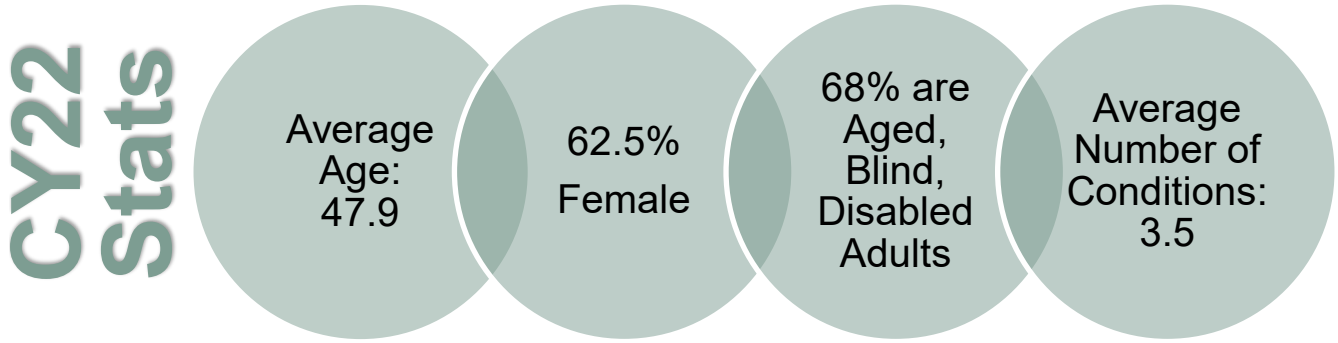
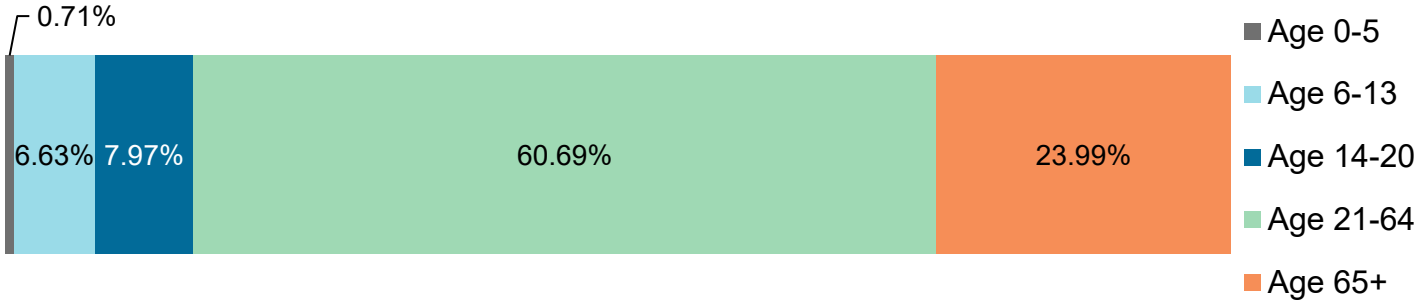
Health Home Data Dashboard

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



Public Health Emergency

The COVID-19 Public Health Emergency (PHE) maintenance of eligibility requirements remained in effect for the duration of CY 2022. This requires states to keep individuals on Medicaid. This pushed the number of individuals in the Health Home Program to an all-time high and eliminated the churn that Medicaid program typically experiences. This resulted in one of the largest average months of eligibility in this programs history.

