Health Home Provider Orientation

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?

4

- **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.

Core Services

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. It requires **developing a comprehensive person-centered care plan** which addresses all clinical and non-clinical needs

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

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

Core Services Cont.

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.
Recipient and Family Support Services	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.
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.

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 now 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.

Health Home Results

- Health Home Program started in July of 2013 to help coordinate care for Medicaid's high cost, high need recipients.

- Providers report outcome measures on a semi-annual basis.

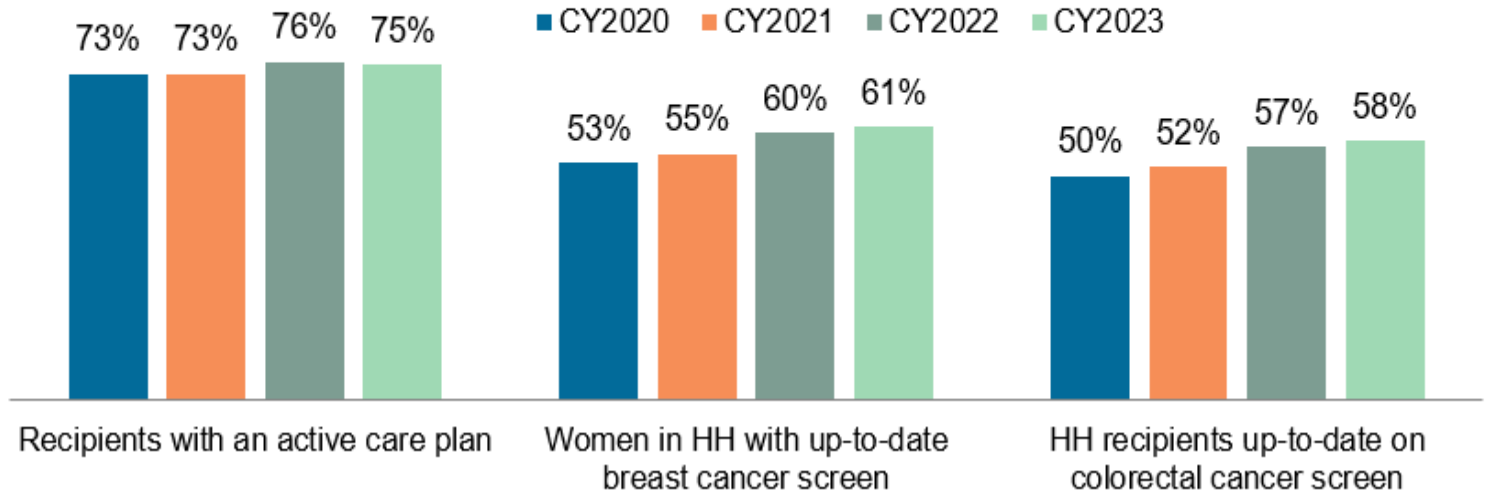
Health Home Results

- DSS uses a vendor to calculate the cost avoidance of the program.
- Health Home Dashboard updated annually with information from both sources. Current version contains the CY 2023 data.
- Some of the results shared today. A full set of information is available on https://dss.sd.gov/healthhome/dashboard.aspx
- Current website has the information in PDF format so it can be printed and shared with others within your organization.

