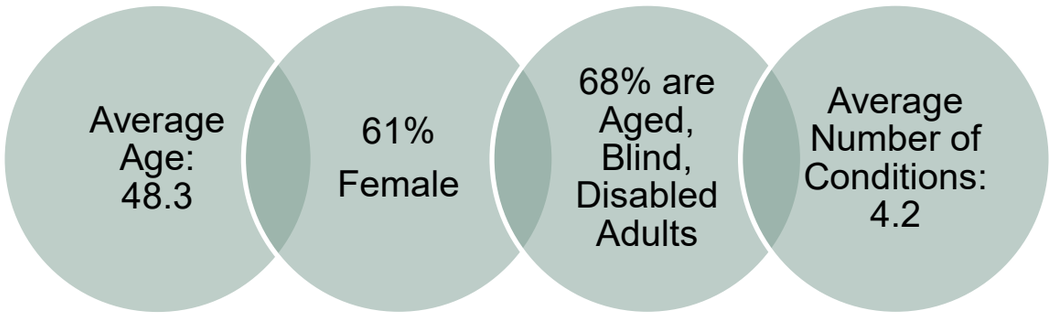
Health Home Data Dashboard

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.

CY21 Stats



Age of Participating Recipients

Public Health Emergency

The COVID-19 PHE maintenance of eligibility requirements 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.

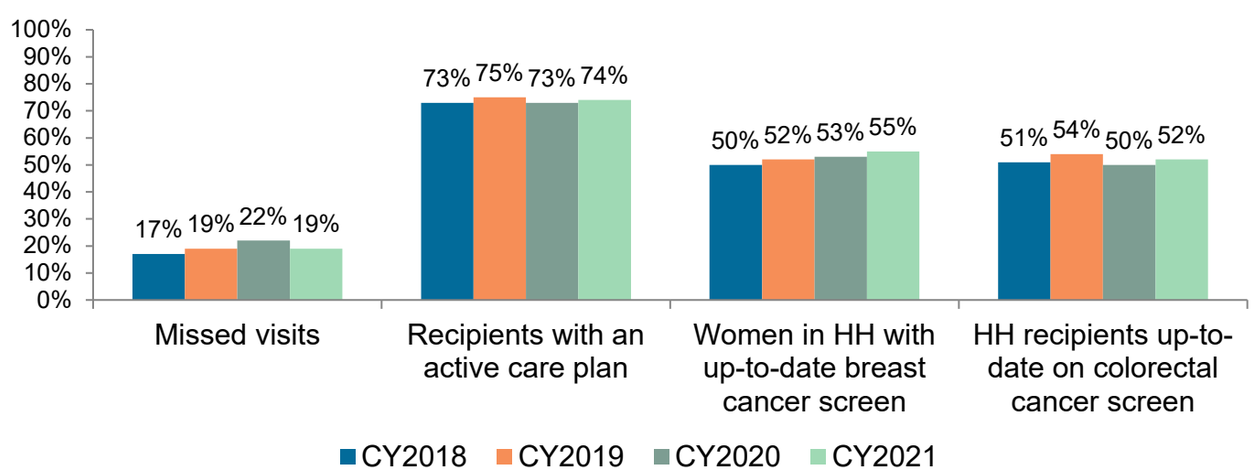
Outcome Measure Update

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. It also shows the percentage of missed visits.

Success Story: A clinic reported they were able to get two sisters to their first mammograms.