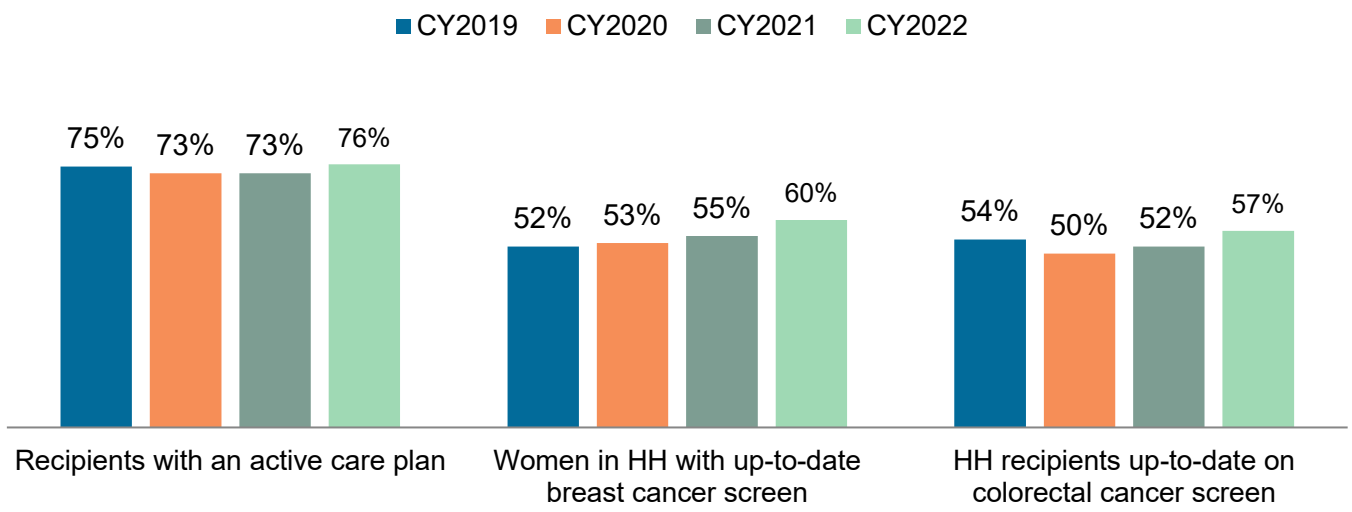
Outcome Measure Update

In Calendar Year 2020, South Dakota Medicaid worked with a Subcommittee to refine the outcome measure set for the Health Home Program. The goal was to reduce the administrative burden for providers reporting this data and align with national data sets. The data reported by providers went from approximately 60 data points to 18. This refined data set was implemented in Calendar Year 2021. As a result, the number of outcome measures reported below will be fewer than past reports.

Increasing Preventive 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. An active care plan can help make sure that all preventive screenings are complete.

Success Story: A health home reported they were successful in having one family with five residents, book appointments, schedule labs and mammograms, and colonoscopies.

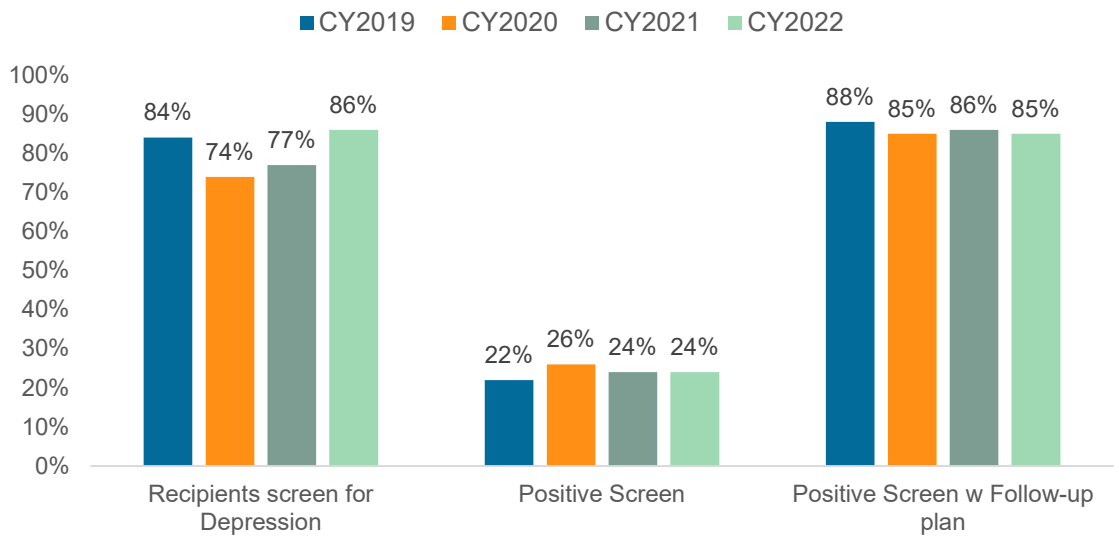


Improving Clinical Outcomes

By increasing preventive services and treating the whole person Health Homes can improve clinical outcomes for patients. Ensuring that behavioral health needs are met is an important part of serving the whole person.

