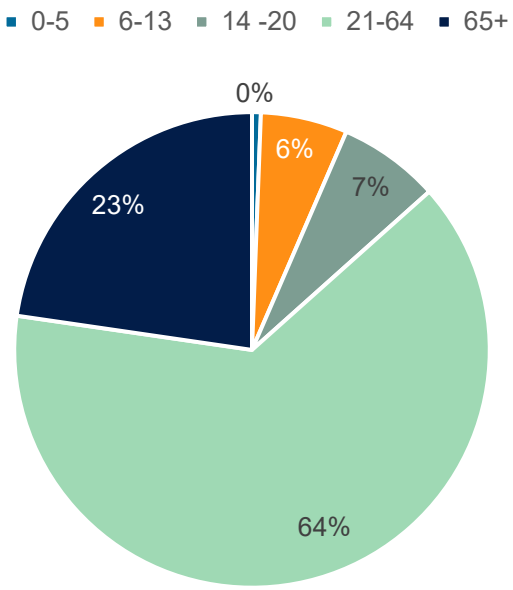
Health Home Data Dashboard

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.

CY23 Stats

- Average Age: 48.4
- 62.2% Female
- 74% are Aged, Blind,or Disabled Adults
- Average Number of Conditions: 4.1

CY2023 Age of Participating Recipients



Public Health Emergency and Medicaid Expansion

Calendar Year 2023 was unique in the sense that it contained both the end of the Public Health Emergency as well as the addition of an expanded Medicaid eligibility threshold. Those factors combined to result in higher-than-average Health Home enrollment numbers.

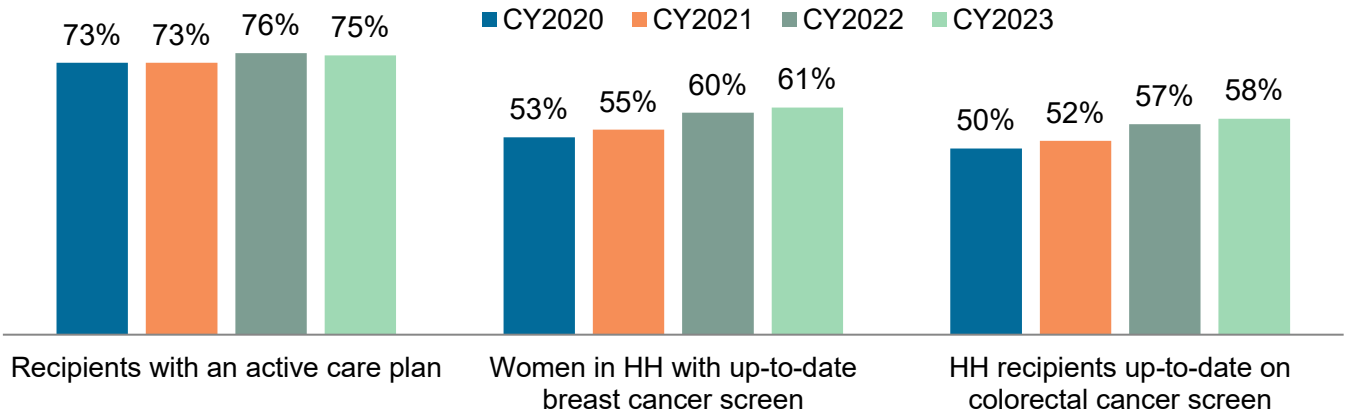
Outcome Measure Update

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 on providers reporting this data and to align with national data sets. The data reported by providers decreased from approximately 60 data points to 18. This refined data set was implemented in Calendar Year 2021. With the completion of the second full year under this new structure (CY23), SD Medicaid expects the data sets to begin stabilizing.

Increasing Preventive Care

Health Home participants have high-cost chronic and/or behavioral health conditions. The goal of the Health Home team is to provide care in primary care settings and help participants effectively manage their conditions by increasing preventive care. The measures below show Health Home's success in increasing preventive screenings. An active care plan can help make sure that all preventive screenings are complete.

