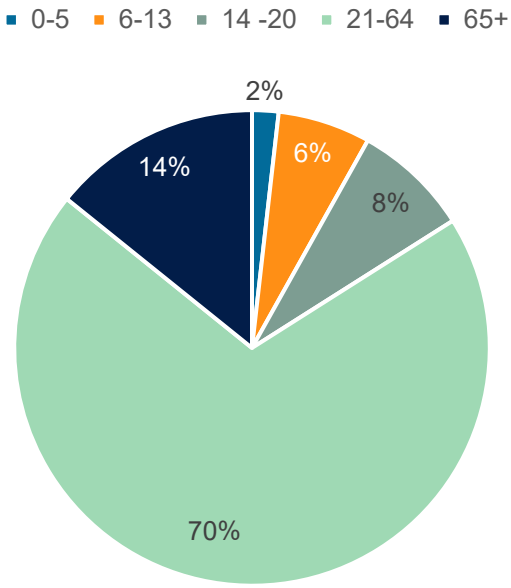
Health Home Data Dashboard

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.

CY24 Stats

- Average Age: 44.1
- 62.2% Female
- 38% are part of the Expansion Group
- Average Number of Conditions: 2.5

CY2024 Age of Participating Recipients



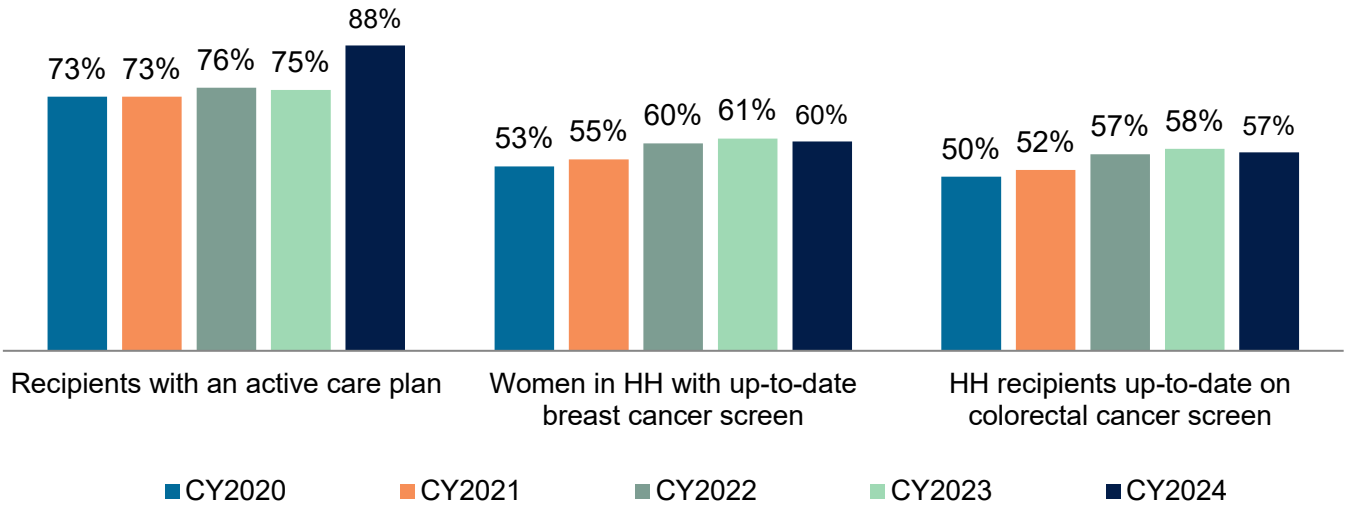
Health Homes and Medicaid Expansion

Calendar Year 2024 was the first complete year of data to include expanded Medicaid eligibility population. The difference in population dynamics and total number of eligible recipients led to more changes when comparing CY24 data to previous yearly trends.

Beginning January 1, 2026 South Dakota Medicaid's Health Home Program will be known as the Care Connect Program

