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Introducing Health Homes

January 2020

South Dakota Health Home Program

Why Health Homes?

What is a Health Home?

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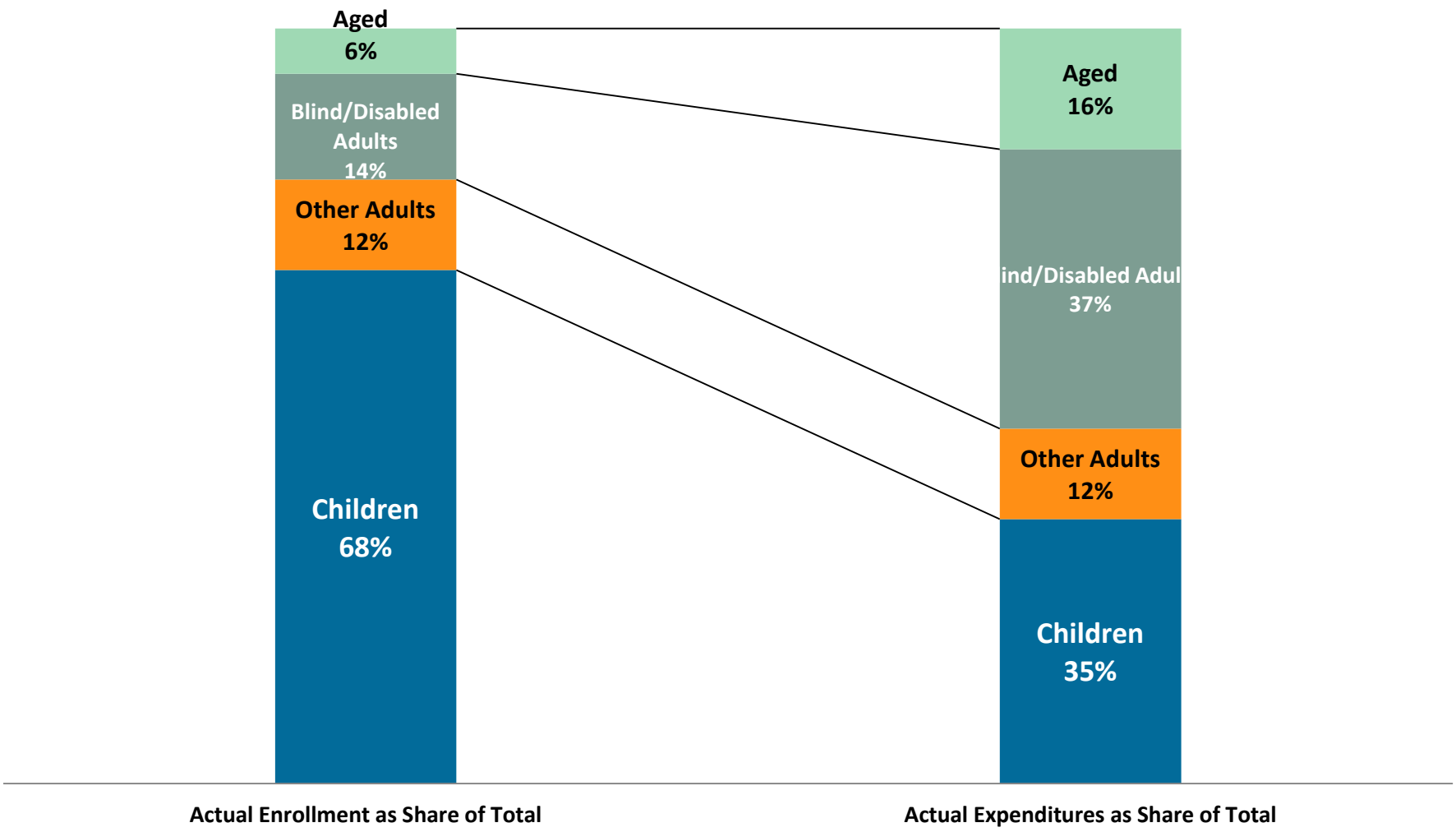
- South Dakota was seeking a way to help manage our high cost, high need recipients.
- Found Health Homes, which is a systematic and comprehensive approach to the delivery of primary care or behavioral health care that we have found offers a better patient experience and better results than traditional care.
- 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.

