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Positive Impacts of the Medicaid Health Home Program

What is the Health Home Program?

- A Medical Home Model focused on Medicaid recipients who have been identified as high cost/high need recipients.
  - Focuses on both Physical and Behavioral Health Conditions

- Program has two main goals
  - Reduce the cost of care for Health Home (HH) recipients.
  - Improve the health outcomes of HH recipients.

History of the Health Home Program

- After the 2010 Legislative Session, the Governor Daugaard appointed the Medicaid Solutions Work group to help develop options for reducing the cost of Medicaid.

- Their first recommendation was to implement a Health Home Program.
  - Created by Section 2703 of the ACA to help reduce the cost of services for some High Cost High Risk Medicaid populations.

  - Health Homes are a systematic and comprehensive approach to the delivery of primary care or behavioral health care that promises 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 outlines by CMS and defined by the Health Home Workgroup must be provided to each Health Home recipient.

History of the Health Home Program

- The Department of Social Services appointed a Stakeholder Workgroup to help design and implement the program.

- This group helped to create the vision for the South Dakota Medicaid Health Home Program. Tasks such as those listed below were part of the decisions the Stakeholder Workgroup helped to make.
  - Outcome measurement development
  - Payment development
  - Conditions to include in the eligibility criteria

- We continue to use this group today to formulate new policy and problem solve as needed.

- This level of inclusion has helped to make the implementation of the program easier and to have a group of individuals to work with to solve issues or to create new policy.

Health Home Design

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Primary Care

- Primary Care
- Physicians Assistants
- Advance 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**
- **Pharmacist**
- **Support Staff**
- **Other appropriate Services**
- **Case Manager**

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 codes
- Recipients are stratified into four tiers based on the recipient's illness severity using CDPS (Chronic Illness and Disability Payment System).

Six Core Services

- CMS requires the six Core Services be provided as appropriate to all enrolled recipients.
- Health Homes are paid a monthly PMPM for the delivery of the Core Services. This payment recently moved to a retrospective payment on a quarterly basis.
- 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:
  - Recipient should be engaged by the action – not simply provider care conference.
  - Core Services are actions that are specific to the patient, tied to their care plan.
  - Documented in the Electronic Health Record.
  - Not already billed using the FFS method.

What are the six Core Services?

Six Core Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Recipient and Family Support Services
- Referrals to Community and Social Support Services

Value Rewards

- Since the inception of the Health Home Program, Shared Savings/Performance Incentives have been part of the dialogue.

- DSS was supportive of this concept from the outset.
  - Needed to wait for the program mature and show success!

- 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.
  - DSS worked with a Subgroup to identify the Methodology used to make the Quality Incentive Payments.
  - Remaining 50% will go 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.

Quality Incentive Payments

- Submitted a State Plan Amendment in February 2019
- DSS received approval for our State Plan Amendment (SPA) to make the Quality Incentive Payments to clinics on April 30, 2019.
- Plans to move forward with making $500,000 in payment in May.

How does Health Homes Help Avoid Medicaid Costs?

- Through Care Coordination
  - Creates a relationship with an individual within the clinic who can serve as an advocate for the recipient.
  - An established relationship increases the likelihood that motivational interviewing or other techniques will succeed.
  - Advocacy helps open doors for recipient when the are unable to open them alone.
  - Care Coordination helps to avoid costs for payers.
    - $7.7 million in both CY2016 and 2017.

