Health Home Administrative Training

South Dakota
Department of
Social Services

What is a Health Home?

Partnership with Medicaid Providers to help manage the high risk, high-cost recipients.

Team Based approach that supports the whole person.

Designed to affect change in the Health Home recipient's health status and reduce utilization of high-cost services.

Based on the provision of the six Core Services outlined by CMS and defined by the Health Home Implementation Workgroup.

Provider Infrastructure

Two Types of Health Homes

Primary Care Provider

- Primary Care Physician
- PA/Advance Practice Nurse

  Working in a
  - Federally Qualified Health Center
  - Rural Health Clinic
  - Clinic Group Practice
  - IHS/Tribal 638

Behavioral Health

- Mental Health Provider working in a Community Mental Health Center (CMHC)

Team

- Care Coordinator
- Primary Care Provider
- Pharmacist
- Support Staff
- Other services as needed
- Behavioral Health Specialist

Who Do Health Homes Serve?

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- **Any** Medicaid Recipient who has…..
  - Two or more chronic conditions or one chronic and one at risk condition (Defined separately below)
    - ❑ **Chronic Conditions include:** Mental Illness, Substance Abuse, Asthma, COPD, Diabetes, Hypertension, Obesity Musculoskeletal and neck and back disorders
    - ❑ **At Risk Conditions include:** 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.
- Eligibility based on 15 months of claims data based on diagnosis.
- Recipients who meet the eligibility criteria are stratified into four tiers based on the recipient illness severity using the Chronic Illness and Disability Payment System (CDPS).

Six Core Services

- CMS requires the six Core Services be provided to all recipients attributed to a provider.
- Health Homes are paid on a quarterly basis a retrospective monthly PMPM for the delivery of the Core Services. All medical services continue to be reimbursed according to the current reimbursement structure.
- Health Home minimum requirement is to provide one of the Core Services to each recipient every quarter.

Six Core Services

Core Services must meet the following criteria

- The Core Service is provided directly to the recipient or to the recipient's guardian for the direct benefit of the recipient;
- The Core Service must be provided either in person, via telemedicine, or via telephone.
- The Core Service is related to individualized goals in the care plan. There may be some exceptions to this requirement such as development of the care plan and assisting with transitional care;
- The Core Service is documented in the EHR including a description of the Core Service and the applicable category of Core Service;
- The Core Service is not reimbursed by South Dakota Medicaid as part of another service;
- The Core Service meets the description of one of the six Core Service categories;
- The Core Service is provided by the Health Home Care Coordinator or another member of the Health Home Care Team. It is anticipated that Core Services would be provided by clinic staff that cannot directly enroll and bill Medicaid.

Six Core Services

- Six Core Services must be provided to the level appropriate for each recipient. More in-depth definitions at:
- https://dss.sd.gov/docs/medicaid/PCP_Core_Services_Specific.pdf

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care/follow-up
5. Patient and family support
6. Referral to community and social support services

1.Comprehensive Care Management

Comprehensive Care Management

Comprehensive Care Management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral, specialty health care, and community support services. Comprehensive care management requires developing a comprehensive person-centered care plan which addresses all clinical and non-clinical needs. Examples:

a. Conducting outreach activities to gather information from the recipient, the recipient's caregiver, and other primary and specialty care providers;
b. Completing a comprehensive needs assessment which includes, behavioral health screenings such as depression and substance use, social determinants of health screening, and other screenings as determined necessary by the team.
c. Developing a comprehensive person-centered care plan including individualized goals and action steps to achieve the goals.

Key Elements of a Care Plan

- Care Plans are an integral part of serving recipients in Health Homes.
- Each clinic or Health System can choose a template for their Care Plan, but a Care Plan must be completed for each recipient in Health Homes.
- If behavioral health needs are identified in the assessment, Care Plan should include plan to address.
- Care Plans should be developed with active participation from the recipient and their supports if applicable.

Key Elements of a Care Plan

- **Care Plans should include:**
  - Basic recipient information (Name, DOB, etc.)
  - Medical conditions
  - Medications or document that the medications listed in the EHR were reviewed and/or updated.
  - A summary of the recipient's health-related social needs (housing, employment, transportation etc.)
  - A summary of durable medical equipment needs if applicable.
  - Goals to improve health and overcome barriers.
  - Progress notes documenting progress made towards achieving goals.
  - Family members/friends involved in care.
  - Behavioral health needs if applicable including documenting:
    - Last depression screening (date and/or results)
    - Last substance use screening (date and/or results)
    - Whether they are engaged in active treatment and when their most recent appointment occurred
  - Community resources the recipient was referred to.
  - Indicate if the recipient can self-manage their conditions including if they are using self-management tools to record the results.
  - Specialist the recipient was referred to including documentation that an electronic summary of care was provided to the specialist.
  - Documentation of future appointments including
    - Next primary care provider appointment, if known.
    - Other healthcare appointments
  - The dates when care plan was originally created.
  - The date the care plan was last updated/reviewed.

2. Care Coordination

Care Coordination

Care coordination is the implementation of the person-centered care plan. The plan must be implemented through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Examples:

a. Monitoring progress towards goals in the person-centered care plan;
b. Coordinating with other healthcare providers;
c. Assisting and supporting the recipient with scheduling health appointments with other healthcare providers;
d. Supporting the recipient's compliance with treatment recommendations; and
e. Communicating and consulting with other providers and recipient/caregiver as appropriate.