Success Story: A patient receiving care at the clinic expressed gratitude stating, "You can make my mountains seem so small just by explaining them better. My anxiety is reduced, and I feel life is more manageable."

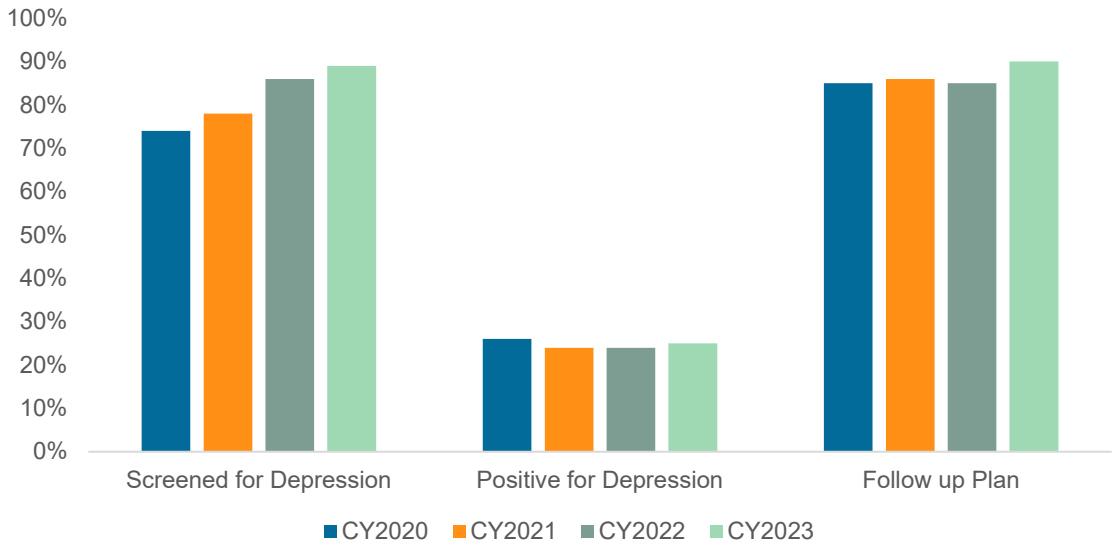


Improving Clinical Outcomes

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 recipient had been on Health Home for some time but wanted a new provider. After connecting them with a new Health Home provider, the recipient attends their office visits monthly as directed. Their health has seen significant improvement. Their A1c was over 14. Four months later, it dropped to 6.9, and since then, it has consistently remained in the 5s with the help of their medications. Additionally, they have lost 71 pounds.

CY2023 Depression Screening, Positive Screen and Follow-up Plan

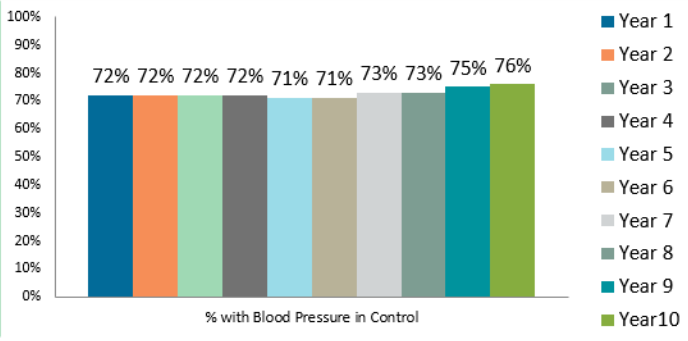


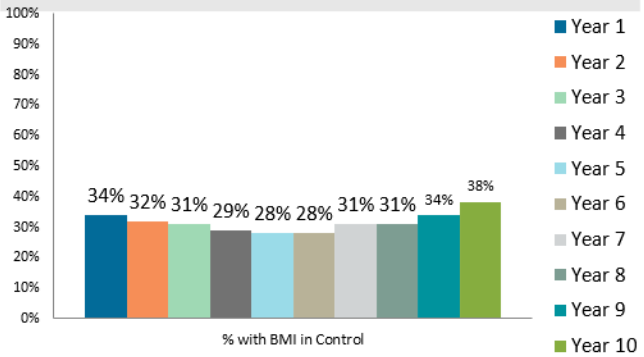
Success Story: A health home care coordinator helped a recipient with a history of significant mental/physical/sexual abuse. Over the past few years the care coordinator worked with the PCP to build rapport with the recipient and has been able to ensure they are coming in routinely for follow-up visits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