Why Health Homes for SD?



South Dakota Health Home Program

Health Home

Infrastructure

Provider Infrastructure

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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

South Dakota Health Home Program

Who do Health Homes serve?

Who do Health Homes serve?

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- 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).

Program Statistics

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- Average number of Medicaid Recipient in SD is around 115,000.
- Total Lifetime eligibility = 78,367
- Tier 2-4
  - Lifetime participants in the program for Tier 2-4 = 17,890.
  - Lifetime eligibility in the program for Tier 2-4 =28,496.
  - 63% of individuals who were put in the program were in the program for at least a month.
- Tier 1
  - Lifetime Eligibility for Tier 1 = 57,620
  - Tier 1 are more than 73% of the recipients made eligible for the program

Provider Capacity

- Current Number of Health Homes – 128 serving 132 locations -01.01.2020
  - FQHCs = 26
  - Indian Health Service Units/Tribal 638 = 12
  - CMHCs = 9
  - Other Clinics = 81
- Around 750 designated providers.
- Average around 5,800 recipient in the program per month

South Dakota Health Home Program

Core Services

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 are defined as follows
  - 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.

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

Six Health Home Core Services

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- **Comprehensive Care Management**
  - Comprehensive Care Management is the **development** of an individualized care plan with active participation from the recipient and health home team members.
- **Care Coordination**
  - Care coordination is the **implementation** of the individualized care plan that coordinates appropriate linkages, referrals, and follow-up to needed services and supports.
- **Health Promotion**
  - Health promotion services **encourage and support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self manage their health.

Six Health Home Core Services

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- **Comprehensive Transitional Care**
  - Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community. Especially after an ER Visit or Hospital Stay (72 hour follow-up).

- **Recipient and Family Support Services**
  - Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes.

- **Referrals to Community and Social Support Services**
  - Referrals to community and social **support services** provide recipients with referrals to support services to help overcome access or service barriers, increase self management skills and improve overall health.

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Quarterly Core Service Requirements

Quarterly Core Service Reporting

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- Health Homes report core services on a retrospective basis. DSS will pay for all recipients where the Health Home has provided at least one core service.
- DSS loads list to our Medicaid Online Portal and Coordinators with access complete yes or no for each recipient.
- The Health Home will use the data provided to indicate if a core service was provided by clicking yes or no and submitting the report.
- If the recipient was not provided at least one core service, the Health Home will not be paid for any of the months in that quarter.
- Reporting schedule for Quarterly Core Service Report.

Submission Deadline	Data to be Submitted
April 30	January – March
July 31	April – June
Oct 30	July – September
Jan 31	October - December

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Outcome Measure Requirements

Health Home Outcome Measures

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- The Health Homes program requires specific measures in the area of Clinical Outcomes, Experience of Care, and Quality of Care.
- Patient Experience Survey (standardized survey)
- Each Health Home submit data electronically at the individual level every 6 months.

Submission Deadline	Data to be Submitted
August 31	January – June
February 28	July - December

South Dakota Health Home Program

Results

How does Health Homes Benefit the Clinics

- More engaged recipients/patients.
- Challenging recipients/patients are getting the care they need and usually their health improves.
- Less ER visits and avoidable Hospital Admissions

Health Home Outcome Measures Results

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- Data Dashboard has full results of outcome measures at http://dss.sd.gov/docs/healthhome/hh_outcome_mesaure_summary.pdf

- Our Health Home Data Dashboard contains other exciting information about the program Found at http://dss.sd.gov/healthhome/dashboard.aspx.

