Health Homes in South Dakota

Behavioral Health Subcommittee
November 19, 2015

DSS
Strong Families - South Dakota's Foundation and Our Future

Health Homes

- Health Homes provide enhanced health care services to South Dakota Medicaid recipients with high-cost chronic conditions and/or serious mental illness. Health Homes aim to improve health outcomes and reduce costs associated with uncoordinated care.
- Health Homes provide 6 Core Services to Medicaid recipients with chronic conditions.
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care/follow-up
  - Patient and family support
  - Referral to community and social support services

Who is eligible to be a Health Home provider?

There are two types of Health Homes

- Primary care
- Behavioral Health (CMHC)

Health Homes are led by Designated Providers.

Designated Providers in Primary Care Health Homes can be:

- Physicians
- Physicians Assistants
- Advanced Practice Nurses

Designated Providers in Primary Care Health Homes must be working in a

- Federally Qualified Health Center
- Rural Health Clinic
- Clinic group practice
- IHS

Health Home Payment Structure

- Health Homes receive a per member, per month (PMPM) payment for provision of 6 core Health Home services.
- PMPM payment is made retrospectively each quarter based on the quarterly core service report submitted by each Health Home.
- PMPM based on the Tier of each recipient. PMPM rates effective July 1, 2015:

CMHC Health Homes	**Primary Care Health Homes**
Tier 1 – 9.00	Tier 1 – 9.00
Tier 2 – 33.00	Tier 2 – 29.00
Tier 3 – 48.00	Tier 3 – 49.00
Tier 4 – 160.00	Tier 4 – 250.00

- Non-Health Home Medicaid covered services continue to be reimbursed fee-for-service.

Case Studies: 4 Tier Model for Behavioral Health Health Home

- Tier 1 Member
  - 25 year old female
  - $4642 total spend
  - $113 Rx spend, 1.5 rx/mo, 1 chronic drug group
  - 0 ER Visits
  - O IP Admits
  - 7 physicians
  - History of ADHD, Depression and Low Back Pain.
- Tier 2 Member
  - 43 year old female
  - $18,393 Total Spend
  - $4,493 Rx spend, 6.1Rx/mo, 8 chronic drug classes
  - 2 ER Visit
  - 1 IP Admit, $2,757 IP spend
  - 16 physicians
  - Hx of Bipolar, Depression, High Cholesterol, Low Back Pain, Migraines, Sleep Disorder
- Tier 3 Member
  - 40-year-old male
  - $28,096 Total Spend
  - $4,544 Rx Spend, 4.7 Rx/mo, 7 chronic drug classes
  - 3 ER Visits
  - 1 IP Admits $2,399 IP spend
  - 5 physicians
  - Hx of Bipolar, COPD, Schizophrenia, Smoker, Substance Abuse
- Tier 4 Member
  - 44-year-old female
  - $49,387 total spend
  - $20,195 Rx Spend, 15.7 Rx/mo, 12 chronic drug classes
  - 15 ER Visits
  - 5 IP Admits, $13,863 IP spend
  - 27 physicians
  - Hx of Bipolar, Chronic Pain, Low Back Pain, Musculoskeletal disorder, obesity, pre-diabetes, Schizophrenia, Sleep Disorder, Smoker and Substance Abuse.

Who is eligible to be a Health Home provider?

Designated Providers in Behavioral Health Health Homes can be:

- Mental health professionals in a community mental health center. Examples include:
  - Psychiatrist
  - Psychologist
  - Licensed Professional Counselor Mental Health (LPCMH)
  - Clinical Social Work CSWPIP

- Other staff including Bachelor level provide services as part of the health home care team.

Who is eligible to be a Health Home provider?

- CMHCs acting as Health Homes must provide same services and meet same requirements as Primary Care Health Homes, including:
  - Serve the needs of the whole person. Including behavioral health and physical health
  - Provide referrals for recipient to obtain other care
  - Conduct follow-up with participants following ER visits and inpatient hospitals stays
  - Have an Electronic Health Record
  - Report outcomes measures, including measures for physical health

Designated providers lead a team of healthcare providers to provide the Core Services based on the needs of each individual recipient. The team could include: a care coordinator, chiropractor, pharmacist, support staff, health coach or other appropriate service providers.

Health Home Outcome Measures

There are 60 outcome measures Health Homes report. Examples of some key outcome measures include:

•The percentage of recipients age 12 and older who were screened for clinical depression using a standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen within the last 12 months.

•Percentage of recipients age 12 years and older (adolescents and adults) with a new episode of alcohol or other drug (AOD) within the last 12 months.

Health Home Outcome Measures

•Percentage of recipients aged 18-75 who had an encounter during the last 12 months, with a diagnosis of diabetes

•**BMI:** Percentage of recipients age 18 - 74 years who had an outpatient visit and whom had their BMI documented during the last 12 months, or

•**BMP:** Percentage of recipient age 6 - 17 years who had an outpatient visit and whom had their BMP documented during the last 12 months

•Percentage of women age 50-75 who were up-to-date on their Breast Cancer Screening by use of a Mammogram or MRI.

•Percentage of recipients with a Chronic Pain Diagnoses where during the past 12 months where documentation of a Pain assessment exists?

Health Home Outcome Measures

While most of the measures are the same as the Primary Care HH measures, there are some measures only reported by CMHCs./ These include:

- Percentage of recipients with a diagnosis of Severe Mental Illness or Emotional Disturbance within the last 12 months.
- Percentage of recipients with SMI or SED where the prescriptions filled 85% of the time.
- Several measures taken directly from the CMHC standard satisfaction tool.

The full list of 60 CMHC Outcome Measures is available at:

http://dss.sd.gov/docs/healthhome/cmhcoutcomeindicatorsdocumentedfinalreviseddraftwoastham.pdf

Health Home Provider Qualifications

- Must be licensed by the State of SD when appropriate.
- Must be enrolled or eligible to enroll in SD Medicaid and agree to comply with all Medicaid program requirements.
- Must be willing to provide the Health Home Core Services.
- Must have completed Electronic Health Record implementation
- Must electronically report to DSS outcomes measures and information about how the provision of the Core Services is being met.
- Must attend Health Home Orientation training.

Health Home Provider Application process

- Settings interested in becoming a Health Home submit an application to the Department of Social Services.
- Providers serving as designated providers within the Health Home must sign the accompanying attestation.
- Health Home Application and attestation are found on the DSS website at: http://dss.sd.gov/healthhome/application.aspx.
- DSS provides technical assistance for completing application.
- DSS reviews submitted applications. Once approved, DSS schedules on-site Health Home Orientation with the clinic. .

Current I.H.S./Tribal Primary Care Health Homes

Urban Indian Health – Sioux Falls
Urban Indian Health – Pierre

Indian Health Services

- Lower Brule
- Ft Thompson
- Eagle Butte
- Pine Ridge
- McLaughlin
- Sisseton
- Rosebud
- Rapid City
- Wagner
- Kyle

Horizon Health operates FQHC Health Homes on reservation land

Questions?

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