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: 26% of enrollees	Hypertension: 49% of enrollees	Obesity: 24% of enrollees	
Goals	• Increase % of individuals with blood pressure in control.		• Increase % of individuals with BMI under control.	

Outcomes



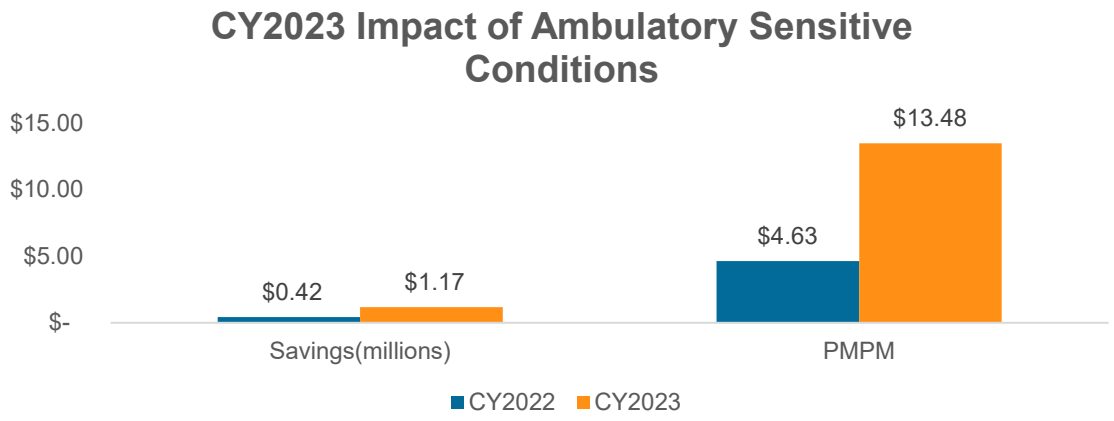


Success Story: A Health Home successfully assisted a patient in arranging for senior meal deliveries to their home. Although they were initially told they didn't qualify, the Health Home nurse was able to coordinate the service based on their comorbidities and a provider's recommendation.

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

Serving Recipients at the Appropriate Level

One of the goals of the program is to help recipients receive care at the appropriate level. This is measured by monitoring Ambulatory Care Sensitive Conditions (ACSC). These are conditions such as prediabetes, diabetes and hypertension that, when appropriately managed at the outpatient level, can reduced the risk of hospitalization. In CY 2022, cost avoidance related to ACSC for Health Home recipients was 23%more than those not in the Health Home program. In CY 2023, it was 49% more than those not in the Health Home Program.