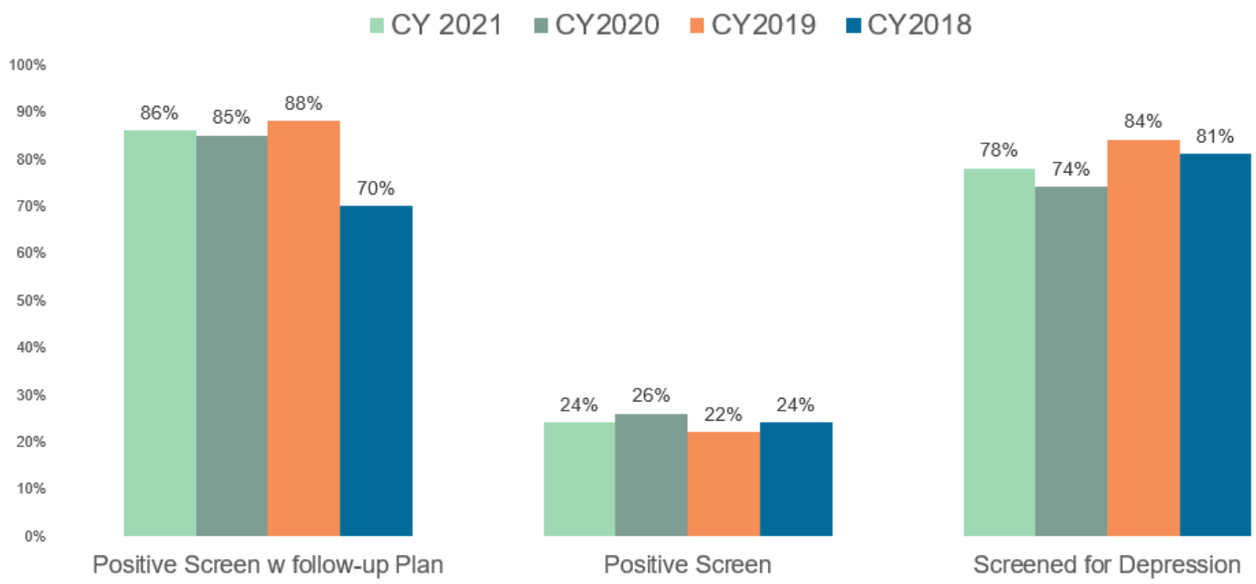


Improving Clinical Outcomes

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 clinic helped a recipient utilize a community garden. This helped with the recipient's grocery costs, food choices, and mental health through the act of caring for the garden.

CY2021 Depression Screening, Positive Screen and Follow-up Plan



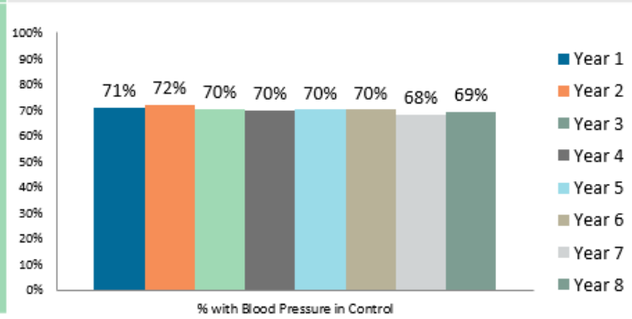
Success Story: A care coordinator helped a recipient successfully navigate a significant life stressor that was having a negative impact on his health. The recipient was connected to resources to ensure that the recipient had a place to live and the recipient is now thriving and safe.

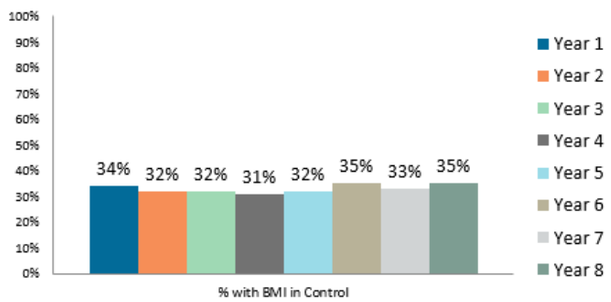
CY2021 Cardiovascular and Obesity Goals and Results

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% of enrollees	Hypertension 50.9% of enrollees	Obesity	23.7% of enrollees
Goals	• Increase % of individuals with blood pressure in control.		• Increase % of individuals with BMI under control.	

