

The State of the South Dakota Health Home Program FY 2016

Abstract

South Dakota Medicaid in partnership with the health care providers and health systems in the state implemented the Health Home program in August of 2013. The program is designed to target high cost/high need recipients in the Medicaid program and provides additional assistance at the clinic level to support increased coordination of the recipient's health care needs. Just 3 years into implementation of the program, the state estimates the Health Home program helped to avoid between \$4.2 and \$ 5.6 million in Medicaid spending in SFY 2016. Additionally, the state found improvements in the overall health of the population.

Introduction

In 2012, based on the recommendations of a Medicaid Solutions Workgroup, South Dakota policymakers launched a Medicaid Health Home program to take advantage of provisions made available in the Affordable Care Act and policy guidance from the Centers for Medicare and Medicaid Services (CMS). The South Dakota Department of Social Services (DSS) implemented the Health Home (HH) program in August 2013 to provide additional Health Home care management services for Medicaid recipients with complex health needs and high costs, with goals to reduce otherwise avoidable use of the emergency department and inpatient hospitalizations, and contain overall Medicaid expenditures.

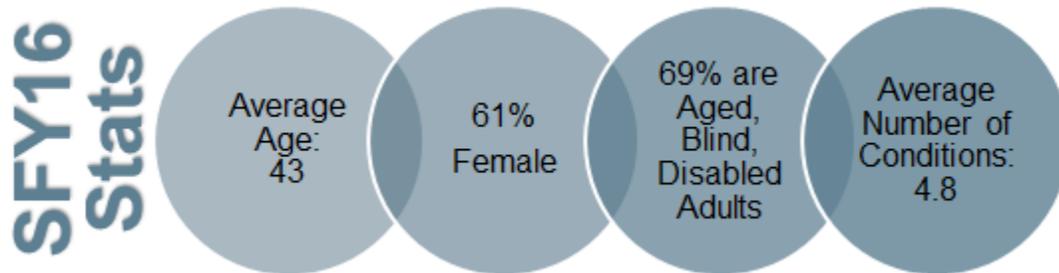
Medicaid recipients eligible for enrollment in a Health Home are those with two or more chronic conditions or one chronic and one at risk condition. Chronic conditions include: Mental Illness, Substance Abuse, Asthma, COPD, Diabetes, Heart Disease, Hypertension, Obesity, Musculoskeletal and Neck and Back Disorders. At-risk conditions include: Pre-Diabetes, tobacco use, Cancer Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of medications). Eligible recipients also include those diagnosed with one Severe Mental Illness or Emotional Disturbance.

Health Home recipients are placed in 1 of 4 tiers using the Chronic Illness and Disability Payment System (CDPS). Tier 1 make up about 60% of the individuals eligible for the program; these recipients meet the Health Home eligibility criteria, but their conditions are well controlled and their health expenditures mirror average Medicaid expenditures per enrollee and are not the priority population. Tier 1 participants are required to opt into Health Homes. The program focuses on Tier 2-4. Increasing tiers are associated with more chronic conditions, uncontrolled conditions, and higher cost patients. Tiers 2-4 are automatically attributed to the program and are required to opt out.

Health Home recipients are served by the following types of providers:



The make-up of the recipients in the health home program is identified as follows:



Core Services

Health Homes are paid a Per Member Per Month payment to provide recipients the Core Services in addition to the Fee for Service Payments made for other healthcare services. These Core Services include Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Recipient and Family Support Services and Referrals to Community and Social Support Services. Additional information about these services can be found at <http://dss.sd.gov/docs/medicaid/pcpcoreservicespecificfinalforweb.pdf>.