3. Health Promotion

Health Promotion

Health promotion services encourage and support healthy ideas and concepts. The intent of the service is to motivate recipients to adopt healthy behaviors and enable recipients to self-manage their health. The Care Coordinator will provide health promotion activities. Examples:

a. Providing health education to recipients and their caregivers specific to the recipient's chronic conditions;
b. Conducting medication reviews and regimen compliance;
c. Teaching self-management skills; and
d. Promoting healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

4. Comprehensive Transitional Care

Comprehensive Transitional Care

Comprehensive transitional care services are for individuals transitioning between levels of care and ensures the recipient/caregiver is supported during those transitions. This includes post-discharge education, follow-up appointments, and access to community resources. Examples:

a. Contacting the recipient/caregiver within five business days discharge from the hospital or emergency department;
b. Providing post-discharge contact with recipient/caregiver to ensure discharge orders are understood and action taken;
c. Coordinating with the recipient/caregivers and providers to ensure smooth transitions to new settings; and
d. Ensuring a follow-up visit with the primary care provider.

5. Recipient and Family Support Services

Individual and Family Support

- Recipient/caregiver or family support services reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/caregiver/family to overcome barriers such as medication adherence, transportation, and keeping appointments. Examples:

a. Providing education and guidance in support of self-advocacy;
b. Identifying resources for recipient/caregiver/family to support the recipient in attaining their highest level of health and functionality in their families and in the community;
c. Coordinating transportation for the recipient/caregiver/family to medically necessary services; and
d. Helping recipient/caregiver to access long-term care and other support services.

6. Referrals to Community & Social Support Services

Referrals to Community and Social Support Services

Referral to community/social supports is providing information and assistance to refer the recipient/caregiver to community-based resources that support the needs identified on the recipient's person-centered care plan. Examples:

a. Providing referral and information assistance to obtain community-based supports or social service supports (may include housing, personal need, and legal services);
b. Assisting recipient/caregiver to obtain and maintain eligibility for health care, disability benefits, etc.
c. Supporting effective collaboration with community-based resources; and
d. Identifying resources to reduce barriers to help recipient in achieving their highest level of function and independence

Health Home Referral Process

- Health Home recipients will be required to obtain a referral prior to seeing a provider other than their designated provider.
- Health Home Referrals in electronic format found on the web at https://dss.sd.gov/healthhome/providers.aspx.
- Health Homes should implement a process for obtaining resulting medical records, test results and/or procedure summaries when providing a referral.
- If the Health Home is the Community Mental Health Centers (CMHCs), the referral **must** start with CMHC.

Quarterly Core Service Reporting

- DSS uses a retrospective payment system for the HH program. Services will be provided and then after the quarter is complete, DSS will pay for all recipients where the Health Home has provided at least one core service within the quarter.
- DSS will upload all recipients enrolled in the clinic's Health Home o the DSS Online Portal each quarter.
- The Health Home will use the data provided to indicate if a core service was provided by clicking yes or no and submitting the report
- One Core Service must be provided within the quarter, or the Health Home will not be paid for any of the months in that quarter.

Quarter	Submission Date
Jan – March	April 30
April – June	July 31
July – Sept	October 31
Oct – Dec	January 31

Health Outcome Measure Reporting

- Health Homes report outcome measures for each recipient for whom a core service is claimed.
- Each Health Home will submit data electronically at the individual level every 6 months.
- Vendor sends out a list of recipients to whom a core service was provided. Health Homes will need to submit data by a specified date https://dss.sd.gov/healthhome/outcomemeasures.aspx.
- Vendor will provide clinic level data back to the HH

Period	Due Date
Jan- June	Set by Vendor
July – Dec	Set by Vendor

Recipient Issues

- Two Types of Recipient Issues

- **Behavior Issues** -Goal is to experience minimal recipient issues, however if over time there are significant issues with a recipient, a disenrollment process has been established. - Review disenrollment process for behavior issues. https://dss.sd.gov/docs/healthhome/recommendeddisenrollmentprocess.pdf

- **Inability to Contact Recipients** –Review Disenrollment process for inability to contact a recipient. https://dss.sd.gov/docs/healthhome/disenrollment.pdf

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.
  - Previous Trainings.
- Recipient Handbook http://dss.sd.gov/formsandpubs/docs/MEDSRVCS/MedicalAssistanceRecipientHdbk.pdf
- Brochure http://dss.sd.gov/formsandpubs/docs/MEDSRVCS/health_home_brochure.pdf
- Monthly ListServ
- DSS Online Provider Portal –HH Functions
  - HH caseload reports
  - HH claims paid reports
  - HH core services reports
  - Eligibility Inquiry
- Access to DSS Health Home team
  - (605) 773-3495
  - CMforms@state.sd.us

Keep DSS in the Loop When…

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

Rewarding Performance

DSS paid High Performing Health Homes a payment based on their CY2022 outcome measures.

Payments totaled $565,000.

More information can be found at:
https://dss.sd.gov/healthhome/paymentinformation.aspx

Questions?

Thank You

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dss.sd.gov