Success Story: A health home reported that a recipient is still sober after quitting 4 years ago.

CY2022 Depression Screening, Positive Screen and Follow-up Plan



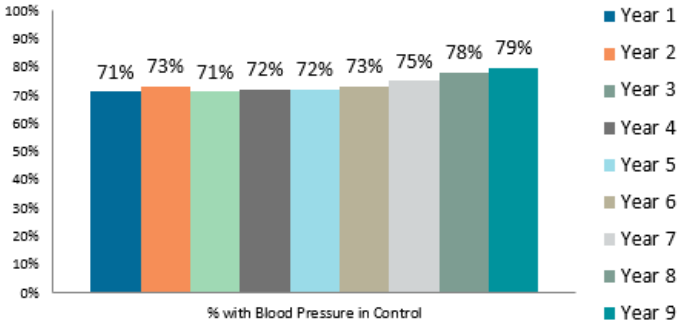
Success Story: A health home care coordinator helped a recipient with a history of significant mental/physical/sexual abuse. Over the past few years the care coordinator worked with the PCP to build rapport with recipient and has been able to ensure she is coming in routinely for follow-up and taking medications as ordered. The health home also included a CHW in her care team to help with SDOH concerns (rental assistance, car repairs, food, travel, etc).

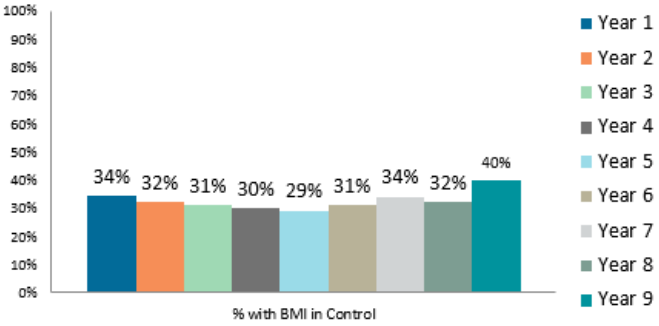
CY2022 Cardiovascular and Obesity Goals and Results

The following charts represent the percentage of recipients in control for Blood Pressure and Body Mass Index (BMI) based on the number of years the recipient has been in the Health Home Program.

	Cardiovascular				Obesity	
Stats	Heart Disease	27.3% of enrollees	Hypertension	52.8% of enrollees	Obesity	22.6% of enrollees
Goals	• Increase % of individuals with blood pressure in control.				• Increase % of individuals with BMI under control.	

Outcomes





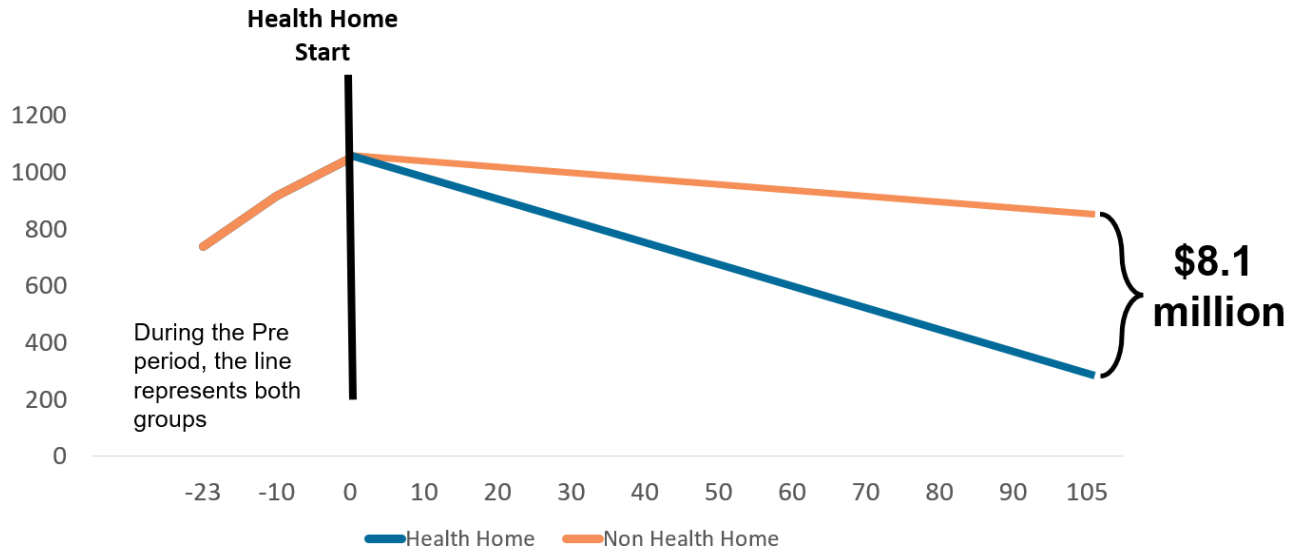
Success Story: A health home care coordinator helped a recipient who was requesting a way to have garden produce in large pots due to living in an apartment. The care coordinator was able to assist the recipient with setting up the rental of an elevated garden box. The recipient was thankful to have fresh produce. The recipient voiced how relaxing gardening was and indicated that the raised beds made it easier to manage their arthritis.