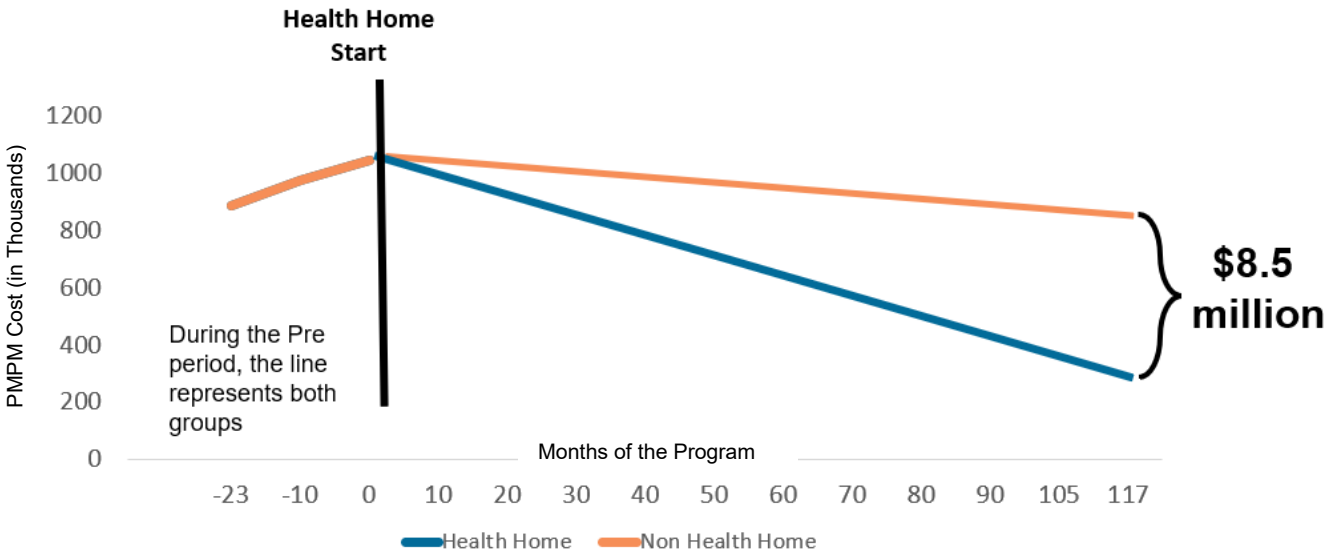


Success Story: A Health Home helped arrange transportation to Sioux Falls for Endocrinology appointment. The Health Home meets with recipient regularly to assist with the CGM sensor placement. The recipient had an A1C of 12 in March 2023 and now their A1C is 7 in March 2024. The recipient is more accountable for their choices with the CGM and feels like they can make life changes that can make an impact on their health.

Cost Effectiveness of the Program

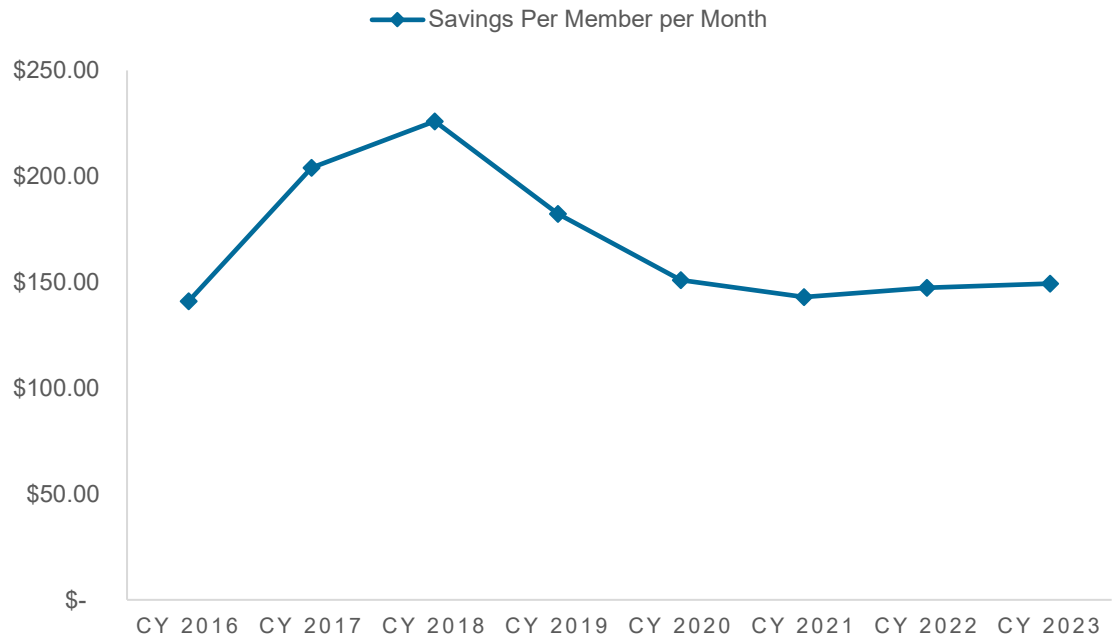
To analyze the cost effectiveness of the Health Home program Medicaid compared Health Home participants and individuals eligible but not participating before and after program implementation. Prior to Health Homes both groups per-member per-month (PMPM) costs increased. After Health Homes, PMPM costs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