Outcomes



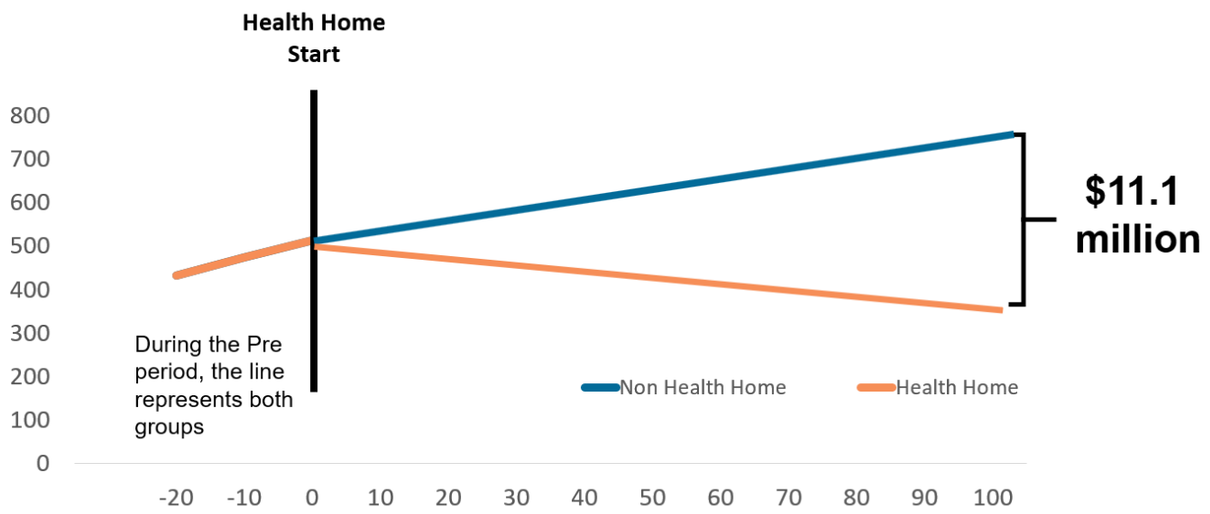


View the full set of Outcome Measures here. Information about how outcome measures are collected and defined is available here.

Cost Effectiveness of the Health Home Program

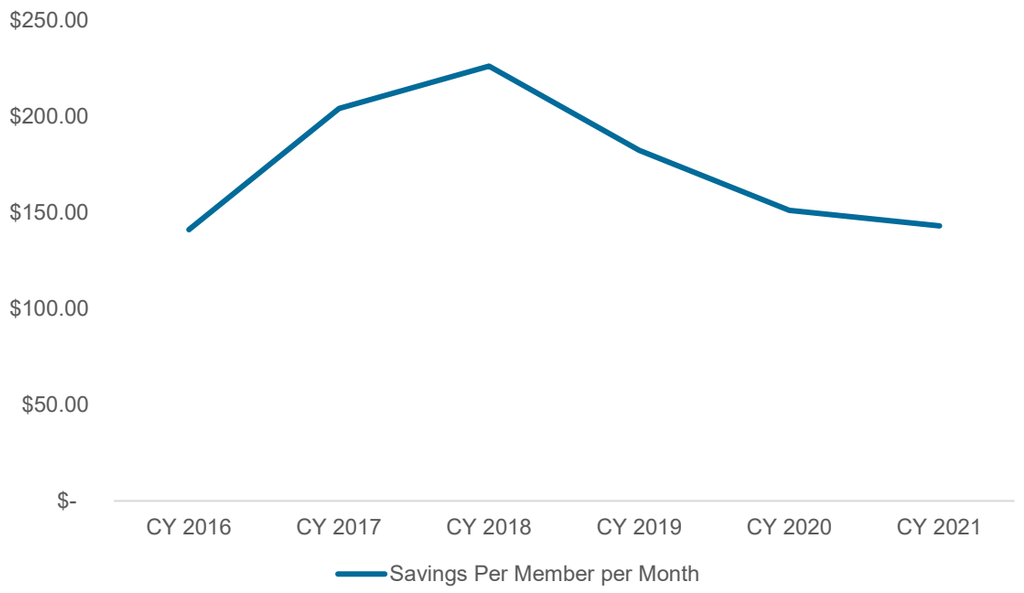
To analyze the cost effectiveness of the Health Home program Medicaid compared Health Home participants and individuals eligible but not participating before and after program implementation. Prior to Health Homes both groups per-member per-month (PMPM) costs increased. After Health Homes PMPM costs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

