Health Home Data Dashboard

South Dakota Medicaid’s Health Homes (HH) program is a person-centered system of care focused on transforming care for high cost, high need Medicaid recipients to improve the patient experience, increase preventive and primary care services while improving outcomes and managing costs to South Dakota’s Medicaid program.

**Age of Participating Recipients**

- 1% Age 0-5
- 6% Age 6-13
- 8% Age 14-20
- 62% Age 21-64
- 22% Age 65+

**Impact of COVID-19**

The Health Home (HH) Program was not immune to the arrival of COVID-19. Since this program provides care coordination to our highest need population, the participants in this program all have conditions that make them susceptible to becoming critically ill from the virus. Individuals in the program were more likely to have high-cost claims due to COVID than their non-HH counterparts.

Care Coordinators were often pulled to the front lines to help with patient care. According to Care Coordinators participants were afraid to come in and see their provider. Participants may have waited too long and ended up in the emergency room where utilization was 14% more than their non-HH counterparts.

**Transforming Care**

South Dakota Medicaid’s Health Homes is changing the way Medicaid recipients receive care by creating a person-centered care team to meet the needs of the patient. The following measures show how the Health Home program is changing the way participants receive care.

- HH recipients with an active person-centered care plan: 93% CY2020, 83% CY2019, 76% CY2018, 73% CY2017
- HH recipients referred for other community services: 93% CY2020, 90% CY2019, 88% CY2018, 75% CY2017
- HH recipients receiving health behavior counseling: 93% CY2020, 86% CY2019, 80% CY2018, 75% CY2017
- HH recipients using self management tools to manage their conditions: 67% CY2020, 56% CY2019, 50% CY2018, 58% CY2017
- HH recipient receiving proactive patient reminders: 81% CY2020, 80% CY2019, 87% CY2018, 81% CY2017
- HH recipients receiving care transition within 72 hours of discharge from a hospital, emergency: 86% CY2020, 59% CY2019, 50% CY2018, 49% CY2017

A previous participant of the program is now a manager of at a grocery store and will be getting full benefits through the store. The participant has been a part of the Health Home program for many years and has been working at the store part time. The participant is diabetic with hypertension, hyperlipidemia, obesity, and mental health diagnoses including inpatient stays for depression. The program helped the participant to secure a full time job and make improvements in recipient’s health and wellness!
Increasing Preventive and Primary Care

Health Home participants have high-cost chronic and/or behavioral health conditions. The goal of Health Homes is to provide care in primary care settings and help participants effectively manage their conditions by increasing preventive care. The measures below show Health Homes success in increasing preventive screenings.

Improving Clinical Outcomes

By transforming care, increasing preventive services, treating the whole person and improving the patient experience, Health Homes can improve clinical outcomes for patients. Some of the charts below represent how health improves the longer participants are in the program.

A care coordinator was told by her participant that when the coordinator called her two years ago, participant was contemplating suicide. The call saved participant’s life that day. Through the efforts with her team, participant is leading an active and productive life.

CY2020 Behavioral Health Outcome Goals and Results
A brittle diabetic participant made frequent trips to the ER when blood sugars would go high or low. The Health Home was diligent in working with participant to better control his blood sugar. A Pharmacist was included in their team approach and got the recipient a Continuous Glucose Monitor. The Pharmacist worked with provider and care coordinator on medication management and diabetic control. The participant’s A1C was consistently around 8.5-8.7 and it’s now 7.3 and is not having the extreme highs and lows. The participant’s clinic visits were also cut in half in 2020 compared to 2019 and he had zero ER visits or hospitalizations. Overall, the Health Home was able to decrease medical costs and increase health and wellness!

Improving Patient Experience
Health Homes are tasked with focusing care on the person, including establishing a relationship with Health Home participants. A positive patient experience helps support the health home model, leading to better continuity of care and better health outcomes. Outcomes in this area are split between primary care clinics and community mental health centers.
View the full set of Outcome Measures here. Information about how outcome measures are collected and defined is available here.
Cost Effectiveness of the Health Home Program

DSS matched Health Home participants and individuals eligible but not participating before and after program implementation. Prior to Health Homes both groups per-member per-month (PMPM) costs increased. After Health Homes PMPM costs for Health Home participants decreased relative to those not participating. Costs for individuals not participating in the program continue to rise.

In CY 2020, participants in the Health Home Program cost $151 less per month than recipients with similar demographics and health conditions. DSS estimates $6.9 million was cost avoided in CY 2020 after payment of the PMPM ($3.92 million) and Quality Incentive Payments ($0.5 million) discussed below. Without Health Homes, DSS would have expended approximately $6.9 million more.

Cost Avoidance by Type of Service

Despite increased utilization in outpatient services among the Health Home (HH) group in comparison to the non-HH group, DSS found that costs were still avoided in outpatient services in comparison to the non-HH group.

The HH group also experienced an increase in utilization in Inpatient services in comparison to the non-HH group. Unlike the outpatient services, DSS found that inpatient costs were higher in comparison to the non-HH group. When examined closer, DSS discovered that only 18% of the claims for the HH group were for diagnosis or procedure that could be avoided through care coordination as compared to the 43% of claims for the non-HH group. When controlling for this variable it appears the Health Home Program resulted in cost avoidance in inpatient services.

Pharmacy costs, physician services and all other services accounted for the remaining decrease.
Cost Avoidance by Tier

Tier 1 participants made up 2% of the cost avoidance. Tier 2 and 3 participants continue to make up most of the cost avoidance. For the first time, Tier 4 participants had a negative cost avoidance of 18%. DSS identified two reasons for this result, several Tier 4 recipients had inpatient services totaling $350,000 for diagnoses or procedures that could not be prevented by care coordination and the reticence of some recipients to seek the care they needed due to concerns of potential exposure to COVID-19.

### CY2020 Percentage of Cost Avoidance by Tier

<table>
<thead>
<tr>
<th>Tier</th>
<th>CY 20 Enrollment</th>
<th>CY 20 Cost Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 4</td>
<td>-18%</td>
<td>18%</td>
</tr>
<tr>
<td>Tier 3</td>
<td>2%</td>
<td>97%</td>
</tr>
<tr>
<td>Tier 2</td>
<td>28%</td>
<td>61%</td>
</tr>
<tr>
<td>Tier 1</td>
<td>2%</td>
<td>97%</td>
</tr>
</tbody>
</table>

A summary of the methodology used to calculate the cost avoidance of Health Homes can be found in written format.

**Quality Incentive Payments**

DSS made Quality Incentive Payments to clinics for the third time in June 2021 in the amount of $500,000. Calendar year 2019 outcome measures were used to determine which clinics should be paid. A subgroup of our implementation workgroup helped do a significant revision to the methodology for these payments. More information about the methodology and the payments made can be found at [here](#).