DSS
Strong Families - South Dakota's Foundation and Our Future

Health Homes Update

October 2019

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South Dakota Health Home Program

Basics

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What is a Health Home?

- Partnership with Medicaid providers to help manage the high cost high risk recipients.
- Team based approach that deals with the whole person.
- This approach is designed to affect change in a Health Home recipient's health status and to reduce utilization of high cost services.
- Six Core Services outlined by CMS and defined by the Health Home Workgroup must be provided to each Health Home recipient at the appropriate level

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Provider Infrastructure

Primary Care

- Primary Care Physicians
- PAs
- Advanced Practice Nurses

Working in:

- Federally Qualified Health Center
- Rural Health Clinic
- Clinic Group Practice
- IHS

Behavioral Health

- Mental Health Providers Working in:
  - Community Mental Health Centers

Health Care Team

- Care Coordinator/ Health Coach
- Case Manager
- Community Support Provider
- Pharmacists
- Support staff
- Other appropriate services

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Who do Health Homes serve?

- Any Medicaid recipient who has…
  - Two or more chronic conditions OR one chronic and at risk for another (Defined separately):
    - **Chronic conditions include:** Mental illness, substance abuse, asthma, COPD, diabetes, heart disease, 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.
- Medicaid recipients that meet criteria are stratified into four tiers based on the recipient's illness severity using CDPS (Chronic Illness and Disability Payment System).

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Provider Capacity

- Current Number of Health Homes – 128 serving 132 locations
  - FQHCs = 24
  - Indian Health Service Units = 11
  - CMHCs = 9
  - Other Clinics = 84
- Around 700 designated providers.
- Average around 5,800 recipient in the program per month.

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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
- Core services must meet these basic criteria:
  - Recipient is engaged in the service but it does not need to be in person
  - Service ties to the care plan
  - Service is documented in the EHR
  - Service has not already been billed to South Dakota Medicaid using a fee for service, encounter or daily rate.

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Six Core Services

- Six Core Services must be provided to the level appropriate for each recipient. More in depth definitions at:

  http://dss.sd.gov/docs/medicaid/pcpcoreservicesspecificfinalforweb.pdf

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

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South Dakota Health Home Program

Results

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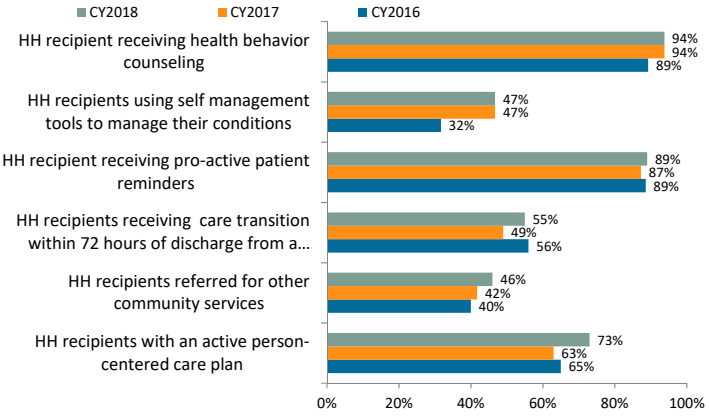
Health Homes Transform Care

Health Homes change the way Medicaid recipients receive care by creating a person centered care team to meet the needs of the patient.



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Health Homes increase Preventive and Primary Care

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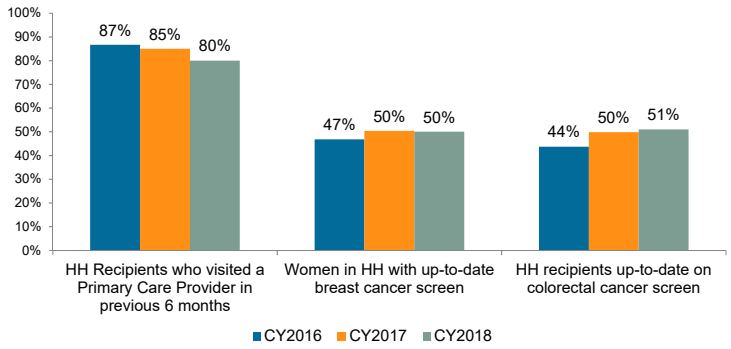
- A team based model takes pressure off of the Primary Care Provider, by allowing members of the team to help the recipient.
- Preventive Care remains stable or continues to show improvements.



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Improving Outcomes

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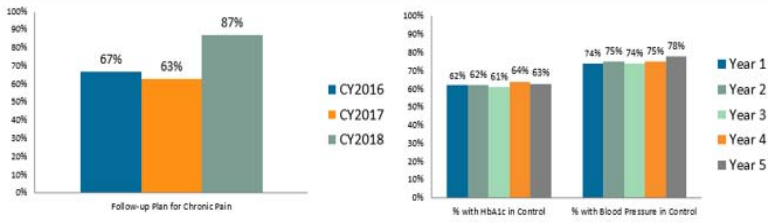
- The Conditions which make a recipients eligible have an outcome measure.
- Outcome Measures are reviewed in two different ways.
  - Calendar Year to Calendar Year to show a change in provider behavior.
  - Results based on the length of time the recipient is in the program to show improved health.

	Skeletal and Connective Disorders				Diabetes			
Stats	Low Back Conditions	39.2% of enrollees	Musculo-skeletal Conditions	6.9% of enrollees	Diabetes	36.9%	Pre-Diabetes	7.9% of enrollees
Goals	• Increase % of individuals with a diagnosis of chronic pain that have a pain management plan.				• Increase % of individuals with HbA1c under control. • Increase % with blood pressure in control.			