Increasing Preventive and Primary Care

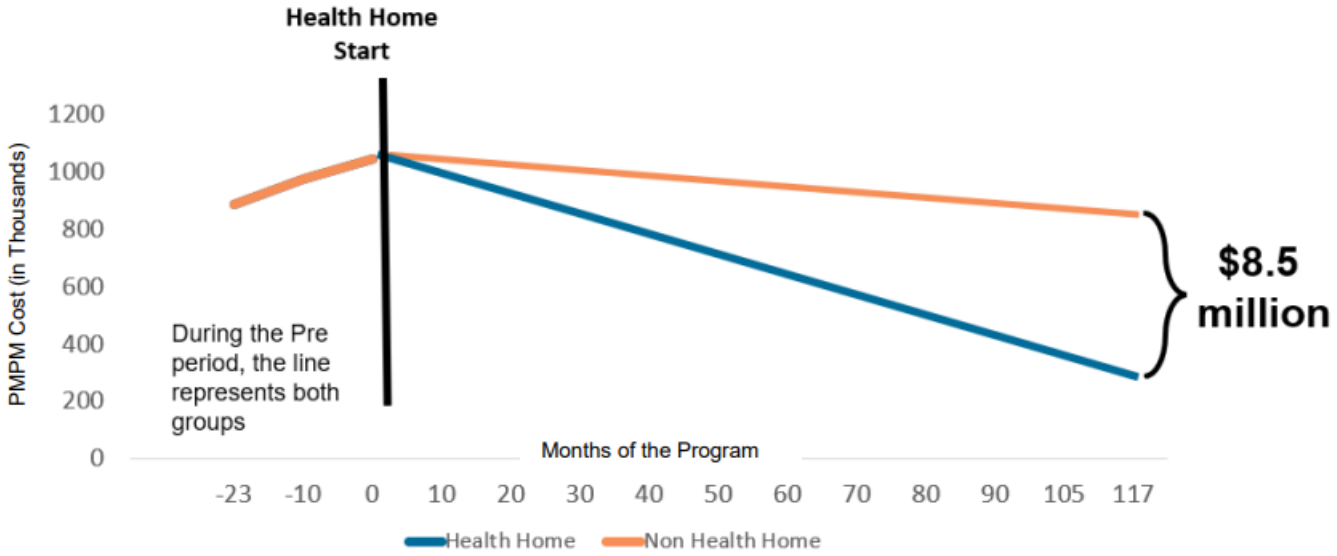
- Preventive Care is an important component to managing recipients with multiple chronic conditions. Under the Health Home Program, preventative Care continues to improve.

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."



Creating Efficiency

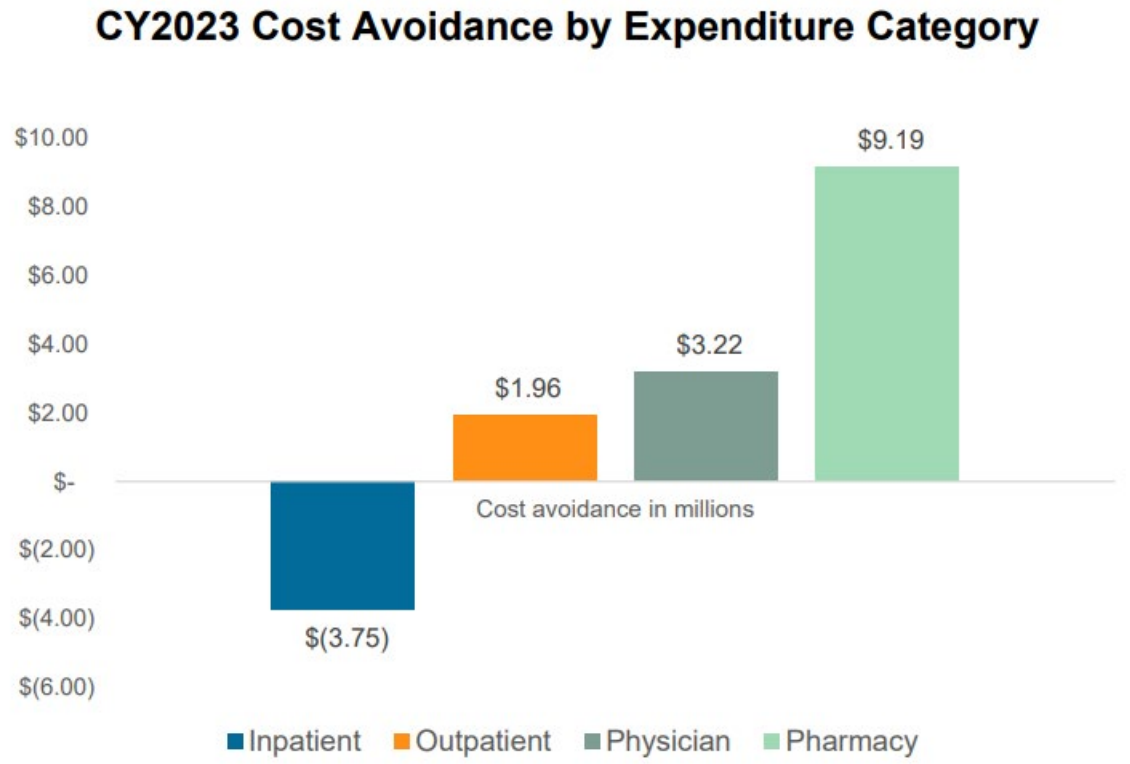
- In CY 2023, HH recipients cost $149 less per month than recipients with similar claims and medical conditions.
- DSS estimates $8.5 million was cost avoided in CY 2023 after payment of the PMPM ($3.96 million) and Quality Incentive Payments ($0.565 million).
- Without Health Homes, DSS would have expended approximately $8.5 million more on medical and behavioral health claims.