View the full set of Outcome Measures here. Information about how outcome measures are collected and defined is available here.

Cost Effectiveness of the Program

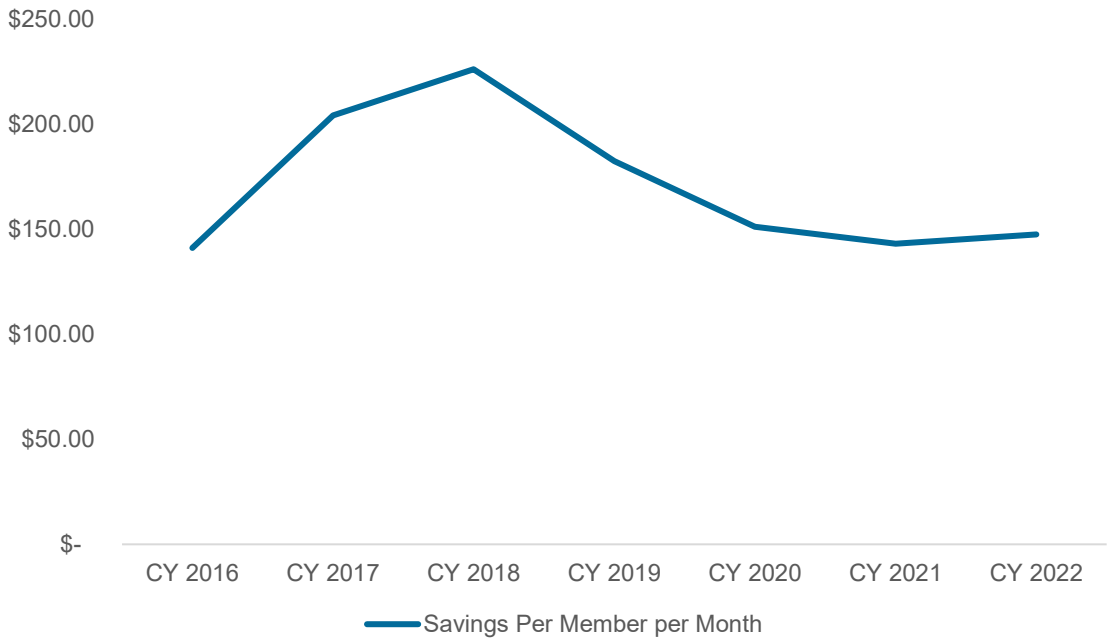
To analyze the cost effectiveness of the Health Home program Medicaid compared Health Home participants and individuals eligible but not participating before and after program implementation. Prior to Health Homes both groups per-member per-month (PMPM) costs increased. After Health Homes PMPM costs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

In CY 2022, participants in the Health Home Program cost $147 less per month than recipients with similar demographics and health conditions. Medicaid estimates $8.1 million was cost avoided in CY 2022 after payment of the PMPM ($4.84 million) and Quality Incentive Payments ($0.5 million). Without Health Homes, it appears Medicaid would have spent approximately $8.1 million more.