Outcomes



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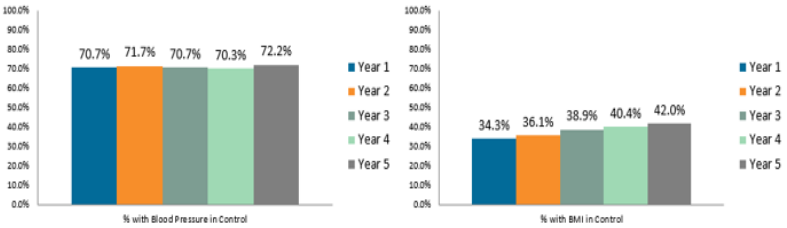
Improving Outcomes

- Measures also display the percentage of individuals who have the condition along with the goal.

	Cardiovascular				Obesity	
Stats	Heart Disease	24.5% of enrollees	Hypertension	50% of enrollees	Obesity	22.5% of enrollees
Goals	• Increase % of individuals with blood pressure in control.				• Increase % of individuals with BMI under control.	

Outcomes



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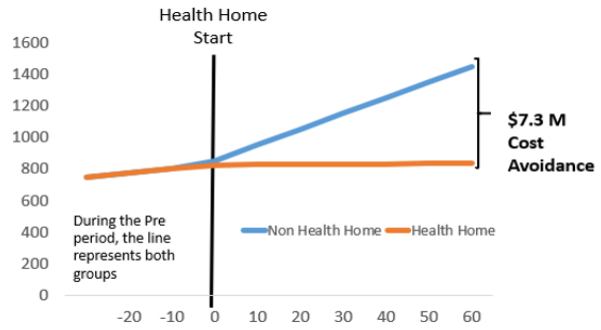
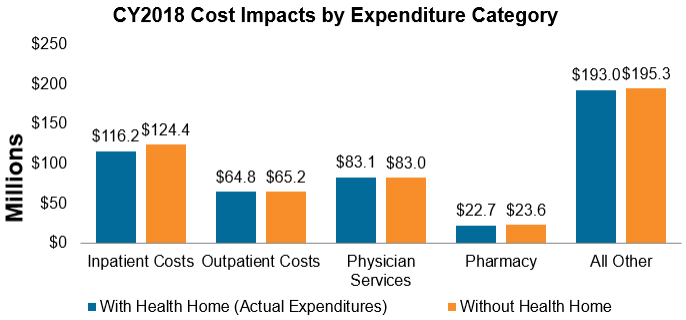
Health Management: Caring for People in the Most Cost-Effective Manner

- **Health Homes – Estimate of Avoided Costs**
  - In CY 2018, HH recipients cost $226 less per month than recipients who looked like them. The Health Home Matched Analysis showed that the Health Home program avoided costs for the Medicaid program for CY 2018. $7.3 Million after PMPMs and Quality Incentive Payments.



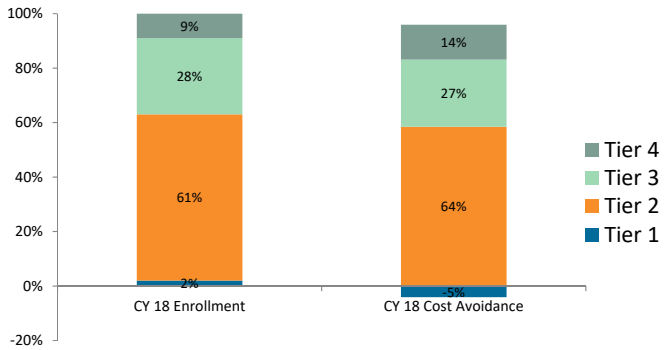
Health Management: Caring for People in the Most Cost-Effective Manner

- **Health Homes – Estimate of Avoided Costs by Type of Service**
  - In CY 2018, DSS found that 70% of costs avoided are due to decreased inpatient admissions, emergency room use. Pharmacy and all other expenditures resulted in the remaining 27%. Physician services accounted for an increase of approximately $50,000.



Health Management: Caring for People in the Most Cost-Effective Manner

- **Health Homes – Estimate of Avoided Costs by Tier**
  - In CY 2018, Tier 2 recipient made up a majority of the avoidance, Tier 3 and 4 made up 41% of the avoidance while Tier 1 recipients cost 5% more than their counterpart not in the program.



Health Home Outcome Measures Results

- Data Dashboard has full results of outcome measures at
- http://dss.sd.gov/docs/healthhome/hh_outcome_measure_summary.pdf
- Our Health Home Data Dashboard was recently updated with CY 2018 information and contains other exciting information, such as success stories, about the program.
- Found at http://dss.sd.gov/healthhome/dashboard.aspx.

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Performance Rewards

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Performance Rewards

- Since the inception of the Health Home program, rewarding Health Homes for their success has been part of the dialogue.
- The State has always been support of this concept, but needed to wait for the program to prove itself and find a method that CMS would approve.
- The Medicaid State Plan allows Quality Incentive Payments to be made when the cost avoidance exceeds $3 million.
- As demonstrated above Health Homes continue to exceed this amount even as PMPMs are inflated and Quality Incentive Payments are made.

Performance Rewards

- The Legislature provided just under $1 million to reward Health Homes for their performance in the 2018 Legislative Session.
  - 50% of the money went to everyone by increasing PMPM around 16%. Took effect for the January –March 2018 quarter.
  - Remaining 50% went to Quality Incentive Payments. Methodology created in concert with a Subgroup of the Implementation Workgroup.
    - Payment for clinics with an average caseload of 15 or less to incentivize participation.
    - Outcome measures as it relates to the state average.
    - Case Mix.
  - Information about the recent Quality Incentive payment is posted on our website at http://dss.sd.gov/healthhome/qualityincentivepayments.aspx.

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Questions and Thank You!

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