Creating Efficiency

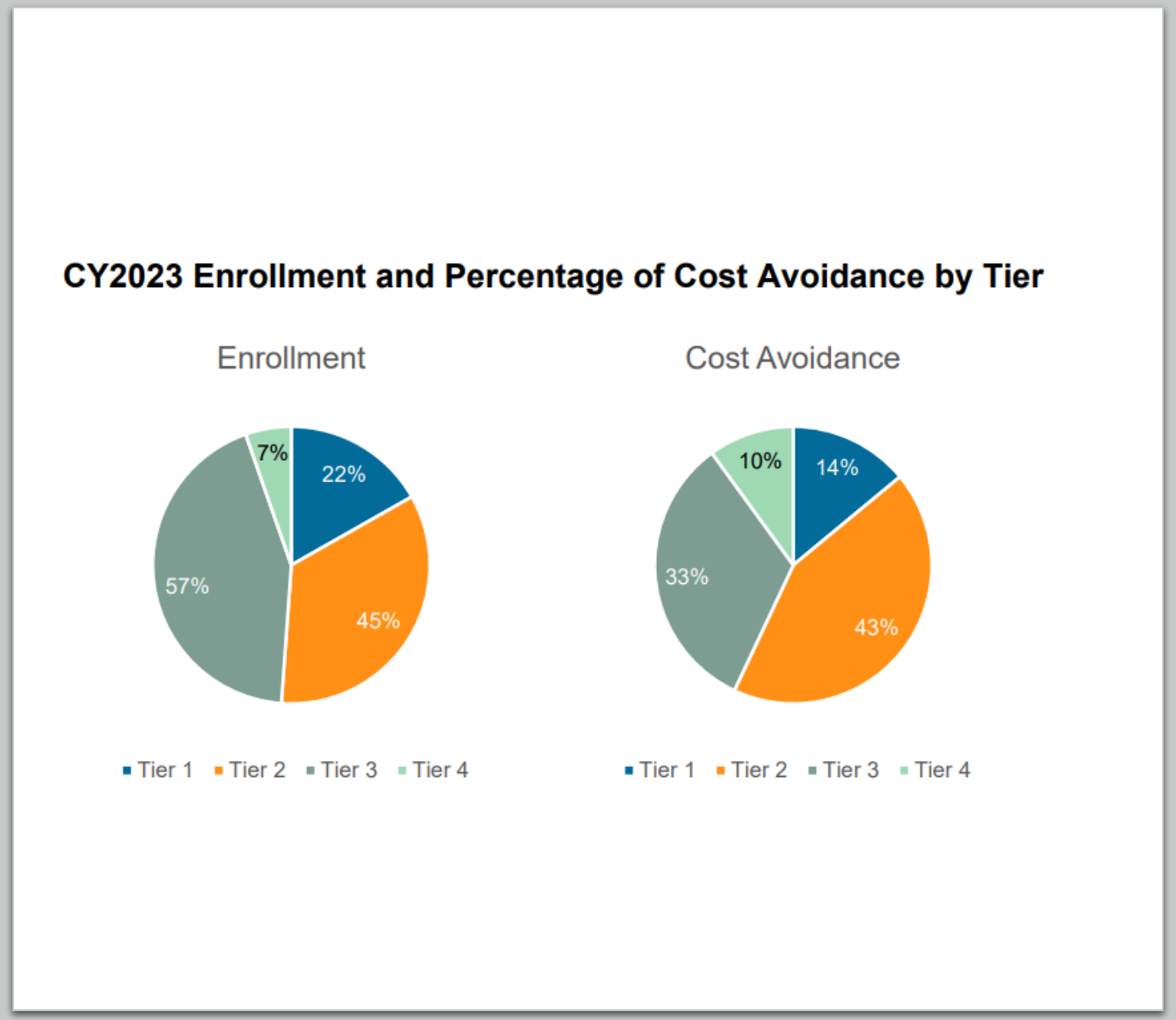
Success Story: The care coordinator discussed transportation challenges with a recipient for both local and out of town specialty appointments. Helped the recipient to set up the first few. Now the recipient is able to set up their own transportation to their visits. The discussion and demonstration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

- 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.



Creating Efficiency

- Tier 1 with 22% of enrollment made up 14% of the cost avoidance.
- Tier 2 with 45% of enrollment achieved 43% of the cost avoidance.
- Tier 3 and 4 recipients made up 64% of the enrollment achieved only 43% of the cost avoidance.



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

Kathi Mueller

605.773.3495

Kathi.Mueller@state.sd.us

dss.sd.gov