Health Homes Intro

Package Header

Package ID SD2018MS0006O

SPA ID SD-19-0003

Submission Type Official

Initial Submission Date 1/31/2019

Approval Date 4/30/2019

Effective Date 1/1/2019

Superseded SPA ID SD-13-008-X

System-Derived

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

MIGRATED_HH.South Dakota Health Homes

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The South Dakota Department of Social Services intends to make changes to the South Dakota Medicaid State Plan concerning the implementation of Health Homes for Medicaid recipients with complex health care needs. Health Homes are an initiative of the Patient Protection and Affordable Care Act. Health Homes began in South Dakota at the recommendation of the Medicaid Solutions Workgroup convened by Governor Dennis Daugaard in 2011. Health Homes are intended to improve health outcomes and the experience of care for eligible Medicaid recipients while realizing cost savings as a result of increased coordination of care.

General Assurances

☑ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

☑ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

☑ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

☑ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☑ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

☑ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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- (●) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with:

☑ Two or more chronic conditions

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI over 25
☑ Other (specify):

Name	Description
COPD	ICD-10 codes related to COPD
Hypertension	ICD-10 codes related to hypertension
Musculoskeletal	ICD-10 codes related to musculoskeletal
Neck and Back Disorders.	ICD-10 codes related to neck and back disorders

☑ One chronic condition and the risk of developing another

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI over 25
☑ Other (specify):

Name	Description
COPD	ICD-10 codes related to COPD
Hypertension	ICD-10 codes related to hypertension
Musculoskeletal	ICD-10 codes related to musculoskeletal

Name	Description
Neck and Back Disorders	ICD-10 codes related to neck and back disorders

Specify the criteria for at risk of developing another chronic condition:

At Risk Conditions Include: Pre-Diabetes, Tobacco Use, Cancer, Hypercholesterolemia, Depression, and Use of Multiple Medications (6 or More Classes of Drugs).

All at risk conditions will be identified from diagnosis information using claims data submitted to SD Medicaid.

☑ One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

As discussed in the Health Home consultation call with the Substance Abuse and Mental Health Services Administration (SAMHSA), South Dakota follows the federal definition of serious mental illness, pursuant to Section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321, which includes individuals with a diagnosable mental, behavioral, or emotional disorder that meets diagnostic criteria in the DSM-IV and functional impairment that substantially limits or interferes with one or more major life activities. In the attribution process, South Dakota utilizes the corresponding ICD-10 diagnoses codes to identify serious mental illness. Subject-matter expert partners from the Department of Social Services' Division of Behavioral Health and the South Dakota Council of Mental Health Centers were important members of the Health Home Workgroup.

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ○ Opt-In to Health Homes provider
- ○ Referral and assignment to Health Homes provider with opt-out
- ◉ Other (describe)

Name:

Combination (Tier 1 opt-in and Tier 2-4 automatic assignment with opt-out)

Description:

South Dakota will use the Chronic Disability and Payment System (CDPS) to assign eligible Health Home recipients into one of four tiers. Test data has shown that individuals assigned to Tier 1 have an average CDPS score of less than 1. 1 is considered normal in terms of future risk of spending for the Medicaid population. Therefore, those determined to be in Tier 1 will not be automatically attributed. Instead, they will receive a letter describing their eligibility and have the opportunity to opt-in.

To ensure continuity of care, claims for recipients determined to be in Tiers 2, 3, or 4 will be reviewed to determine if they have an existing relationship with a provider. If that provider is a designated provider, they will automatically be attributed. Alternatively, if there is no existing relationship with a designated provider, they will be sent a letter asking them to choose a Health Home Providers. If they do not make a decision within 30 days, they will be attributed and will receive notification of their assignment. Recipients in Tiers 2, 3, and 4 have the option of opting-out at any time.

Designated providers can submit recipients to the Department to be considered for eligibility. A registered nurse will review the documentation and determine if the individual meets eligibility criteria and, if so, which tier.

Recipients will be flagged as a Health Home participant in the MMIS recipient screen.

Participation is voluntary. All eligible recipients have the opportunity to opt-in or out at any time as long as they continue to be eligible.

The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.