Cost Avoidance by PMPM

The PHE resulted in the largest average number of recipient months in program history. PMPM cost avoidance peaked in CY 2018 at $226.00 PMPM and has subsequently trended down. For CY 2022 PMPM cost avoidance was $147.37.



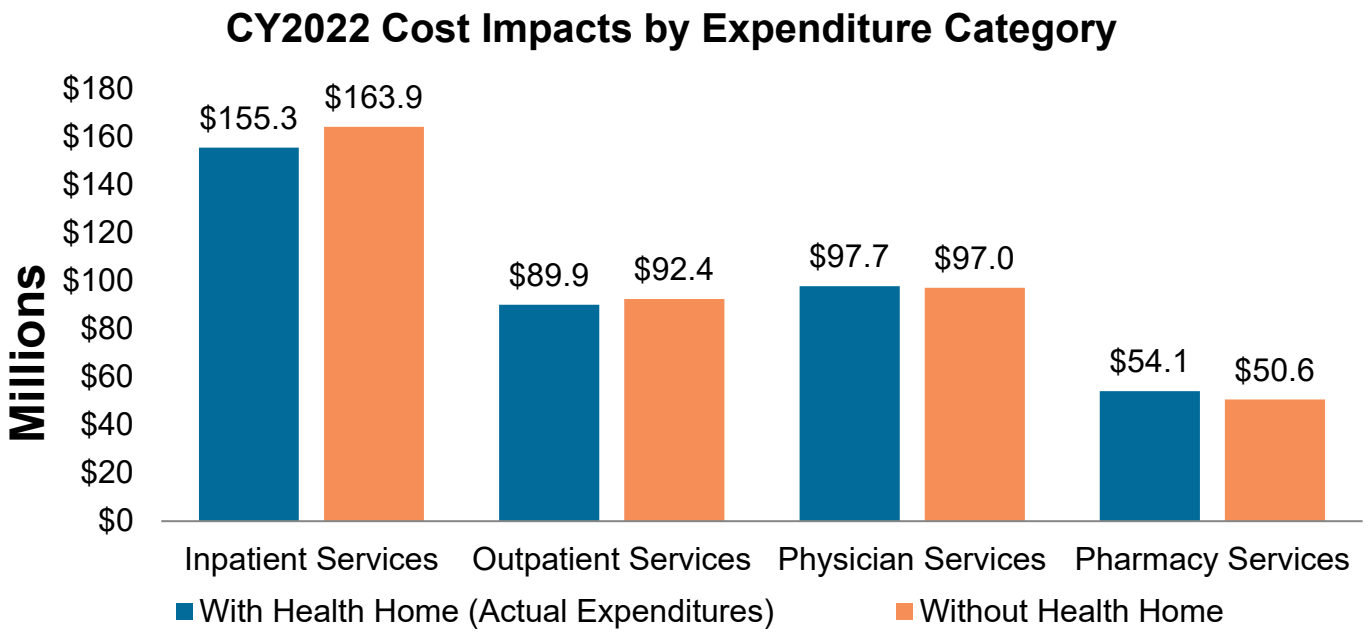
Cost Avoidance by Type of Service

In CY 2022, recipients who participated in the health home program had fewer inpatient stays that the control group. Participants had 4.85 fewer stays per 1,000 members per month or 22% fewer stays than the control group. This decrease resulted in an estimated $8.57 million cost avoidance related to inpatient stays. Additionally, there have been $420,000 in cost saving with ambulatory care sensitive conditions through the Health Home program.

Participants also had fewer Emergency Department (ED) visits than the control group. Participants had 8.46 fewer visits per 1,000 members per month or 10% fewer visits than the control group. This decrease resulted in an estimated $2.44 million cost avoidance related to ED visits.