In CY 2021, participants in the Health Home Program cost $143 less per month than recipients with similar demographics and health conditions. Medicaid estimates $11.1 million was cost avoided in CY 2021 after payment of the PMPM ($4.2 million) and Quality Incentive Payments ($0.5 million). Without Health Homes, it appears Medicaid would have spent approximately $11.1 million more.



Cost Avoidance by PMPM

The PHE resulted in the largest average number of recipient months in program history. The combination of the high number of recipients and high average member months resulted in the Health Home Program achieving the largest estimated cost avoidance in the history of the program. PMPM cost avoidance peaked in CY 2018 at $226.00 PMPM and has subsequently trended down. For CY 2021 PMPM cost avoidance was $143.00.



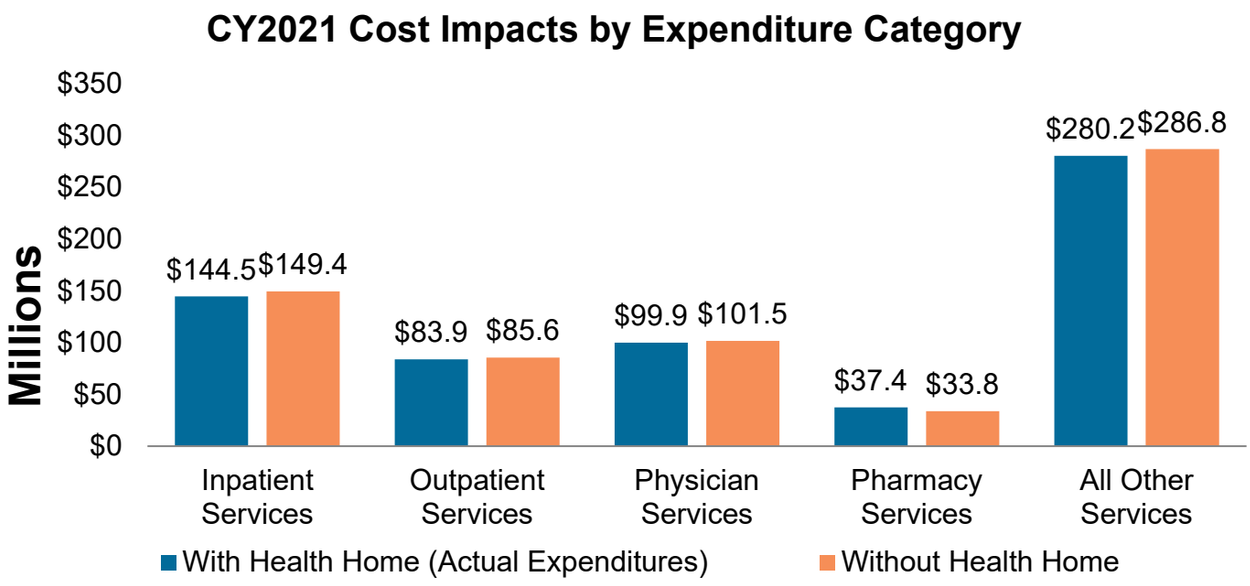
Cost Avoidance by Type of Service

In CY 2021, recipients who participated in the health home program had fewer inpatient stays that the control group. Participants had 1.72 fewer stays per 1,000 members per month or 8% fewer stays than the control group. This decrease resulted in an estimated $4.89 million cost avoidance related to inpatient stays.