South Dakota has invested considerable resources to modify the MMIS legacy system to identify and track Health Home recipients

Health Homes Providers

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Types of Health Homes Providers

☑ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☑ Physicians

Describe the Provider Qualifications and Standards

Physicians must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. To serve as a designated provider, physicians must sign the Attestation and take the initial Health Home Training. Physicians must be licensed and must attest to meeting provider standards.
Physicians will act as designated providers and will be responsible for the overall provision of the Health Home core services.

☐ Clinical Practices or Clinical Group Practices

☑ Rural Health Clinics

Describe the Provider Qualifications and Standards

Rural Health Clinics must be enrolled as entities as Medicaid providers. They must meet federal requirements to obtain their federal designation prior to enrollment. Designated providers working within a Rural Health Clinic (physicians, Advanced Practice Nurses, and Physicians' Assistants) must be licensed and must attest to meeting provider standards.
The medical staff of Rural Health Clinics will act as designated providers and will be responsible for the overall provision of the Health Home core services.

☑ Community Health Centers

Describe the Provider Qualifications and Standards

Community Health Centers must be enrolled as entities as Medicaid providers. They must meet federal requirements to obtain their federal designation prior to enrollment. Designated providers working within a Community Health Center(physicians, Advanced Practice Nurses, and Physicians' Assistants) must be licensed and must attest to meeting provider standards.
The medical staff of Community Health Centers will act as designated providers and will be responsible for the overall provision of the Health Home core services.

☑ Community Mental Health Centers

Describe the Provider Qualifications and Standards

Community Mental Health Centers must be enrolled as entities as Medicaid providers. They must also be licensed by the DSS Division of Behavioral Health. Mental health professionals working in a Community Mental Health Center must attest to meeting provider standards.
The mental health professionals of Community Mental Health Centers

will act as designated providers and will be responsible for the overall provision of the Health Home core services.

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

☑ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

FQHCs must be enrolled as entities as Medicaid providers. They must meet federal requirements to obtain their federal designation prior to enrollment. FQHCs must make application and all designated providers must sign the Attestation and take the initial Health Home Training.
The medical staff of FQHCs will act as designated providers and will be responsible for the overall provision of the Health Home core services.

☑ Other (Specify)

Provider Type	Description
Advanced Practice Nurses	Advanced Practice Nurses must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed and must attest to meeting provider standards. Advanced Practice Nurses will act as designated providers and will be responsible for the overall provision of the Health Home core services.
Physicians' Assistants	Physicians' Assistants must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed and must attest to meeting provider standards. Physicians' Assistants will act as designated providers and will be responsible for the overall provision of the Health Home core services.

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Designated providers for Health Homes include licensed providers who practice as a primary care physician, (e.g., family practice, internal medicine, pediatrician or OB/GYN), physician's assistants, an advanced practice nurse practitioner working in a Federally Qualified Health Center, Indian Health Service Unit, Rural Health Clinic, or a mental health professional working in a Community Mental Health Center.

A Health Home may include multiple sites identified as a single organization that shares policies, procedures, and electronic systems

The designated provider leads a team of health care professionals and support staff that may include a primary care physician, physician assistant, advance practice nurse, behavioral health provider, a health coach/care coordinator/care, chiropractor, pharmacist, support staff, and other services as appropriate and available. Each designated provider will sign an attestation that they meet the provider standards.

Practice sites will submit the application to become a Health Home and the designated providers are listed in the application.

Applications are submitted to the DSS Division of Medical Services. The applications are reviewed and approved by the Managed Care/Health Home Program Manager.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