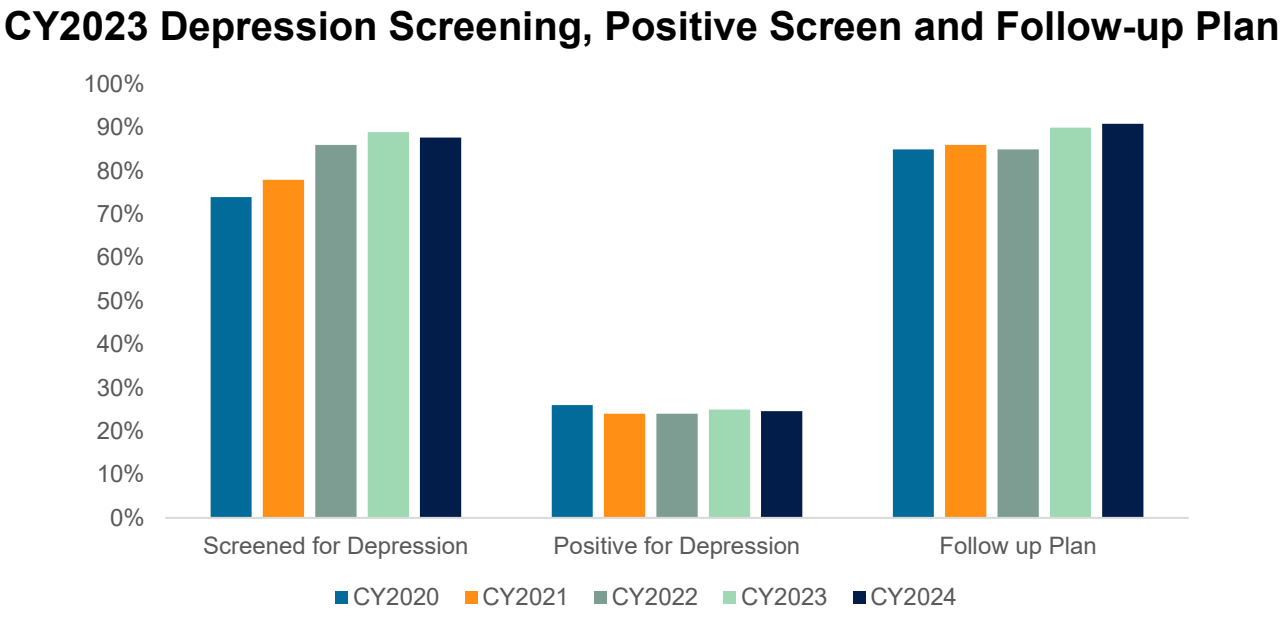
Increasing Preventive Care

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.



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.



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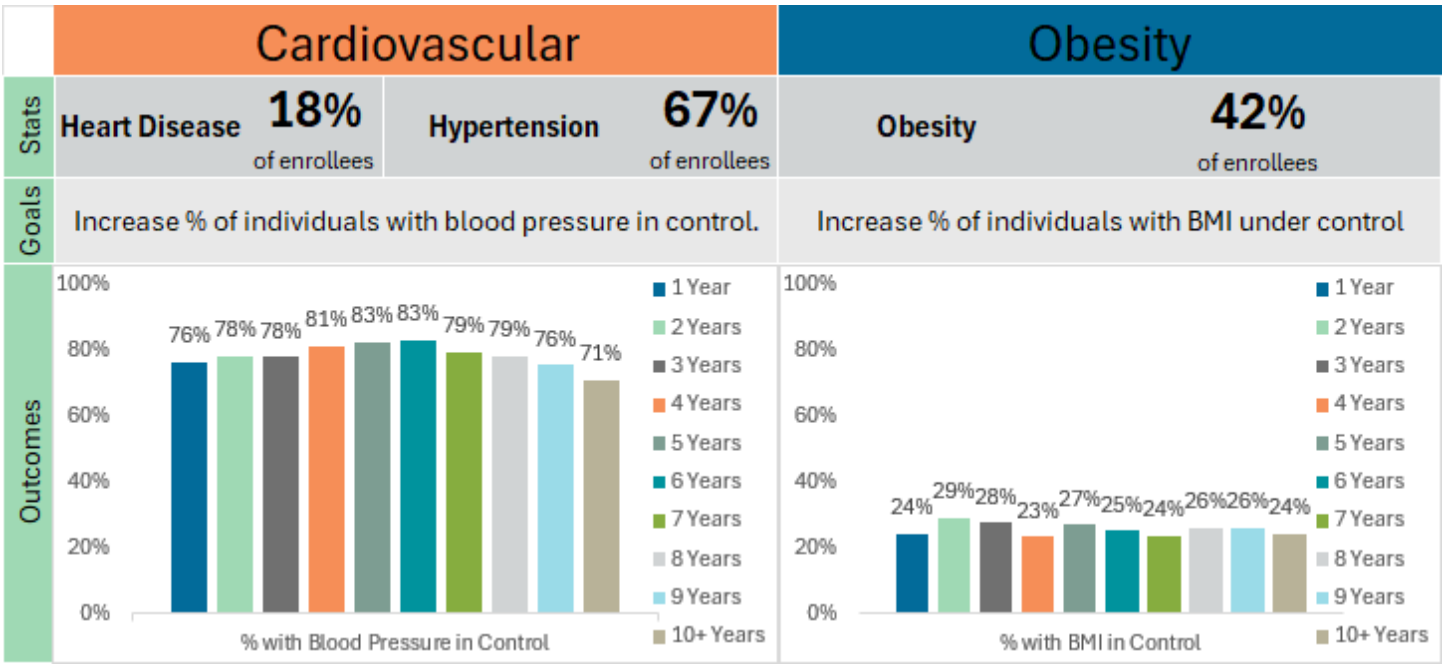
CY2024 Cardiovascular and Obesity Goals and Results