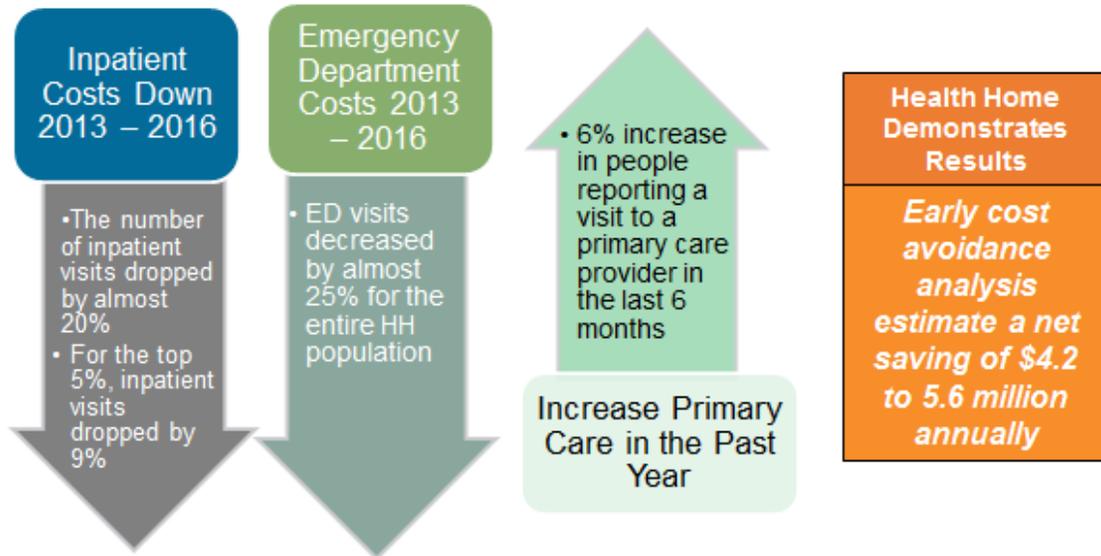
Methods

Financial Analysis

South Dakota has an average participation in the health home program of 5,800 health home recipients per month. Due to the relatively small number of participants in comparison to other states, South Dakota created a methodology to work with small numbers. During SFY 2015, the state received a preliminary analysis indicating successful avoidance of Medicaid expenditures in the Health Homes Program. The analysis supported a reduction of 1.2 claims per member per month (PMPM). A full financial analysis was unable to be completed due to the limited data for the program available in SFY 2015.

