Health Home Update 2024

September 2024

Care Management Programs

- Primary Care Provider Program: Creates a Medical Home which improves recipient access to Medical Care and improves quality of recipient care. 80% of Medicaid recipients are required to be in this program.
- Health Home Program: Coordinates the care of Medicaid Recipients who have high cost and high needs which reduces the cost of care for these recipients and improve the health outcomes of the recipients who meet the criteria.
- BabyReady Program for Pregnant Women: Improves health outcomes for pregnant women and babies. Targets woman who are less than 21 weeks gestation at enrollment.

Care Management Team

- Kathi Mueller | Care Management Administrator - Slow dripping knowledge to the others so I can retire in April.
- Chris Soukup | Care Management Program Manager Provides support needed for the Primary Care Provider (PCP) and Health Home (HH) programs during expansion; recommending and implementing enhancements to the PCP program to strengthen the program by implementing components that encourage improved outcomes and cost savings and facilitating policy decisions to make updates; provide technical assistance to providers about PCP/HH policies and procedures.
- Dawn Schnabel | Care Management Program Assistant Assist recipients with Primary Care Provider (PCP) and Health Home (HH) provider changes; enroll providers into the PCP/HH Program and update PCP/HH system; provide technical assistance to providers about PCP/HH policies and procedures; and provides support for recipients and providers using PCP/HH online tools.
- Valerie Kelly | BabyReady Program Manager Implement and oversee the BabyReady Program. The BabyReady Program seeks to offer enhanced care management services by obstetric care providers to pregnant Medicaid recipients. The program will provide incentives to providers to offer services in accordance with standards of care through quality improvement initiatives to achieve better health outcomes.
- Sarah Houska | Care Management Program Specialist Works with the Primary Care Provider (PCP) and Health Home (HH) programs as well as assists the BabyReady Program Manager to implement and run the BabyReady Program. This position with help with the day-to-day functions of the Care Management Programs.

- **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).

- QMB or SLMB Only recipients are not able to participate in the HH program.
- Qualified Medicare Beneficiary (QMB) is a designation based on income that allows Medicaid to pay for Medicare Part A and B.
- Select Low-Income Beneficiary (SLMB) is a separate designation also based on income where Medicaid pays for the Medicare Part B premiums.
- Individuals who are eligible for Medicaid and QMB or SLMB are eligible, but recipients with only this coverage will not be eligible.

Health Home Capacity

As of October 1, 2024, we will have 141 Health Homes serving 145 locations.

- FQHCs = 30
- Indian Health Service/Tribal 638 = 11
- CMHCs = 8
- Other Clinics = 91

- **October 1, 2024**
  - Northeastern Mental Health will discontinue providing HH services.

Year	Monthly Average
FY2019	5,954
FY2020	5,864
FY2021	6,581
FY2022	7,015
FY2023	7,006
FY2024	6,908
CY2025 YTD	7,689

August 2024 Participation Numbers

Type	Tier 1	Tier 2	Tier 3	Tier 4	Total
CMHC	11	191	329	91	622
IHS	257	1,127	537	267	2,188
Other	431	3,155	1,507	574	5,664
Total	699	4,473	2,373	929	8,474

- DSS implemented Medicaid expansion on 07.01.2023.
  - Requirements for the expansion
    - At least age 19 but not yet 65
    - Not on Medicare or able to sign up for Medicare
    - Income under 138% of the Federal Poverty Level
    - August 2024 25,276
    - These recipients now have enough claims to make them eligible for the HH Program.

Income Limits	
Household Size	Maximum Gross Monthly Income
1	$1,677
2	$2,286
3	$2,859
4	$3,450