Participants also had fewer Emergency Department (ED) visits than the control group. Participants had 4.8 fewer visits per 1,000 members per month or 5.6% fewer visits than the control group. This decrease resulted in an estimated $1.61 million cost avoidance related to ED visits.

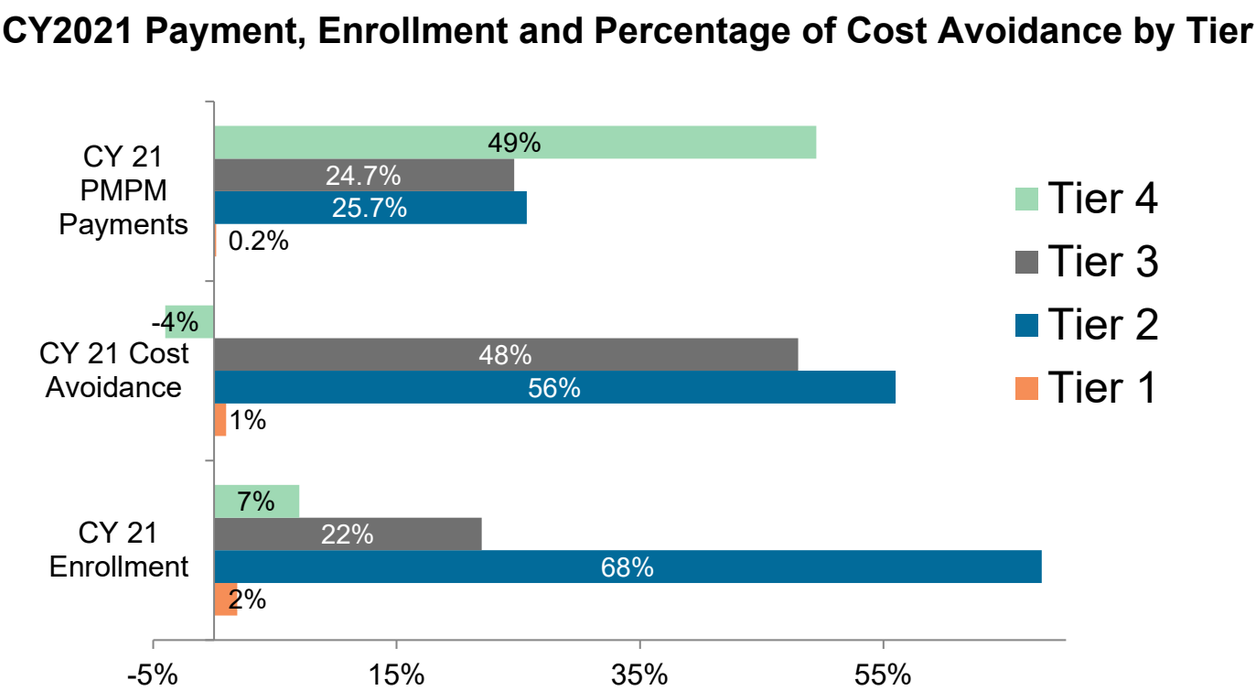
Physician services and all other services accounted for the remaining decrease. Pharmacy service cost more for recipients who participated in the Health Home Program than the control group. This may be due to better medication adherence due to care coordination. The following chart represents the overall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

Success Story: A care coordinator worked with a recipient who had repeated ED visits. The care coordinator communicated with the local EMS and ED to discuss options. The recipient is now contacting the local crisis line when appropriate instead of emergency services.



Tiers by the Number

Tier 1 participants made up 1% of the cost avoidance. Tier 2 and 3 participants made up the remaining 99% of the cost avoidance. For the second year in a row, Tier 4 participants had a negative cost avoidance. Tier 4 recipients were 4% more expensive than the control group. This is an improvement from CY 2020 when Tier 4 recipients were 18% more expensive than the control group. South Dakota Medicaid has formed a Subgroup to explore options to create a positive Return on Investment (ROI) for the Tier 4 group.