- Summary of some of the information from the Dashboard is as follows

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

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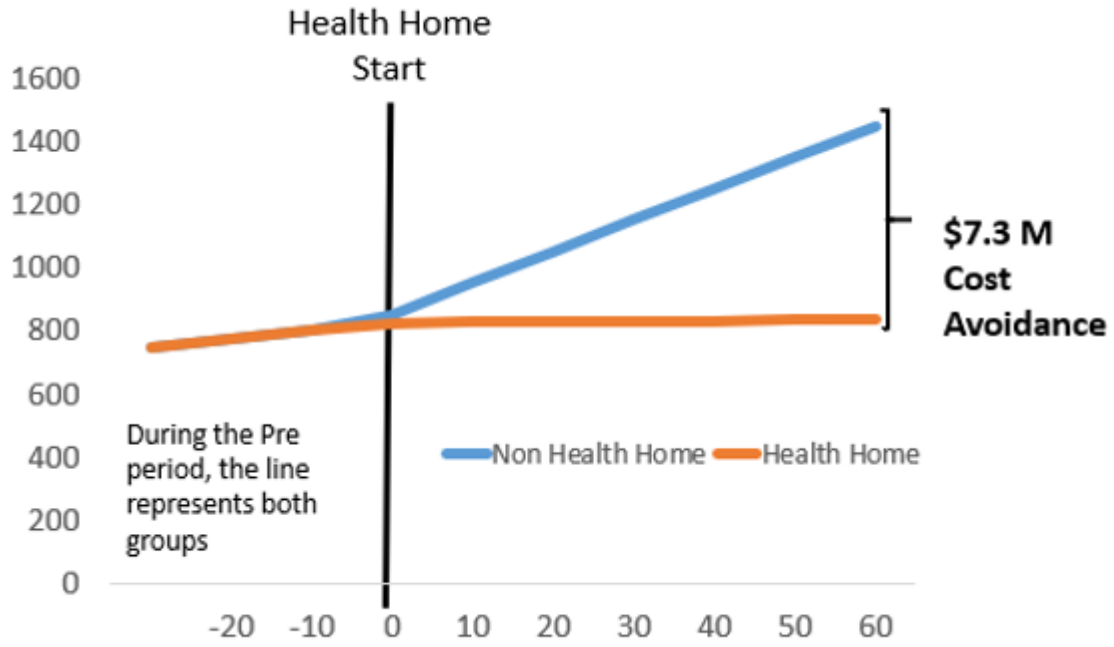
- **Health Homes – Estimate of Avoided Costs**
  - In CY 2018, HH recipients cost $226 less per month than recipients who looked like them. The Health Home Matched Analysis showed that the Health Home program avoided costs for the Medicaid program for CY 2018. $7.3 Million after PMPMs and Quality Incentive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