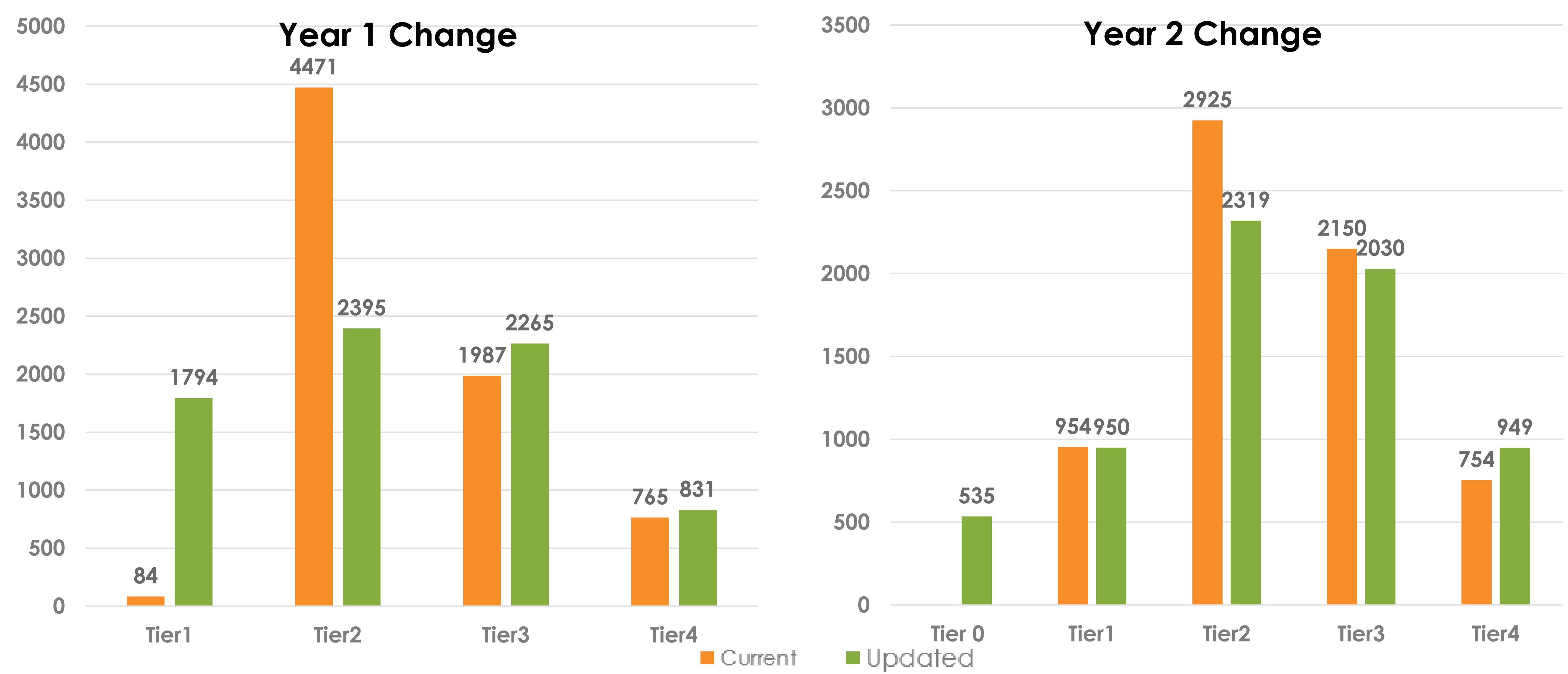
- Expansion recipients can be identified by their aid categories of 92-95.
  - 92 – Parent/caretaker over 21
  - 93 – Parent/caretaker under 21
  - 94 – Individual over age 21
  - 95 – Individual under age 21

Tier Update Review

Year 1 Retier Review

- Completed December 2023
- A new occurrence was created with the same provider that took effect on January 1, 2024, for recipients with an active provider where the tier was changed.
- Otherwise, the occurrence was left the same.
- A new Tier was stored for every recipient.
- A Retier caseload report was created for each provider indicating the new tier.

Year 1 vs Year 2 Change



Optout removal

- After two years of removing opt outs after 12 months, DSS is moving to a 36-month cycle.
- DSS has spent 2-3 months answering hundreds of calls following the opt out removal process.
- Moving to 36 months should decrease the number of recipients whose opt outs are removed.

Tier 1 Individuals

- In August we had 699 Tier 1 individuals. While better than the 1006 we had at this time last year, this is still higher than expected
- How are you finding these individuals?
- Should we automatically remove any individuals who fall to a Tier 1?

Quality Incentive Payment

Example Calculation

- DSS worked with our vendor to calculate a Composite Score for each Clinic.
- Improvement is any improvement.
- Attainment is greater than or equal to the target.
- Clinic must have provided 50% or more of the recipients on their caseload a core service.