In CY 2023, participants in the Health Home Program cost $149 less per month than recipients with similar demographics and health conditions. Medicaid estimates $8.5 million was cost avoided in CY 2023 after payment of the PMPM ($3.96 million) and Quality Incentive Payments ($0.56 million).



Cost Avoidance by PMPM

The combination of PHE and expansion factored into high average enrollment in CY 2023. The PMPM cost avoidance peaked in CY 2018 at $226.00. The PMPM cost avoidance has subsequently trended down. For CY 2023 PMPM cost avoidance was $149.35.



Cost Avoidance by Type of Service

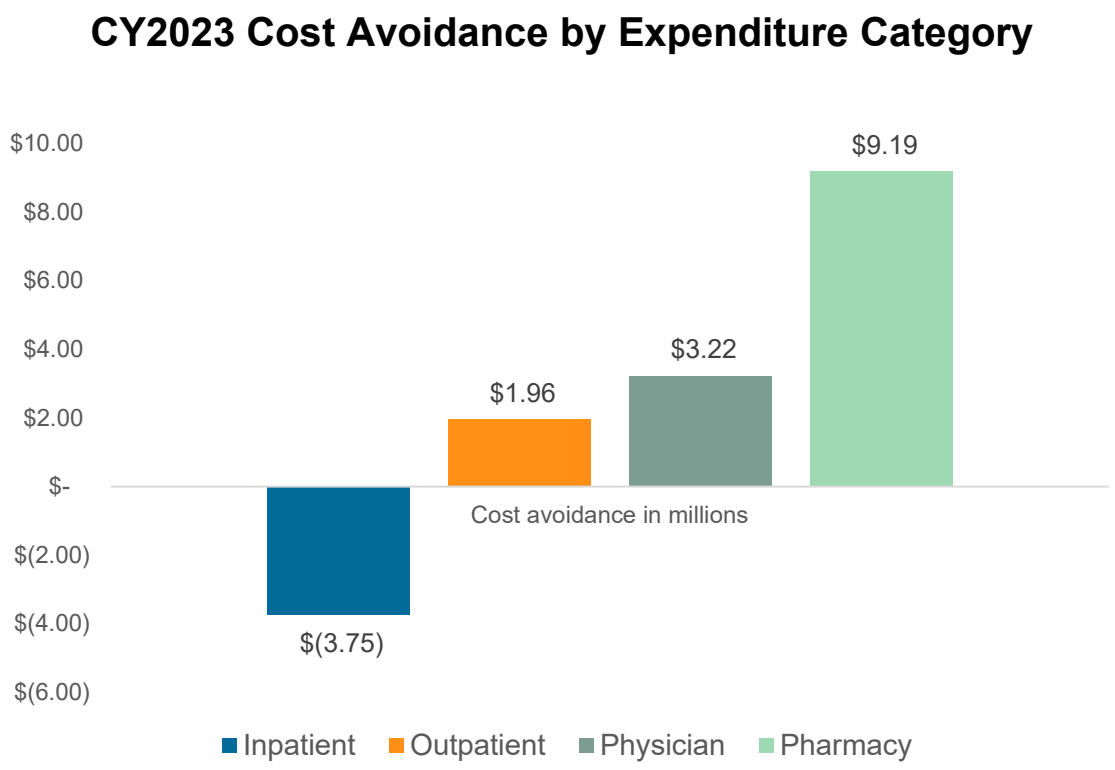
In CY 2023, recipients who participated in the Health Home program had fewer inpatient stays when compared to the control group. Participants had 1.87 fewer stays per 1,000 members per month or 5.21% fewer stays than the control group. Unfortunately, the cost of the IP stays for this group were higher than the control group resulting in an increased spend of $3.75 million.