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

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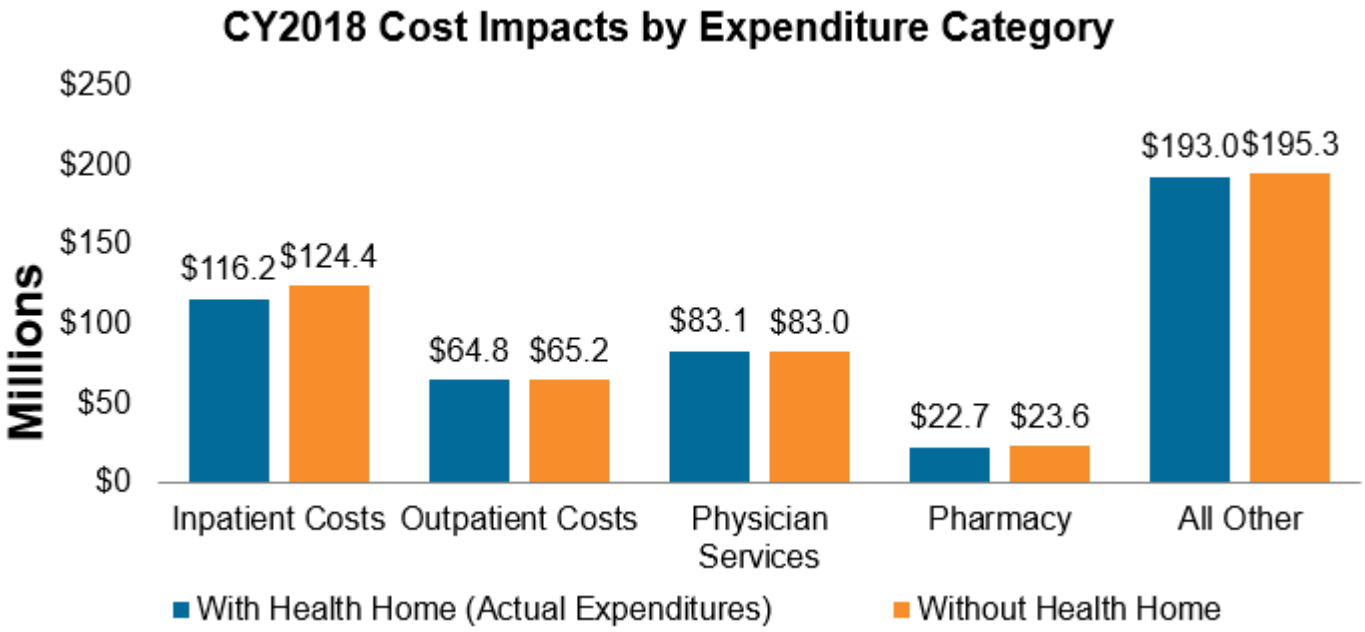
- **Health Homes – Estimate of Avoided Costs by Type of Service**
  - In CY 2018, DSS found that 70% of costs avoided are due to decreased inpatient admissions, emergency room use. Pharmacy and all other expenditures resulted in the remaining 27%. Physician services accounted for an increase of approximately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



Health Management: Improves Health

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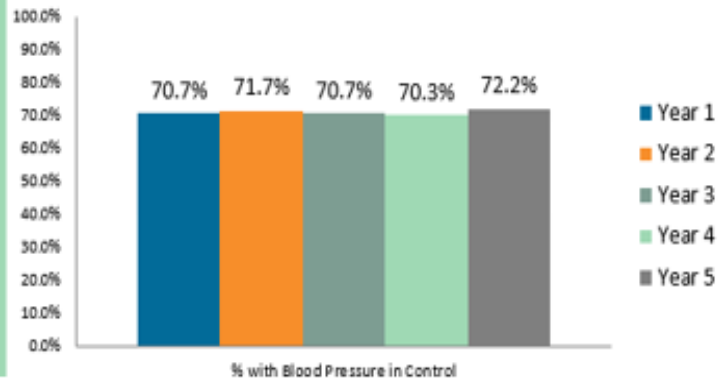
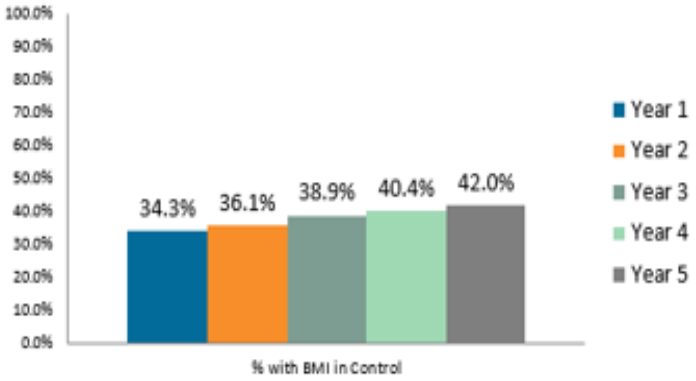
- Longer recipients in the program, the better their health.