Expenditure Trendline

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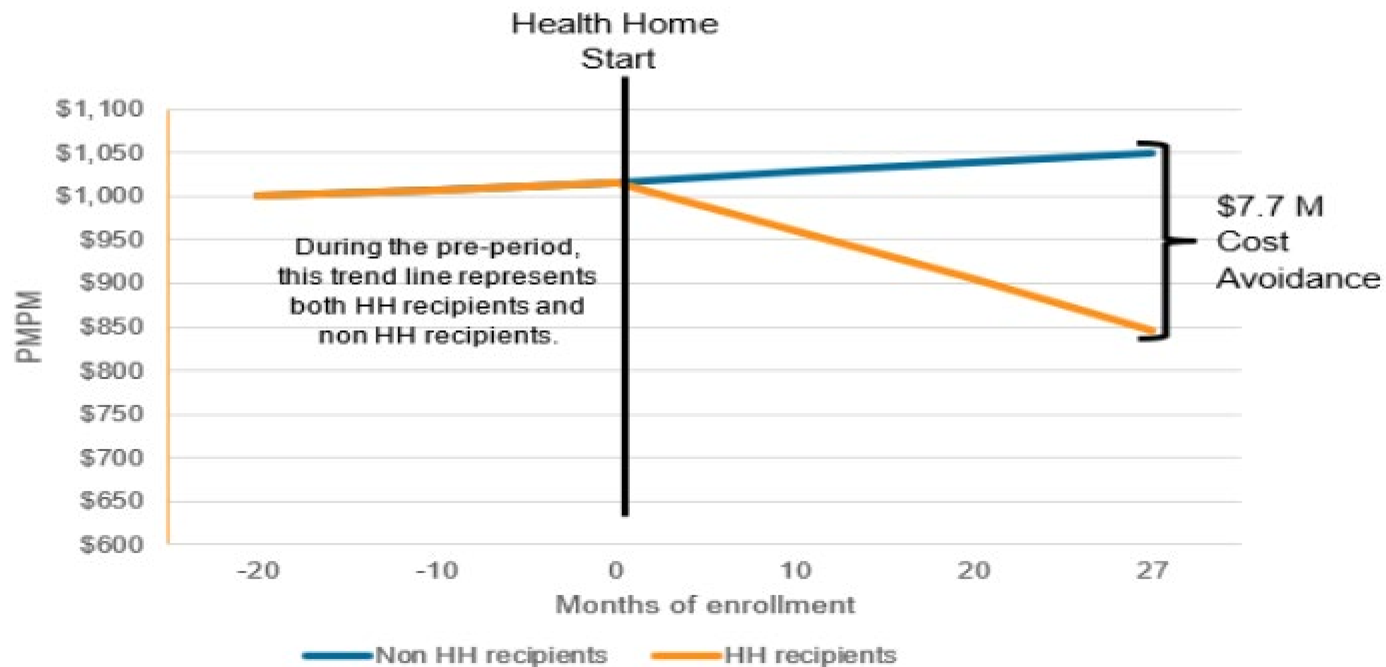

Positive Impacts of the program on Clinics

- 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
- Better Health outcomes= Performance Awards.
- Health Home Dashboard outlines success
  - https://dss.sd.gov/healthhome/dashboard.aspx.

Success Stories

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Health Home Recipient Success Story

Recipient became a part of our Health Home program in 2016. At that time recipient's BMI was 62 and was dealing with hypertension, uncontrolled diabetes, sleep apnea, reflux, hyperlipidemia, and depression/anxiety.

Recipient was not working due to her poor health status. Recipient started working with us and we helped recipient to improve mental health which then led to motivation to improve physical health. Recipient received gastric bypass in 2017 and as a result has seen improved health.

Recipient is now working part time, diabetes is very controlled (not on any medications), and all other conditions are improved and controlled. Recipient's BMI is now 46. Recipient continues to work on wellness and weight improvements but has seen a great improvement in health and wellbeing and is grateful for our support, coaching, and education.

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.
- Provided repeated demonstrations on how to check blood sugar.
- Recipient came into the clinic every 2-4 weeks.
- HgA1c decreased from 11 down to 7. Emergency Room admissions declined and there have been no hospital admissions.

Success Stories

- Recipient with Diagnosis of Obesity, Hypertension, Asthma and Anxiety. Started in the program in 2013.
- Recipient had long history of monthly or twice monthly ED visits (25) from 2009-2013. Provider scheduled monthly meeting with PCP to help reduce anxiety.
- Recipient has had only (4) ED visits since 2013 to 2016. No behavioral health issues. Recipient prefers to see only HH provider.
- Recipient remains on the program even today. Uses the ER only when appropriate, takes medications and prescribed still sees provider on a monthly bases which is working well. Recipient feels “like someone is watching things.”

Why should I be a health Home Providers

- 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 Quality Incentive Payments.

How can I 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.

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