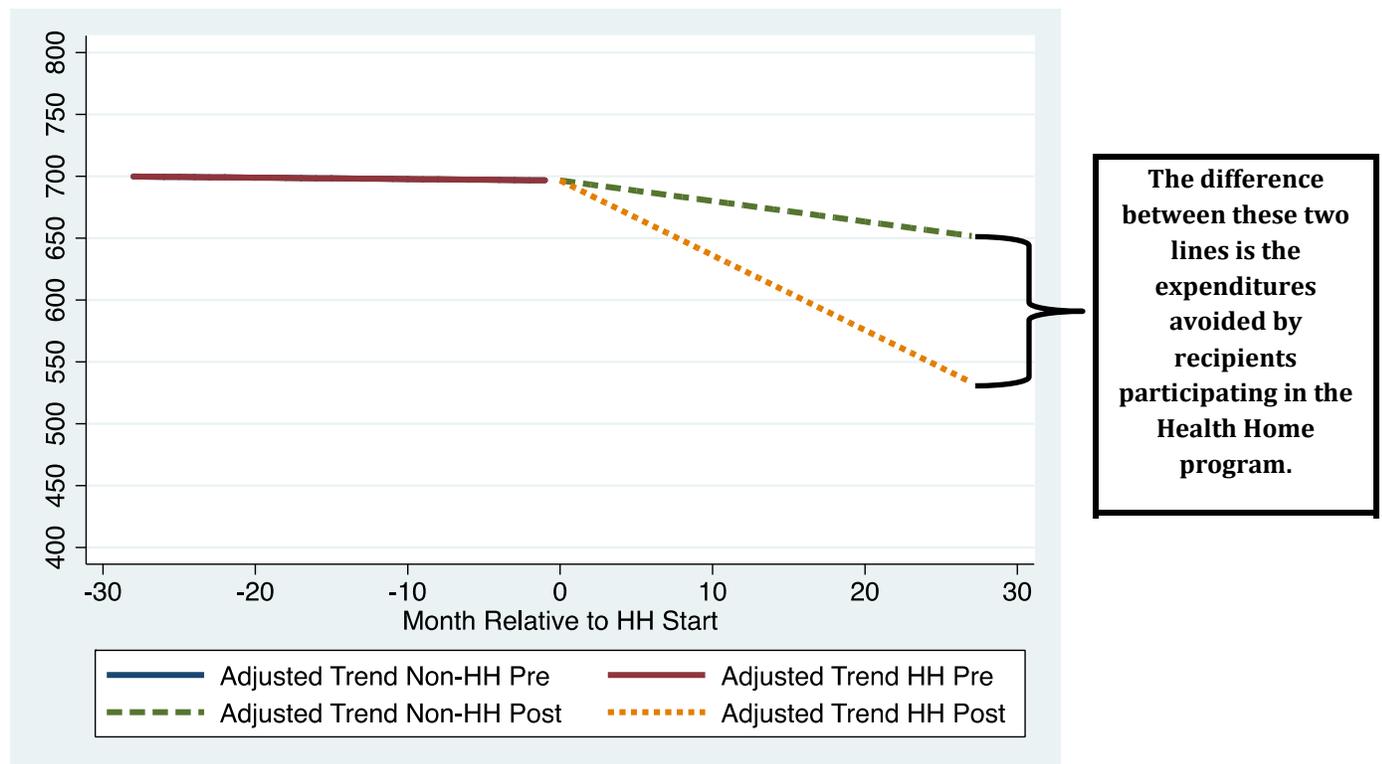
After SFY 2016, the state determined there was enough historical data to begin a full financial analysis of avoided expenditures as a result of the Health Home program. Two methodologies were used in SFY 2016 to provide further confirmation that the Health Home program is successfully avoiding Medicaid expenditures. Both analyses yielded similar results.

Analytical Method 1 compared key measures of success such as ER visits, Hospital Admissions, and average recipient Medicaid spending per month between SFY2011 and SFY 2016. This method yielded a net avoidance of \$4.2 million in Medicaid spending in SFY 2016. In addition this method provided the results identified on the next page.



Analytical Method 2 used a more statistically rigorous approach to identify a group of similar individuals not enrolled in the Health Home program and compared their spending to those enrolled in the program. This method yielded a net cost avoidance of \$5.6 million in Medicaid spending. In other words, the Medicaid budget would have been \$5.6 million dollar higher without the program. See Figure 1.

Figure 1: Adjusted Trend in Monthly Cost for Matched HH-Enrolled Recipients and Non-HH-Enrolled Recipients