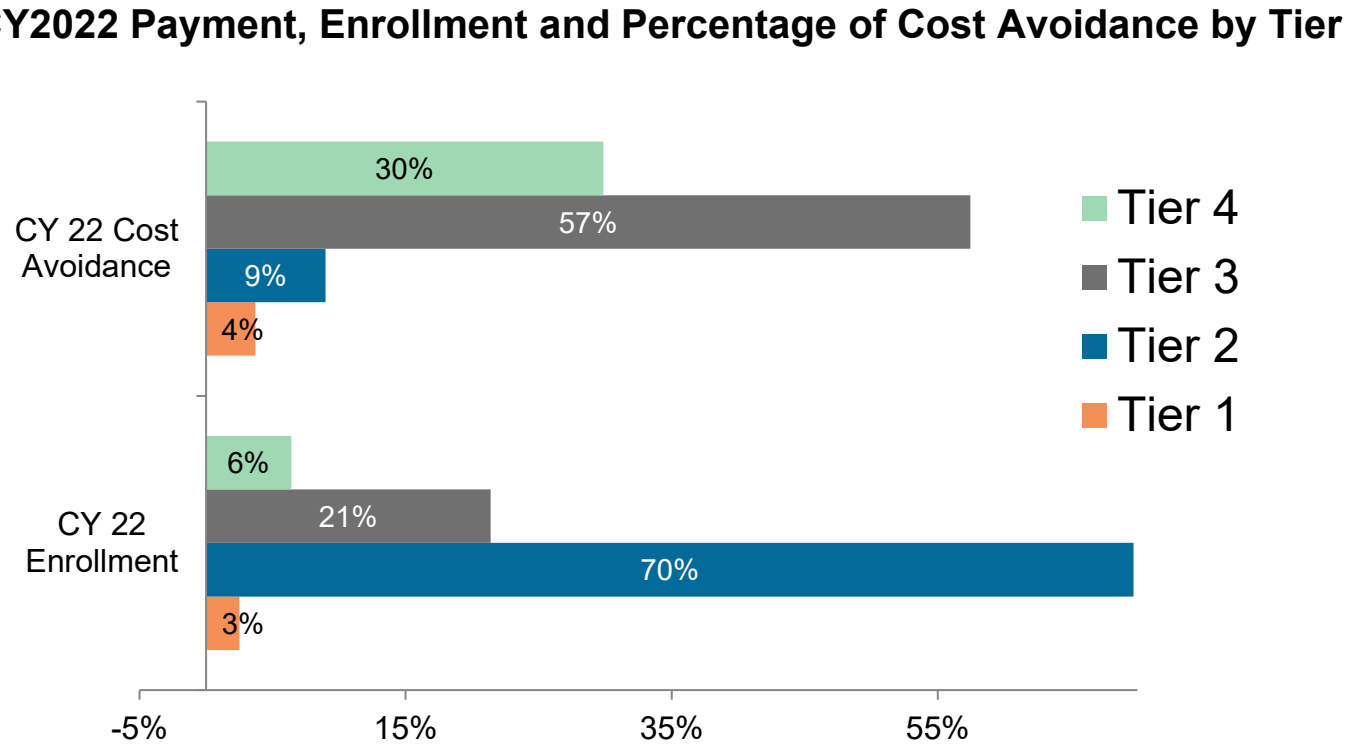
All other services accounted for the remaining decrease. Pharmacy services cost more for recipients who participated in the Health Home Program than the control group. This may be due to better medication adherence due to care coordination. Physician services also cost slightly more for recipients who participated in the Health Home Program than the control group. The following chart represents the overall impact to the South Dakota Medicaid budget by expenditure category.

Success Story: A health home care coordinator worked with a recipient with Emergency Department (ED) overuse. The recipient has started calling the care coordinator and coming to clinic instead of going to ED for non-emergent conditions.



Tiers by the Number

Tier 1 participants made up 4% of the cost avoidance. Tier 2 and 3 participants made up 66% of the cost avoidance. Tier 4 participants achieved aggregate cost avoidance after costing more than the control group in recent years. Tier 4 recipients account for 30% of the total cost avoidance.



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

Quality Incentive Payments

Medicaid made Quality Incentive Payments to clinics in June 2023 in the amount of $530,000. Calendar year 2021 outcome measures were used to determine which clinics should be paid. The methodology remained the same as the payment made in 2020 when subgroup of the implementation workgroup helped do a significant revision to the methodology for these payments. More information about the methodology and the payments can be found here.