Health Home Composite Scoring

Measure	Weight	Improvement	Attainment	Caseload Severity Score	Measure Total -
Depression Follow-Up Plan Doc	15	0.5		20.75	155.63
Active Care Plan	25		1	20.75	518.75
BMI in Control	12	0		20.75	0.00
Mammogram up to date	12		1	20.75	249.00
Colonoscopy up to date	12		1	20.75	249.00
Blood Pressure in Control	12	0.5		20.75	124.50
Face to face visits missed	12	0.5		20.75	124.50
CLINIC COMPOSITE SCORE					**1421.38**

Example Distribution

Pool Funding = $561,500 Small Clinic Payment = $75,000 Clinical Outcome Payment Dollars = $481,500					
CLINIC	**Clinic Composite Score**	**Dollars per point**	**Clinical Outcome Payment**	**Small Clinic Payment**	**Health Home Total Payment**
1	1421.38	$60.01	$85,297.61	$25,000.00	$110,297.61
2	2110.00	$60.01	$126,621.10	$25,000.00	$151,621.10
3	1820.75	$60.01	$109,263.21	$0.00	$109,263.21
4	1220.75	$60.01	$73,257.21	$25,000.00	$98,257.21
5	1450.75	$60.01	$87,059.51	$0.00	$87,059.51
Totals	8023.63	$60.01	**$481,500.00**	**$75,000.00**	**$561,500.00**

- Each qualifying clinic receives a portion of the funds based on their composite score. The higher the score the more money is received
- As the number of clinics increases, the incentive dollars per point decreases.
- Payment were adjusted at the rate of provider inflation again.

Quality Incentive Payment

More information about the Quality Incentive Payment can be found on our website at https://dss.sd.gov/healthhome/paymentinformation.aspx

Quality Incentive Payments

DSS has made Quality Incentive Payments based on CY2020 and CY2021 data to the following clinic locations based on the results of their outcomes data.

Clinic Payments CY2020 | CY2021 | CY2022

The methodology used to calculate these payments is summarized in the documents below.

Methodology CY2020 | CY2021 | CY2022

Information about this payment can also be found on Health Home Quality Incentive Payments.

Fee Schedule CY2020 | CY2021 | CY2022

Quality Assurance Review

Quality Assurance Review

Overall Results

- Period of Review was 10.01.2023-12.31.2023.
- Reviewed 370 Charts (100% completed)
- 133 clinics (100% complied)

Quality Assurance Review

Care Plans

- 28% of patient charts did not have care plans for this review period
- 72% had care plans that met the requirement of being updated within the last year
  - 63% of PCP providers updated the Care Plan within the quarter
  - 59% of CMHC providers updated the Care Plan within the quarter
- 98% of those the Care Plans are actively using them
- 92% of the care plans contained individualized goals and a medication list

Quality Assurance Review

Core Services and Screenings

- 87% documented evidence of a core service in the EHR
- 79% of the Core Services tied to the care plan
- 79% of the recipients had an annual depression screening documented in the EHR
- 83% had an annual Substance use screening documented in the EHR
- 70% had a plan for integration of other physical health services if necessary
- 50% had a plan for integration of other mental health services if necessary

Quality Assurance Review

ED and Inpatient

- 76% of recipients with an ED visit had the visit documented in the EHR.
- 50% were contacted within 72 hours
- 21% of recipient with an inpatient admission were contacted within 72 hours

Quality Assurance Review

Next Steps

- Clinics will receive a letter with their results.
- SDFMC will do a presentation with the overall results.
- Based on the results of the past two years, some clinics will be asked to complete a corrective action plan.

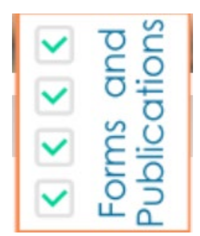
Online Tools and Resources

Online Selection Tool Demo and Eligibility Functionality

- One of the most important advancements we have made recently has been to create the Online Selection Tool.
- Last year the Online Selection Tool was updated to allow the user to substitute the last 4 of the SSN for the Case Number.
- Demonstration https://dss.sd.gov/docs/medicaid/providers/ProviderBulletins/Online_Selection_Tool_PowerPoint.pdf

Online Ordering

- From any page on the DSS website https://dss.sd.gov/
- Click on the Forms and Publications Icon



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.
  - Updated Orientation trainings to use with your new providers and team members
  - Previous Trainings
  - Recipient Handbook
  - Health Home Brochure