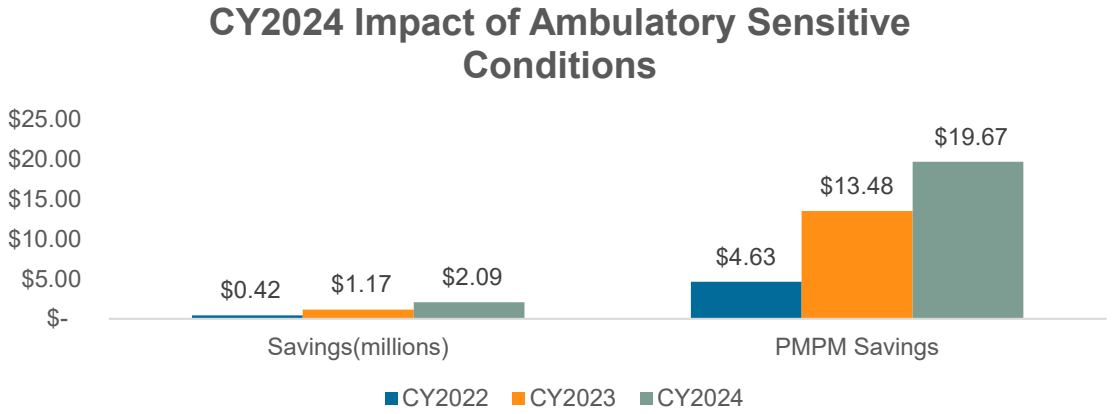
The following charts represent the percentage of recipients in control for Blood Pressure and Body Mass Index (BMI) based on the number of years the recipient has been in the Health Home Program.



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. And in CY2024, it was 71% more than those not in the Health Home Program.



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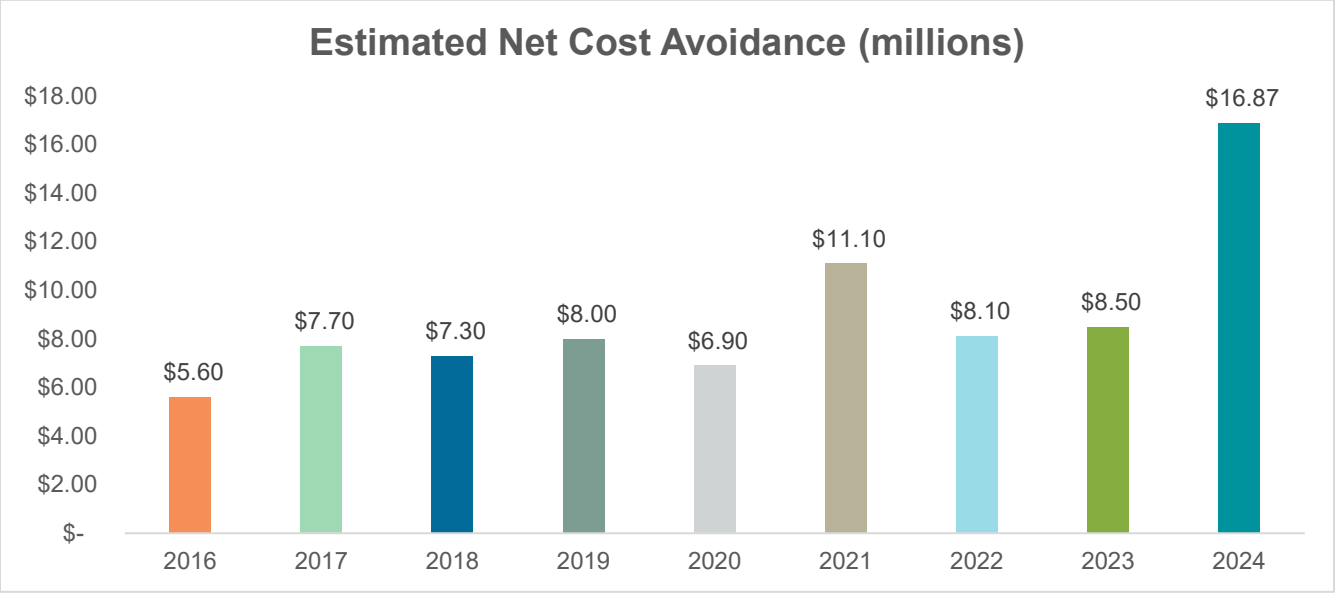
Cost Effectiveness of the Program