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 2022 in the amount of $500,000. Calendar year 2020 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.

National Outcomes Data

While South Dakota has been submitting data to the Centers for Medicaid and Medicare Services (CMS) for years, CMS released national data results by state for the first time in 2020 for CY 2018. CMS also released CY 2019 data earlier this year. The CY 2019 data only included the national results with the Median, Upper Quartile and Lower Quartile for each measure and did not include state-by-state results. South Dakota also added data for CY 2020 where applicable. This delay in reporting and inconsistent method of reporting by CMS has made it challenging to include the National data in this dashboard.

Data for Screening for Clinical Depression and Follow-up and Controlling High Blood Pressure were not released by CMS, so there is not applicable comparative data available. South Dakota's results for these two measures are listed below. Measure 9 related to Inpatient Utilization was submitted by the states but is still under review by CMS and has not been released.

On the remaining 8 measures South Dakota outperformed other states in the 4 of the measures and under performed in the other 4.

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

The following two measures were submitted to CMS; however, CMS did not publish other state's data, so the South Dakota is unable to compare the data to other states.

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

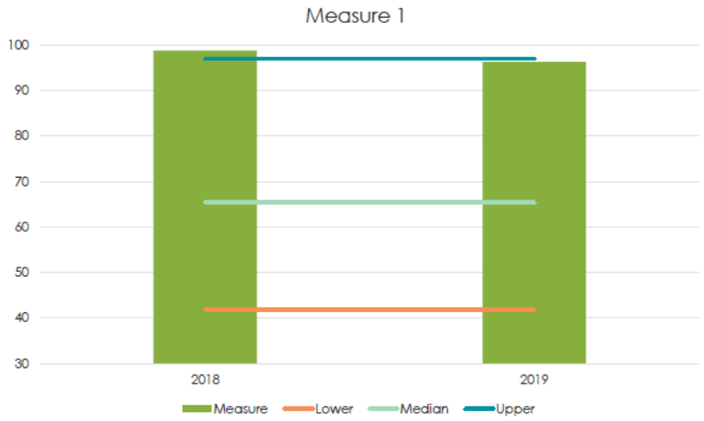
FFY20	Total	Age 18-64	Age 65-85
Denominator (Number of People with Hypertension)	1,213	796	417
Number of People with Hypertension with Controlled BP	1,116	718	398
Percent with hypertension that is controlled	92.0%	90.2%	95.4%

Data for the following set of measures was published by CMS. The charts below display South Dakota's performance on the measure and includes lines that provide context regarding whether South Dakota is in the lower, median, or upper quartile for each measure relative to national Health Home Programs' data. It is also noted in each section whether "Higher" or "Lower" is better for the measure.

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



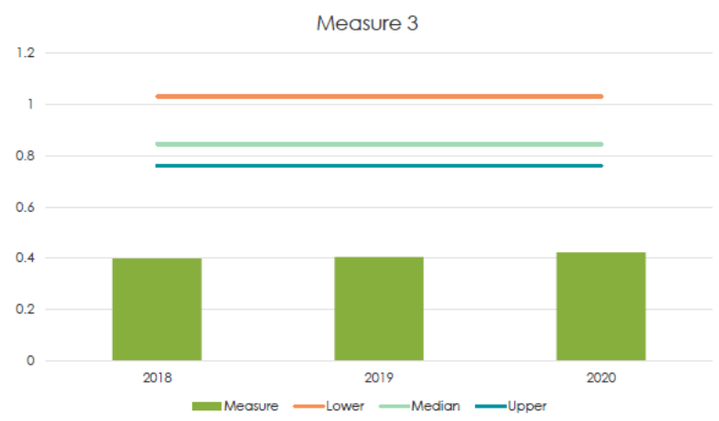
Year	Measure
2018	98.8
2019	96.3
2019 Quartile Data	
Lower	41.8
Median	65.4
Upper	97

