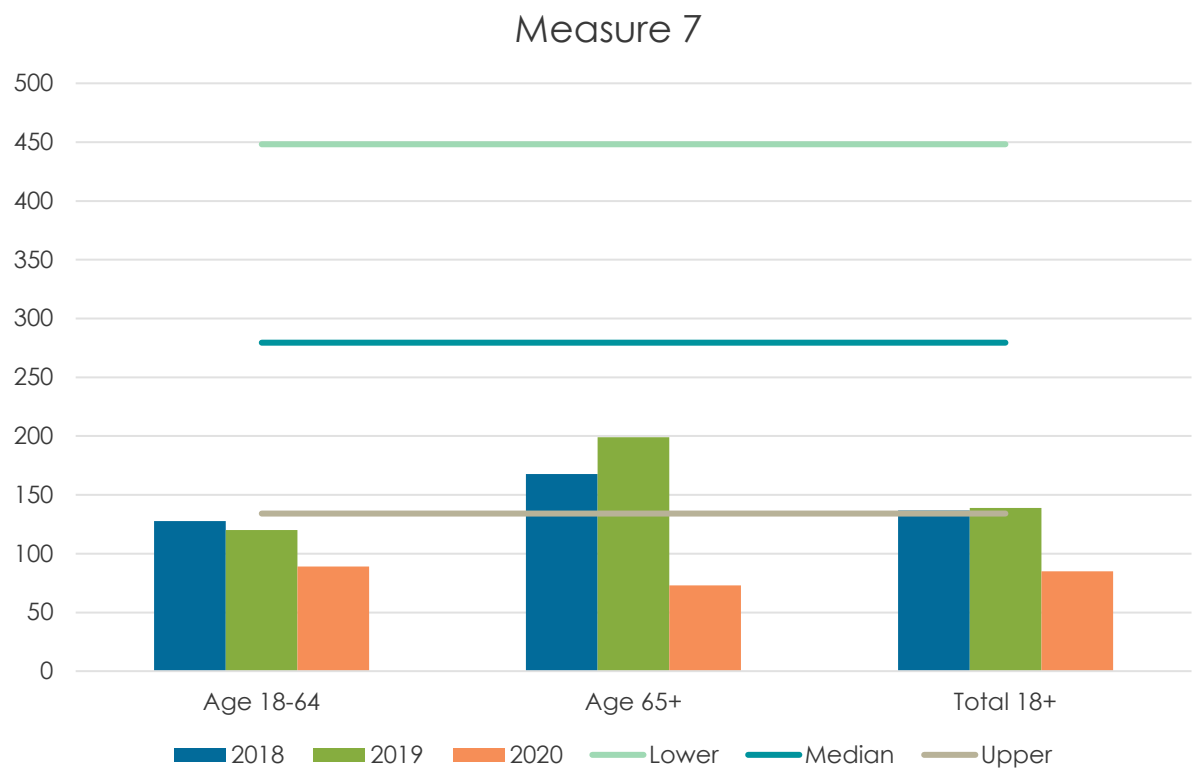


Year	Initiation Ages 18-64	Initiation Age 13+	Engagement Age 18-24	Engagement Age 13+
2018	30.6	27.8	14.3	13
2019	41.5	40	12.2	11.1
2020	36.4	33.3	9.1	7.4
2019 Quartile Data				
Lower	32.6	33	9.7	9.3
Median	38.9	39.5	13	13.5
Upper	45.3	45.2	20.9	20.8

Measure 7
PQI92-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite Out Performer

Number of Inpatient Hospital Admissions for Ambulatory Care Sensitive Chronic Conditions per 100,000 Enrollee Months for Health Home Enrollees Aged 18 and Older