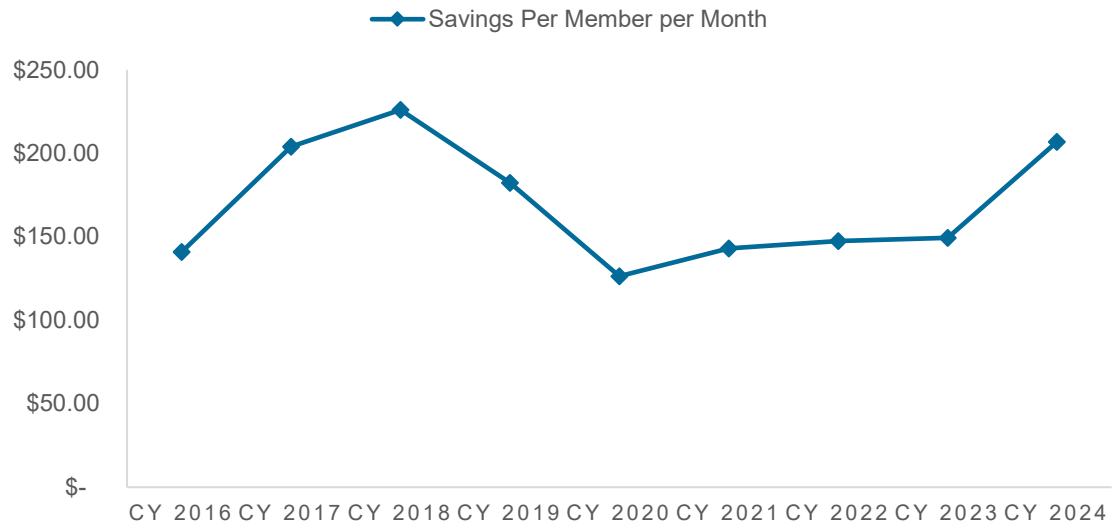
To analyze the cost effectiveness of the Health Home program Medicaid compared Health Home participants against a control group of individuals that would be eligible, but not participating in the program. Once there was enough historical data to accurately compare the two groups, Medicaid has calculated the estimated net cost avoidance amount by subtracting the Per Member Per Month case management fees and the annual Quality Incentive Payment from the total estimated value.

In CY 2024, participants in the Health Home Program cost $206.82 less per month than recipients with similar demographics and health conditions. Medicaid estimates $16.87 million was cost avoided in CY 2024 after payment of the PMPM ($4.48 million) and Quality Incentive Payments ($0.58 million). The significant increase in overall cost avoidance appears to be due to a combination of a higher PMPM savings amount as well as an increase in Health Home participants. In CY 2023, the average number of monthly participants was 6,579. In CY 24, the average number of monthly participants increased to 7,987.



Cost Avoidance by PMPM

With a full year of data including the expansion population, the Health Home Program's enrollment has shown a generally, more medically diverse population in CY 2024. The PMPM cost avoidance has continued grow since CY2020. For CY 2024 PMPM cost avoidance was $206.82.



Cost Avoidance by Type of Service

In CY 2024, the cost and frequency of inpatient admissions for Health Home participants was significantly lower when compared to the control group, generating a PMPM cost avoidance of $250.24 for inpatient charges and contributing the largest share, $26.54 million, of the overall cost avoidance for the program.