DSS Health Home Resources

- Monthly List Serv
- DSS Online Provider Portal –HH Functions
  - HH caseload reports
  - HH claims paid reports
  - HH core services reports
  - HH remits
  - Health Status Report
  - Eligibility Inquiry
  - Service Limits
  - Appeals – Communication Tabs | Reviews and Requests
- Access to DSS Health Home team
  - (605) 773-3495
  - Cmforms@state.sd.us

The primary focus of the BabyReady program is to improve health outcomes through the following:

- Enhanced care coordination and collaboration with Department of Health programs;
- Agreeing to provide services in accordance with ACOG standards of care;
- Addressing barriers to care through provider selected initiatives;
- Enhanced reimbursement for care coordination, prenatal, and postpartum care; and
- Publishing program and provider outcomes data.

Care Coordination Services

The provider must have sufficient staffing to provide the required care coordination services for recipients on the providers' caseload. Care coordination staffing may be at the health system or clinic level but must be available to assist women served by individual participating providers. All care coordination services must be documented.

- Care coordination staff may include RNs, LPNs, CHWs, or other staff qualified and trained to deliver a specific care coordination service.
- Required care coordination services include:
  - Person-Centered Care Plan
  - Health Education and Promotion
  - Health System and Resource Navigation
  - Transitional Care Coordination

Provider Enrollment

- Providers enroll in the program by completing a clinic/practice application, Barriers to Care Initiative form and Addendum https://dss.sd.gov/medicaid/care_management/provider_pregnancy.aspx

- We currently have enrolled 41 clinics with a total of 159 servicing providers.

Recipient Qualification

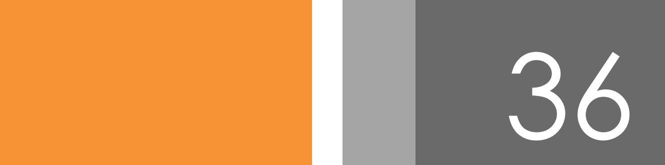
Qualifications

- All pregnant Medicaid-eligible recipients who are less than 21 weeks gestation at the time of program enrollment qualify for the BabyReady Program.
- Recipients will be transitioned from the program to the PCP program 3 months after the end of their pregnancy.

Note: If recipients select a non-participating provider, they are opted out of BabyReady

Misc.

Communication Updates



- Specific Health Home information now in a ListServ. Let me know if you are not getting these messages.
- Information on the latest provider communications can be found at https://dss.sd.gov/medicaid/providers/communication.aspx.
- Providers should also sign up for the Medical Services ListServ. Link is found on the same website as above, but a direct link to sign up is as follows: https://dss.sd.gov/medicaid/contact/ListServ.aspx.

Keep DSS in the Loop When…

- Provider Changes
  - Servicing address, new hires, retirements etc.
- Care coordinators change
- Data contacts change
- Training is needed
- Unable to meet deadlines
- Recipient Information is incorrect
- Others?

Submission of Forms

- Selection Forms should be submitted using the Online Selection tool at https://pcphhselection.appssd.sd.gov/
- If you have the ability, please submit all other forms via secure email to CMforms@state.sd.us rather than fax.
- If emailed, a member will confirm receipt, and you will know it has been received.
- The Care Management Program (CMP) does not have its own fax machine. It is shared with our nurses who do prior authorizations who receive a large quantity of multiple page faxes.

Questions/ Concerns

Thank You

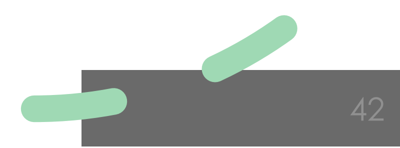
Care Management Team
605.773.3495
CMForms@state.sd.us
dss.sd.gov

South Dakota Department of Social Services

Core Services Round Table Discussion

Core Service Definition

- 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.



Care Plan/Goals Round Table Discussion

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.
- Care Plans should:
  - Include basic information about the recipient;
  - Summarize/List the recipient's medical conditions and medications;
  - Identify those involved (providers, family, other services)
  - Summarize recipient's social situation (housing, employment, transportation etc.);
  - Summarize recipient's barriers;
  - Establish goals to improve health and overcome barriers.
  - New Elements from the former outcome measure set Items for the Care Plan
- 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 natural supports of their choosing.

Workflows | Templates Round Table Discussion