Lower is Better

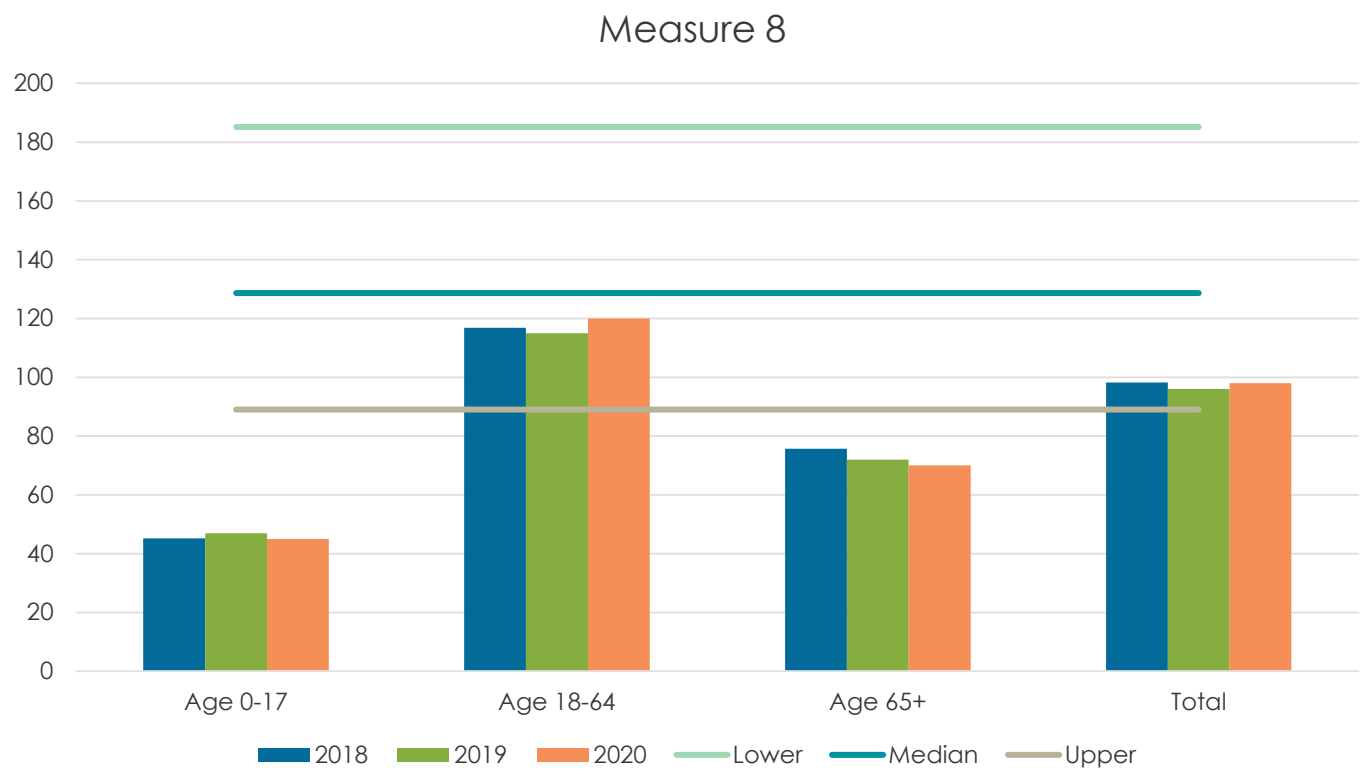


Year	Age 18-64	Age 65+	Total 18+
2018	127.7	167.7	136.7
2019	120	199	139
2020	89	73	85
2019 Quartile Data			
Lower	441.9	662.8	448.1
Median	292	401.6	279.4
Upper	134	134	134.1

Measure 8
AMB-HH: Ambulatory Care - Emergency Department Visits Out Performer

Rate of Emergency Department Visits per 1,000 Enrollee Months for Health Home Enrollees