*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

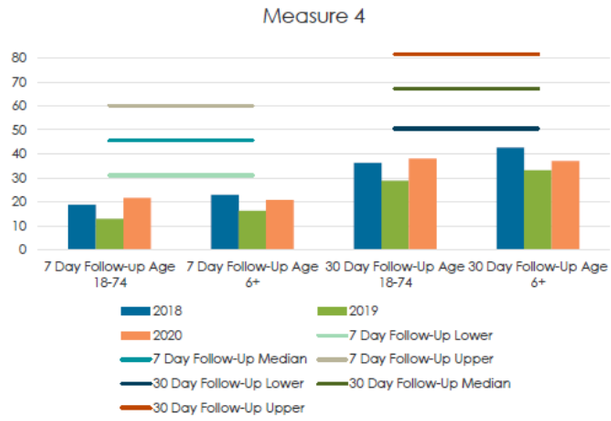


Year	Measure
2018	0.3988
2019	0.4041
2020	0.4223
2019 Quartile Data	
Lower	1.0311
Median	0.4852
Upper	0.7605

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

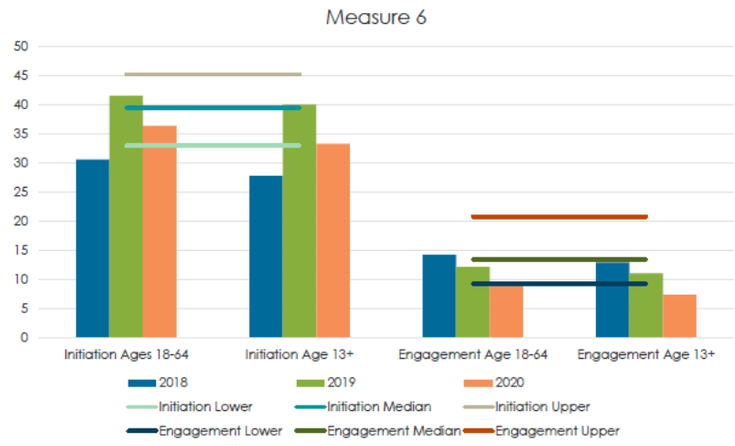


Year	7 Day Follow-up Age 18-74	7 Day Follow-Up Age 6+	30 Day Follow-Up Age 18-74	30 Day Follow-Up Age 6+
2018	18.8	22.9	36.2	42.7
2019	12.9	16.3	28.8	33.2
2020	21.6	20.7	38.1	37
2019 Quartile Data				
Lower	29.8	31.1	44.9	50.6
Median	42.2	45.6	65	67.2
Upper	57.3	60.1	77.9	81.5

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

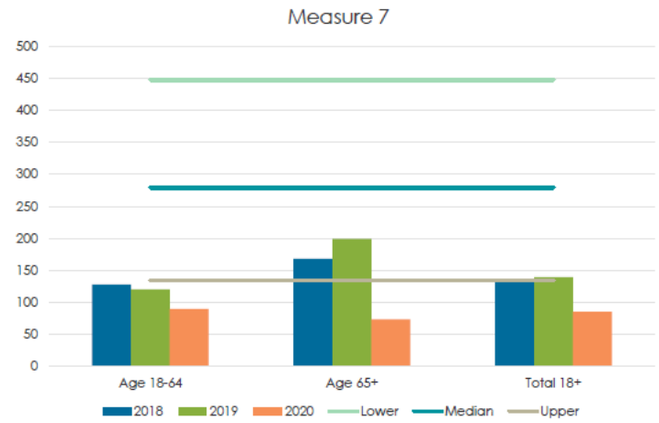


Year	Initiation Ages 18-64	Initiation Age 13+	Engagement Age 18-24	Engagement Age 13+
2018	30.6	27.8	14.3	13
2019	41.5	40	12.2	11.1
2020	36.4	33.3	9.1	7.4
2019 Quartile Data				
Lower	32.6	33	9.7	9.3
Median	38.9	39.5	13	13.5
Upper	45.3	45.2	20.9	20.8