Each Health Home and designated provider must complete a mandatory Health Home Orientation before recipients will be attributed to the Health Home. The State foresees providing optional ongoing training via webinar on a quarterly basis, recording the sessions for future viewing by those unable to attend the live session.
The State has established positive, effective working relationships with its Health Home providers during the implementation phase. Ongoing, individual technical assistance will be provided on an as needed basis. South Dakota has already witnessed occurrences of Health Homes collaborating to address barriers to effective service delivery. The State facilitates this collaboration by connecting Health Homes in similar geographic areas and those with similar problems/solutions to problems.
The State has convened a Health Home Implementation Workgroup comprised of Health Home providers representing the wide range of provider types. The Implementation Workgroup will provide input on a wide variety of topics including ongoing training. Additionally, the Health Home Implementation Workgroup will focus on topics with systemic impact and resulting discussions and decisions will be shared with all Health Home providers.
There will also be a variety of quality assurance methods that South Dakota will use to ensure the eleven functional components are being performed. First, the DSS nurses will do random reviews which will include reviewing how the eleven functional requirements are being handled for the records reviewed on the recipients. Based on these results, individual technical assistance will be provided to the Health Home by the Program Manager who works with the Health Home Program.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Under South Dakota's approach to Health Home implementation, a Health Home designated provider is the central point for directing patient centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up and improving patient outcomes by addressing primary medical, specialist, long term care, home health and behavioral health care needs through direct provision, or through arrangements with appropriate service providers of comprehensive integrated services. General qualifications are as follows:

Health Home providers must be enrolled (or be eligible for enrollment) in the SD Medicaid program and agree to comply with all Medicaid program requirements, including those outlined in this HH Provider Standards document and the Health Home Core Services document.

- Health Home providers can either directly provide, or arrange for the provision of, Health Home services. The Health Home designated provider remains responsible for all program requirements.
- Health Home providers must have completed Electronic Health Record (EHR) implementation and use the EHR as its primary medical record solution, prior to becoming a Health Home provider.
- Health Home providers must electronically report to the State (in a manner defined by the Department of Social Services) information about how the Core Services are being met and the outcome measures.
- Health Home providers must work in concert with the South Dakota Department of Social Services, on an as needed basis, to evaluate and continually improve the South Dakota Health Home model as a means to achieve accessible, high quality care, and demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.
- Health Home providers must comply with 42 CFR as it pertains to sharing data for patients with substance abuse disorders.
- Health Home providers must attend all required Health Home trainings.

Health Home providers must make Health Home services available to recipients on a 24 hour/7 day a week basis.
Health Home providers must work to establish relationships with hospitals and other facility based settings to ensure coordination of all

aspects of transitional care for current and eligible recipients.

- Health Home providers must provide the services as outlined in the Medicaid Directors letter SMDL 10-24 including
- Provide quality driven, cost effective, culturally appropriate and person-and family center health home services;
- Coordinate and provide access to high quality health care services informed by evidence based clinical practice guidelines;

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

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CMS-10434 OMB 0938-1188

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | SD2026MS0001O | SD-26-0004 | MIGRATED_HH.South Dakota Health Homes

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Superseded SPA ID SD-25-0010
System-Derived

Payment Methodology

The State's Health Home payment methodology will contain the following features

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [x] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [ ] Other
  - [ ] Comprehensive Methodology Included in the Plan
  - [x] Incentive Payment Reimbursement
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

Describe below

South Dakota will provide a supplemental quality incentive payment to Health Homes when the Health Home intervention produces at least $3 million in savings through efficiencies. Savings through efficiencies is calculated by determining the per member per month (PMPM) for Health Home participants and individuals eligible for Health Homes that do not participate in the program. The PMPMs are multiplied by the number of Health Home member months and the numbers are compared to determine the amount of savings through efficiencies.

South Dakota Medicaid worked with a subgroup of the Implementation Workgroup to identify a payment methodology. The payment methodology is targeted to:

- Incentivize providers with small caseloads usually in rural and frontier areas to continue to participate in the program; and

- Reward providers who make progress towards reaching the established targets or meet/exceed the established target.

To receive either payment type, providers must have participated in the Health Home program during the outcome measurement year, be in good standing with the program by providing a core service to at least 50% of their caseload and reporting outcome measures for each recipient that was provided a core service. Payments are based on outcomes reported on a calendar year basis and average annual caseload and tier are calculated on a calendar year basis.

The amount is divided into the small caseload incentive payment and the clinical outcome measure payment. The small caseload incentive payment amount is divided equally between each qualifying designated Health Home.

South Dakota has 66 counties; only 2 of the 66 counties are urban. For statewide implementation, smaller providers in rural and frontier areas must participate. The small caseload payment promotes access to the Health Home program across the state by incentivizing participation when a caseload may not be large enough to support independent adoption of the program. This encourages health systems to implement the Health Home program in all locations, regardless of size.