Lower is Better

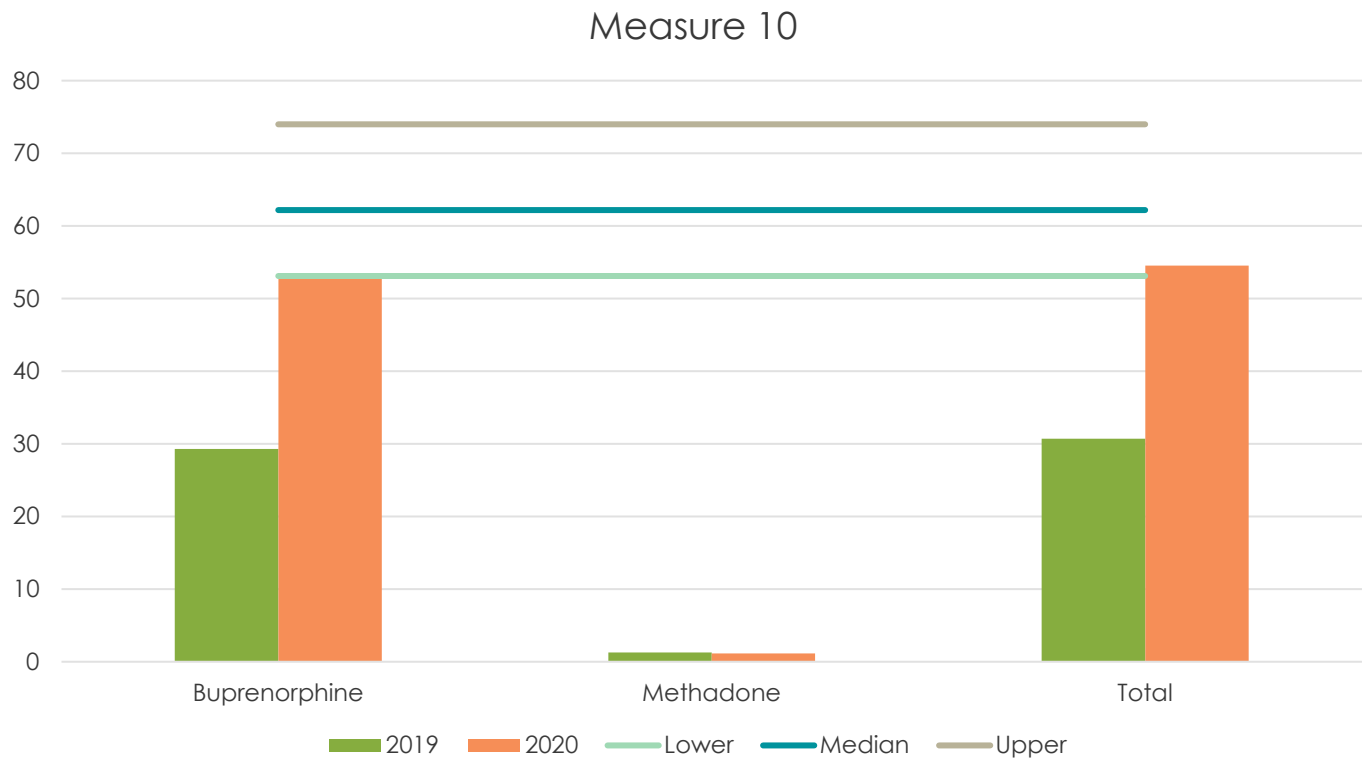


Year	Age 0-17	Age 18-64	Age 65+	Total
2018	45.2	116.8	75.7	98.20
2019	47	115	72	96
2020	45	120	70	98
2019 Quartile Data				
Lower	95.7	189.9	127.9	185.1
Median	76.4	150	93.9	128.7
Upper	53.3	105.8	69.8	89

Measure 10 OUD-HH: Opiate Use Disorder Utilization Under Performer

Percentage of Health Home Enrollees Ages 18 to 64 with an Opioid Use Disorder who Filled a Prescription for or were Administered or Dispensed an FDA-Approved Medication for the Disorder