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

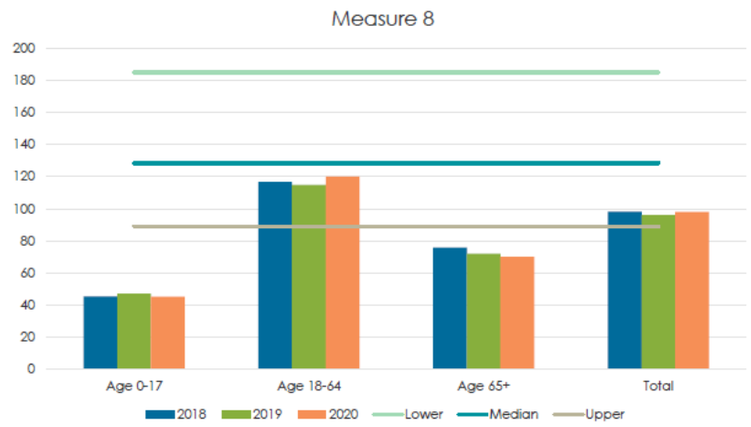


Year	Age 18-64	Age 65+	Total 18+
2018	127.7	167.7	136.7
2019	120	199	139
2020	89	73	85
2019 Quartile Data			
Lower	441.9	662.8	448.1
Median	292	401.6	279.4
Upper	134	134	134.1

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

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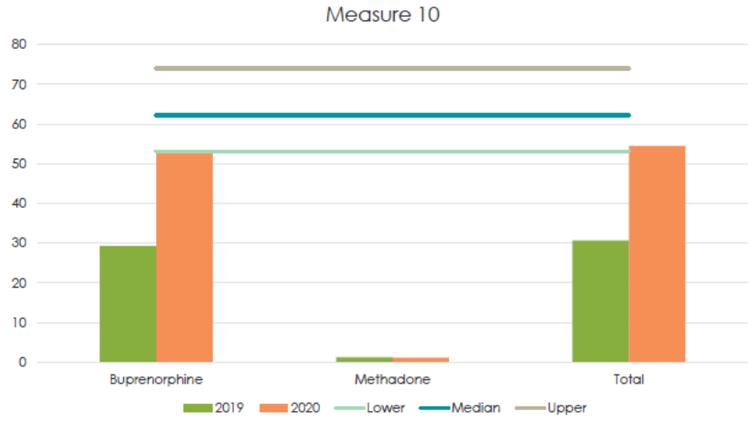
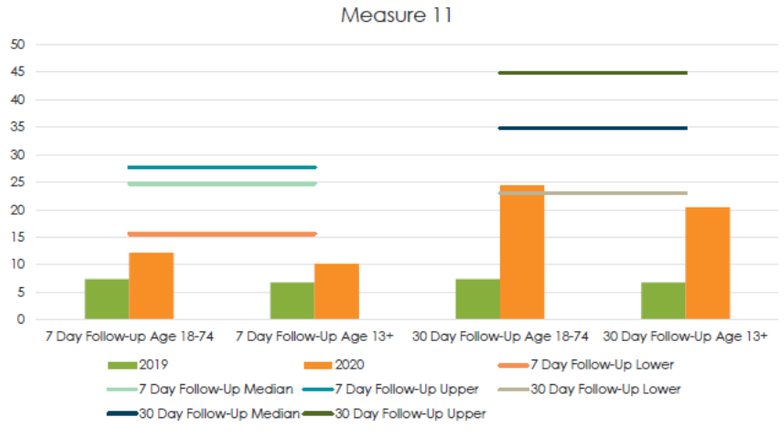


Year	Buprenorphine	Methadone	Total
2019	29.3	1.3	30.7
2020	53.41	1.14	54.55
2019 Quartile Data			
Lower	29	7.1	53.1
Median	39.2	22.9	62.2
Upper	50.8	29.7	74.01
***2018 Data Not Available**			

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**				