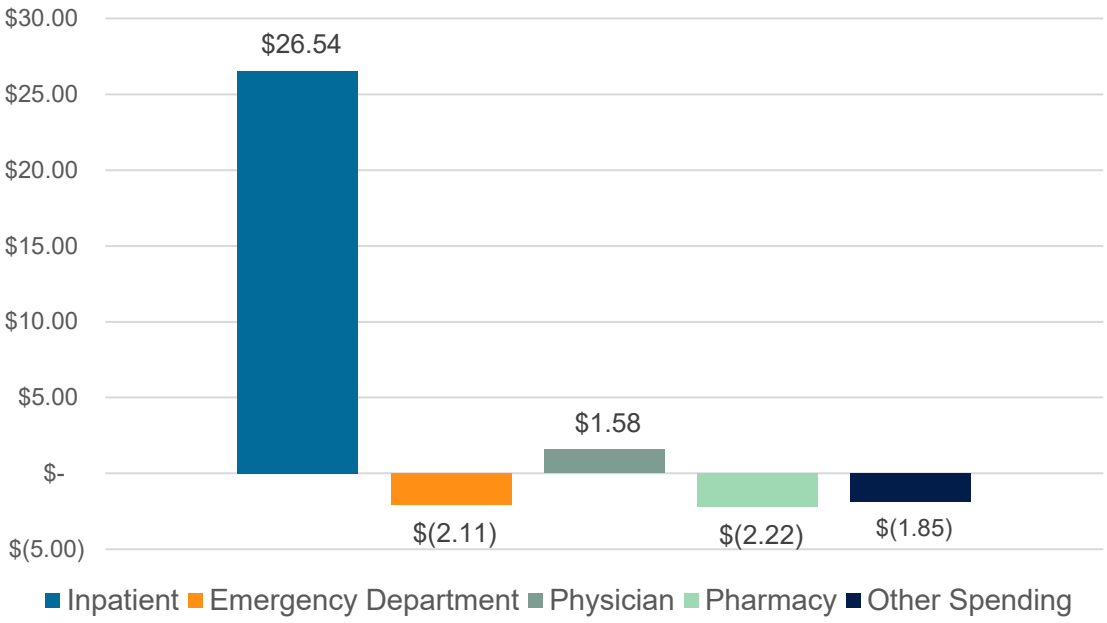
Emergency Department (ED) utilization resulted in total costs approximately 3% ($2.11 million) higher for Health Home members compared to the control group, driven by a higher number of ED visits.

Pharmacy services accounted for $2.22 million in spending above the control group. Participants spent $20.95 PMPM more than the control group.

Physician services accounted for $1.58 million in cost avoidance. Participants spent $14.88 PMPM less than the control group. All other services accounted for the remaining $1.85 million in spending above the control group. The following chart represents the overall impact to the South Dakota Medicaid budget by expenditure category.

CY2024 Cost Avoidance by Expenditure Category

(millions)

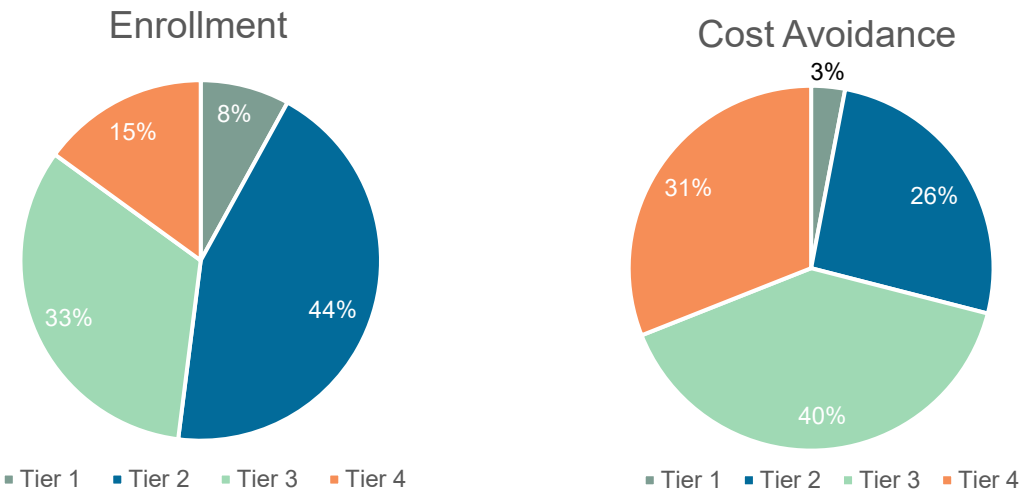


Tiers by the Number

Tier 1 participants made up 3% of the cost avoidance. Tier 2 and 3 participants made up 66% of the cost avoidance Tier 4 recipients accounted for 31% of the total cost avoidance. While all Tiers achieved savings in CY 2024, the level of cost avoidance PMPM by tier differed significantly:

- Tier 1 was $6.20 PMPM,
- Tier 2 was $53.77 PMPM,
- Tier 3 was $82.73 PMPM,
- Tier 4 was $64.11 PMPM.

CY2024 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 2025 in the amount of $578,760.00. CY 2023 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.