Higher is Better

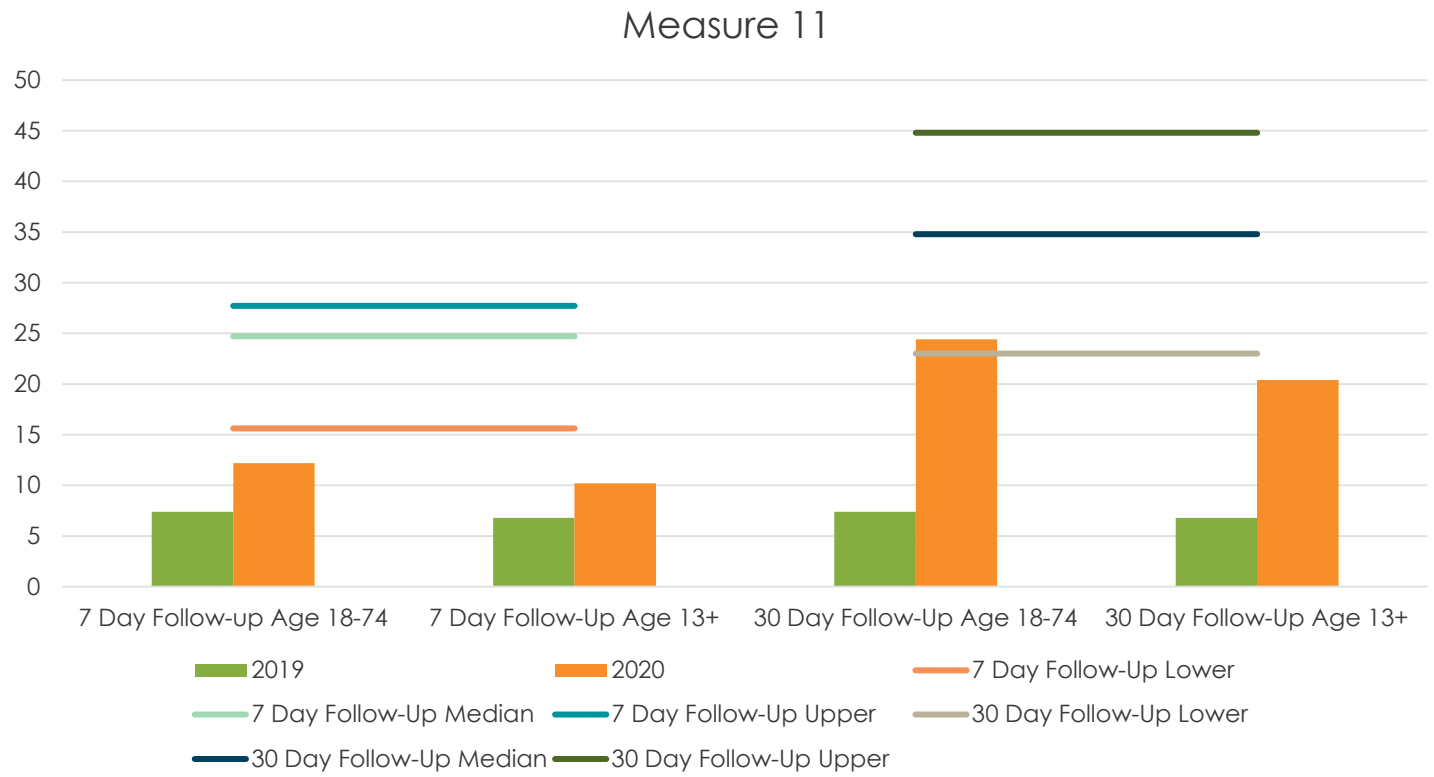


Year	Buprenorphine	Methadone	Total
2019	29.3	1.3	30.7
2020	53.41	1.14	54.55
2019 Quartile Data			
Lower	29	7.1	53.1
Median	39.2	22.9	62.2
Upper	50.8	29.7	74.01
***2018 Data Not Available**			

Measure 11
FUA-HH: Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence Under Performer

Percentage of Emergency Department (ED) Visits for Health Home Enrollees Aged 13 and Older with a Principal Diagnosis of Alcohol or Other Drug (AOD) Abuse or Dependence with a Follow-Up Visit within 7 and 30 Days After the ED Visit