CY2018 Cardiovascular and Obesity Goals and Results

	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





Health Management: Success Stories

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- *Medicaid recipient with Diabetes was noncompliant due to inability to read or comprehends materials. Care Coordinator picked up on his literacy issues and explored options to help recipient with insulin injections, medications, diet, exercise and glucometer testing.*
- *Set recipient up with a pharmacy that does bubble packs to help recipient take medications correctly. Used a digital clock to help recipient correspond time to the bubble packs.*
- *Provided recipient pictures of food to eat and at what meal times with pictures of what the plate should look like if the sun is rising or setting.*
- *Recipient came into the clinic every 2-4 weeks and was provided repeated demonstrations on how to check blood sugar.*
- *HgA1c decreased from 11 down to 7. Emergency Room admissions declined and there have been no hospital admissions.*

Health Management: Success Stories

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- Recipient with significant mental illness had been living in a hotel for the last 2 years. Provider indicated that recipient had applied for subsidized housing in the past but was unable to complete all the required paperwork independently. Coordinator helped recipient with the application and the required documentation. Recipient was approved for a subsidized apartment and moved in July 3, 2019.
- Local community helped to furnish the apartment with a queen size bed and a sofa most everything recipient needed. Recipient was able to pay the first month's rent and security deposit and back electric bill.
- The move from a rundown dark depressing motel to an apartment completely changed the recipient's life. With a kitchen the recipient cooks healthier meals no longer relies on processed foods.
- The improved living situation has also improved the recipient's outlook. They have started to dress up to go out, meet neighbors, focus less on self and more on others.
- The program has completely changed recipient's life.

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Performance Rewards

Performance Rewards

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- Since the inception of the Health Home Program, Shared Savings/Performance Incentives have been part of the dialogue.
- State supported this concept
  - Needed to wait for the program mature.
- CMS guidance around how states can share money back with providers.
  - SMDL# 13-005 outlines the guidance
  - https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-005.pdf.

Performance Rewards

- 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.
    - Base 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.

Why Health Homes?

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- PMPM provides coverage for items not reimbursed by Medicaid.
- Happier patients because they feel like they have been heard.
- Team based approach frees up providers to take care of patients, while the coordinator can be the first line of contact.
- Cost avoidance created through the program helps to increase rates for both the PMPM and Performance Bonuses.

How do clinics become a Health Home?

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- Submit a completed Application http://dss.sd.gov/healthhome/application.aspx
- Have each designated provider reviews the Health Home Provider Standards and Core Services Definitions and complete and sign an Attestation
- Health Homes may only begin providing services at the beginning of a Quarter.
  - Quarters start on April, July, Oct and Jan 1.
  - Applications must be submitted at least 40 days in advance of the quarter start date.

How are recipients attributed?

- Recipients returned to DSS by Vendor with a Tier 1-4
- Tier 1 sent a letter indicating eligibility but are required to Opt-in – Out until they say they are in!
- Tier 2-4 In until they say they are out. Sent one of two letters:
  - If we find a continuity of care (COC) provider. They are sent a letter indicating they are placed with this provider.
  - If no COC provider, letter asks them to pick.

PMPM payments

- **CMHC Health Homes**
  Tier 1 – 10.63
  Tier 2 – 38.95
  Tier 3 – 56.65
  Tier 4 – 188.84

- **PCP Health Homes**
  Tier 1 – 10.63
  Tier 2 – 34.23
  Tier 3 – 57.83
  Tier 4 – 295.06

PMPM payments

- Initial Tiers calculated by Vendor to take into account the amount of Uncoordinated Care for each Tier in each type of Health Home.
- Uncoordinated care is considered
  - Non-Emergent ER visits
  - Avoidable IP admissions
  - Avoidable readmissions.
- Payments amounts different types because we are only paying CMHCs to manage the additional Physical condition.

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Questions and Thank You!