Emergency Department expenditures were $1.96 million less than those in the control group.

Pharmacy services accounted for $9.19 million in cost avoidance. Participants spent $105.50 PMPM less than the control group.

Physician services accounted for $3.22 million in cost avoidance. Participants spent $36.99 PMPM less than the control group. All other services accounted for the remaining $2.39 million in cost avoidance. The following chart represents the overall impact to the South Dakota Medicaid budget by expenditure category.

Success Story: The care coordinator discussed transportation challenges with a recipient for both local and out of town specialty appointments. Helped the recipient to set up the first few. Now the recipient is able to set up their own transportation to their visits. The discussion and demonstration helped the recipient to achieve improved appointment compliance.

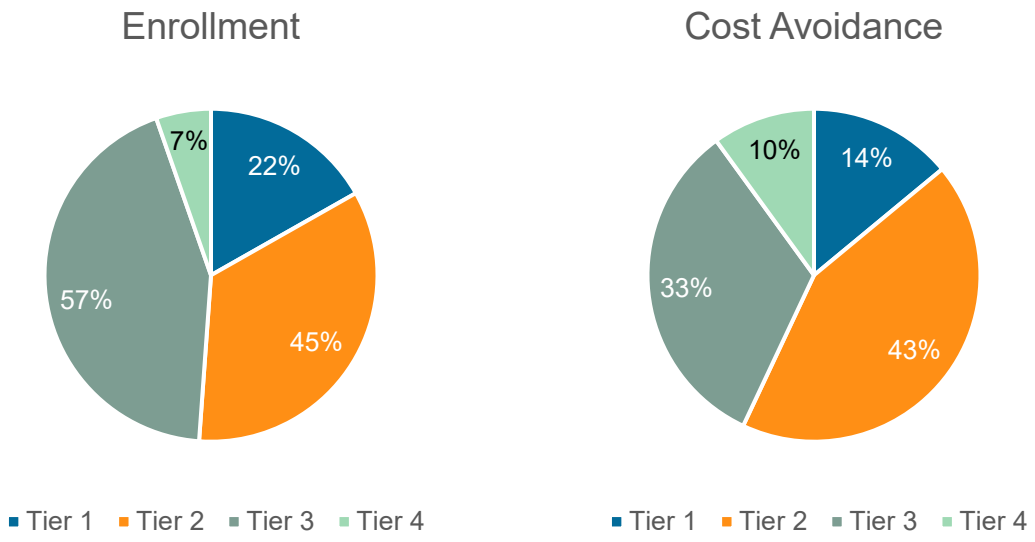


Tiers by the Number

Tier 1 participants made up 14% of the cost avoidance. Tier 2 and 3 participants made up 76% of the cost avoidance. Tier 4 recipients accounted for 10% of the total cost avoidance. While all Tiers achieved savings in CY 2023, the level of cost avoidance PMPM by tier differed significantly:

- Tier 1 was $96.23 PMPM,
- Tier 2 was $142.96 PMPM,
- Tier 3 was $187.34 PMPM,
- Tier 4 was $209.30 PMPM.

CY2023 Enrollment and Percentage of Cost Avoidance by Tier



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 $556,500.00. CY 2022 outcome measures were used to determine which clinics should be paid. The methodology remained the same as the payment made in 2020 when a subgroup of the implementation workgroup helped complete a significant revision to the methodology for these payments. The clinical outcome payment pool payments were based on performance on the following measures:

- Depression follow-up plan documented
- Active care plan
- BMI in control
- Mammogram up to date
- Colonoscopy up to date
- Blood pressure in control
- Face-to-face visits missed

More information about the methodology and the payments can be found here.