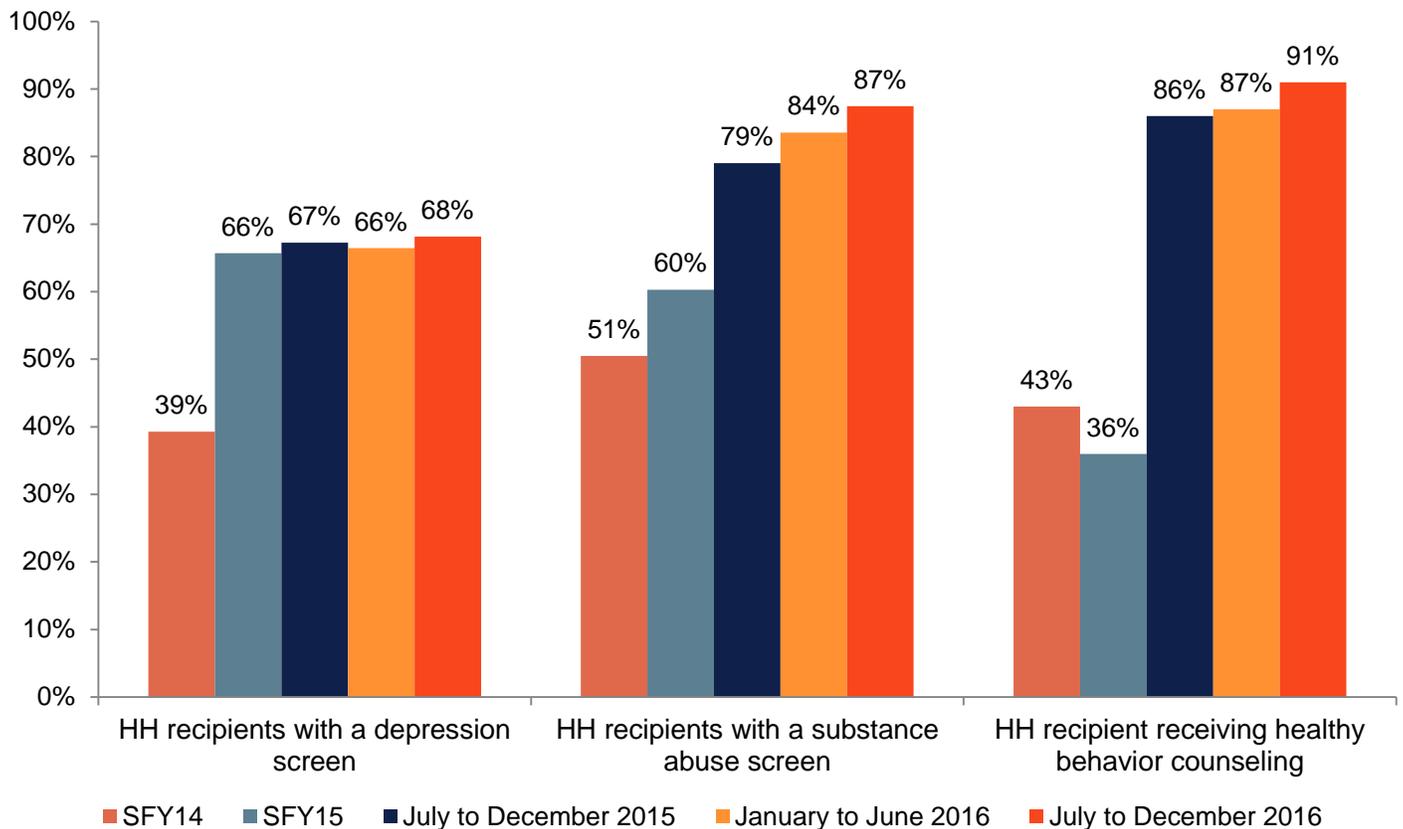


Outcomes Analysis

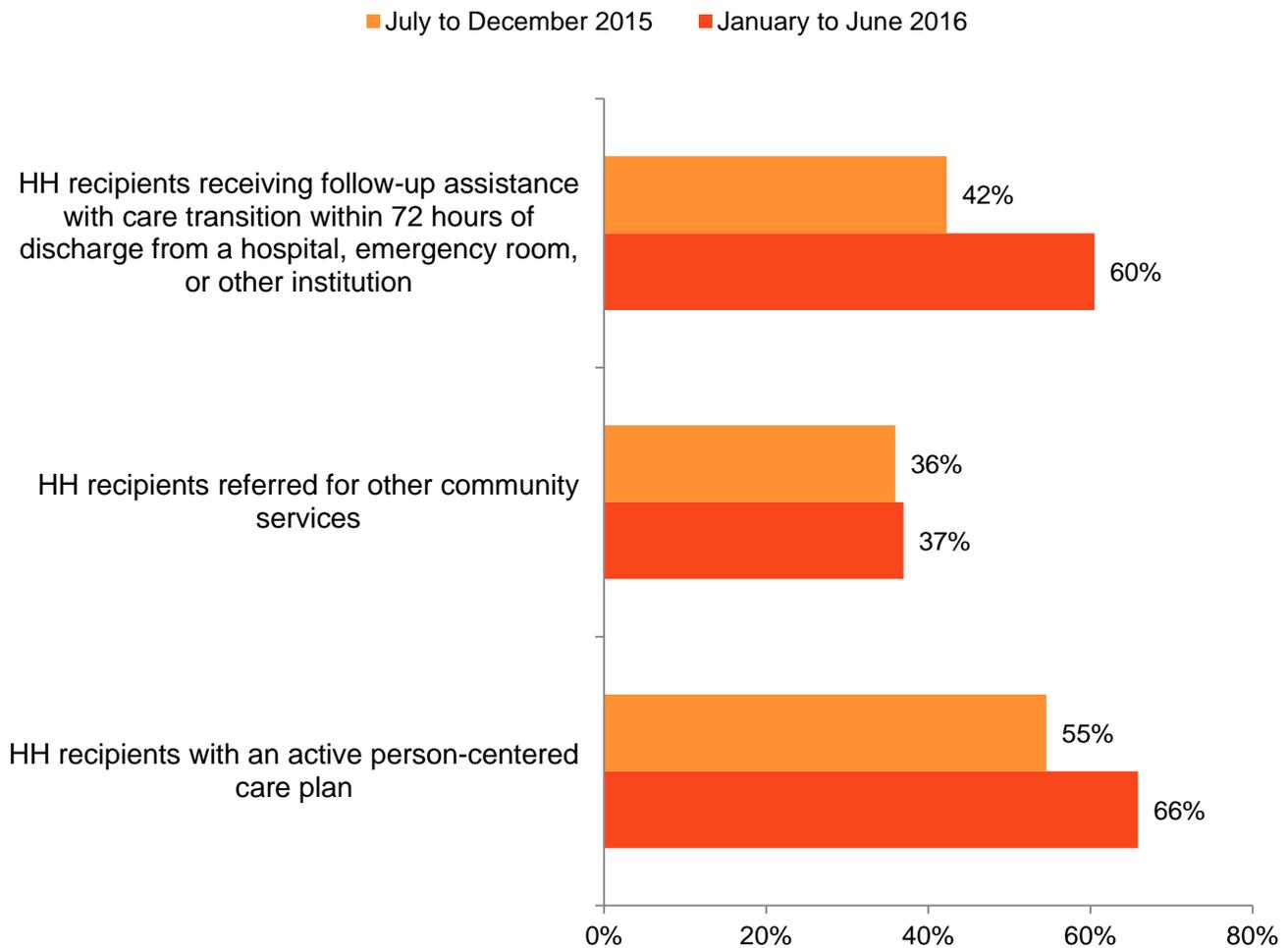
On a bi-annual basis, Providers who participate in the Health Home program are required to report outcome measures for each recipient provided a core service in that timeframe. The outcome measures include clinical outcome measures, patient experience measures, and measures to gauge the saturation of the health home model in participating clinics.

Although outcome measures have been collected since implementation of the Health Homes program, initial results indicated that several measures needed to be adjusted in order to ensure that the measures collected were yielding accurate results. South Dakota Medicaid worked with a group of stakeholders to refine outcome measures to optimize reporting. Most measures established a baseline with the July 1 to December 31, 2015 reporting period in SFY 2016.

Measures with a consistent data source between SFY 2014 and SFY 2016 show improvement in the health of participants and success in transforming primary care in the Health Homes program:



Measures that established a baseline in SFY16 show improvement between Period 5 and 6 of SFY 16. Selected measures are shown below:



A full set of outcome measure results can be found at http://dss.sd.gov/docs/healthhome/hh_outcome_mesaure_summary.pdf.

Conclusion

Both the financial and outcome analysis show that the Health Home program is a cost effective way to help high costs/ high needs recipients improve their health and quality of life.

As DSS plans to build on the initial success of the Health Home program by working to increase the number of providers throughout the state and serving more individuals in the Medicaid program. Additionally, DSS is exploring methods for sharing avoided costs with participating providers.

Other Documents

The following document is another summary of this information and can be found at <http://dss.sd.gov/healthhome/dashboard.aspx>.

- FY 2016 Financial Analysis Summary Power Point