Higher is Better



Year	7 Day Follow-up Age 18-74	7 Day Follow-Up Age 13+	30 Day Follow-Up Age 18-74	30 Day Follow-Up Age 13+
2019	7.4	6.8	7.4	6.8
2020	12.2	10.2	24.4	20.4
2019 Quartile Data				
Lower	12.9	15.6	19.2	23
Median	24	24.7	34.9	34.8
Upper	26.6	27.7	41	44.8

***2018 Data Not Available**

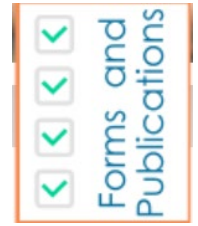
Online Tools and Resources

Online Selection Tool Demo and Eligibility Functionality

- One of the most important advancements we have made this past year has been to create the online Selection Tool. There is a Webinar and PowerPoint available at https://dss.sd.gov/medicaid/providers/

Online Ordering

- From any page on the DSS website https://dss.sd.gov/
- Click on the Forms and Publications Icon



DSS Health Home Resources

- Website http://dss.sd.gov/healthhome/providers.aspx.
  - Forms –Decline to Participate, Selection and Change Form, Manual Tier
  - Electronic referral forms
  - Provider map and online selection tool
  - Information about Health Home Outcome Measures and the template.
  - Updated Orientation trainings to use with you new providers and team members
  - Previous Trainings
  - Recipient Handbook
  - Health Home Brochure

DSS Health Home Resources

- Monthly Emails
- DSS Online Provider Portal –HH Functions
  - HH caseload reports
  - HH claims paid reports
  - HH core services reports
  - HH remits
  - Eligibility Inquiry
  - Service Limits
- Access to DSS Health Home team
  - (605) 773-3495/6652
  - Kathi.Mueller@state.sd.us

Misc.

Communication Updates

- Information on the latest provider communications can be found at https://dss.sd.gov/medicaid/providers/communication.aspx.
- Providers should also sign up for the Medical Services ListServ Link is found on the same website as above, but a direct link to sign up is as follows: https://dss.sd.gov/medicaid/contact/ListServ.aspx.

Keep DSS in the Loop When…

- Providers leave and arrive
- Care coordinators change
- Data contacts change
- Training is needed
- Unable to meeting deadlines
- Others?

Submission of Forms

- Selection Forms should be submitted using the Online Selection tool at https://dss.sd.gov/pcphhselection
- If you have the ability, please submit all other forms via secure email to me rather than fax.
- If emailed, I will confirm receipt and you will know it has been received.
- The Care Management Program (CMP) does not have its own fax machine. It is shared with our nurses who do prior authorizations who receive a large quantity of multiple page faxes.

HIE Update

- DSS now providing 3 files of information to the Health Information Exchange
  - Member file
  - Pharmacy claims
  - Dental claims – Use to identify dental procedures and preventative visits.

Affinity Groups

- **Well-Child Affinity Group**
  - Aim: Increase the percent of American Indian Alaska Native children 0-15 months who have 6 or more well-child visits by 10 % points from 20.63 to 30.63 percent, but December 2023.
  - Activity
    - Well Child Rack cards
    - Social Media focused on this population
    - Billing a well child visit as part of an acute visit
  - Partners: Horizon, IHS, SDUIH, SDDOH

Affinity Groups

- **Oral Health Affinity Group**
  - Aim: Increase the number of fluoride varnish applications for children aged 1-5 years old by non-dental providers by 50% by June 2023.
  - Activity: Delta Dental offers training and support tools for non-dental providers on how to deliver preventive oral health services.
    - Hands on practice in applying fluoride varnish.
    - Tips on providing risk assessments and oral health anticipatory guidance.
    - Free starter kit of fluoride varnish.
  - Providers interested in in-person fluoride varnish application training can contact Cori Jacobson with Delta Dental 605.494.2552 or Cori.Jacobson@deltadentalsd.com

Questions/ Concerns

Thank You

Kathi Mueller

605.773.3495

Kathi.Mueller@state.sd.us

dss.sd.gov