To determine if a Health Home should receive the small caseload payment, South Dakota Medicaid will average the caseload receiving a Health Home core service for each Health Home for every month of the measurement year. To qualify for this payment, providers must have been an active Health Home Provider during the outcome measurement year and have an average caseload that received a core service of 15 or less.

The clinical outcome measure

payment is based on the clinical outcome measures submitted by each clinic to South Dakota Medicaid. These measures help demonstrate the successful provision of core services to Health Home recipients and demonstrates the provider's successful implementation of the Health Home model. South Dakota Medicaid worked with a subgroup to establish targets for each of the outcome measures. The outcome measure payment recognizes quality of care by rewarding providers who either improved from the previous calendar year on a specified measure or met/exceeded the established the target for each measure.

South Dakota Medicaid chose two types of measures for the new methodology:

1. Measures that showed successful implementation of the Health Home Model, where the clinic had complete control over the outcome.
2. Measures were also selected which required recipient compliance.

South Dakota worked with our stakeholder group to weight each measure appropriate. The weights of the 10 measures totaled 100.

Once weights were assigned, the past year's and the current year's outcomes were compared for each of the measures and if they improved from the previous year, they were awarded 0.5 points for the measure and if the met or exceeded the target, they were awarded 1.00 point for the measure.

A Severity Score was calculated for each clinic based on the average number of recipients in each Tier whom they provide a core service within the evaluation period and applied to each measure. Scores were assigned to each Tier as follows:

- Tier 1 - 0.25
- Tier 2 - 0.50
- Tier 3 - 0.75
- Tier 4 – 1.00

The severity score was calculated as follows [number of recipients in Tier 1*0.25] + [number of recipients in Tier 2 * 0.50] + [number of recipients in Tier 3 * 0.75] + [number of recipients in Tier 4 *

1.00].

A score was calculated for each measure using the following equation. (Improvement or attainment score * weight) * severity score.

The scores for each measure were added together to get a composite score for each clinic. The composite scores for each clinic were added together. Dollars are awarded for each point in the composite score by taking the dollars for the Clinical Outcome Payment and dividing it by the total composite score for all clinics. Then the dollar amount per point is multiplied by the composite score for each clinic to get the total payment for the Clinical Outcome Payment. A Health Home's total payment is the sum of the Small Caseload Incentive Payment and the Clinical Outcome Measure Payment.

The calculation and distribution methodology utilizes a payment pool. The calculation is attached as Attachment 1.

The supplemental quality incentive payment (Small Caseload Incentive Payment, Clinical Outcome Measure Payment) is distributed as an annual, lump sum amount. Payments will be made within 18 months following the end of the outcome measurement calendar year. The payment will be made to the provider through the MMIS system. Payments will be made directly to the qualifying provider through a supplemental payment mechanism and will appear on their remittance advice. Each provider will receive written notification at the time of payment of the payment amount from DMS.

Payments made in error will be recovered via a supplemental recovery mechanism and will appear on the provider's remittance advice. The agency will notify the provider in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Each of the four tiers will have an individual per member per month (PMPM) payment. South Dakota will update the tier of each active recipient annually. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. Health Home services will be provided by Community Mental Health Centers (CMHC) and Primary Care Providers (PCP). The agency's rates are set and effective July 1, 2026 for services provided on or after that date. All rates are posted on the agency website at

https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The state developed fee schedules are the same for both governmental and private providers of health home services.

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

1945 Health Home Payment Methodologies

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Package Header

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Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ◉ Comprehensive methodology included in plan
- ○ The agency rates are set as of the following date and are effective for services provided on or after that date

1945 Health Home Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Each of the four tiers will have an individual per member per month (PMPM) payment. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. In order to receive the PMPM payment, designated providers must provide at a minimum one core service per quarter. Core services provided must be documented in the EHR and responses must be submitted online following each quarter through the DSS online provider portal. The agency's rates are set and effective July 1, 2026 for services provided on or after that date. All rates are posted on the agency website at https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The state developed fee schedules are the same for both governmental and private providers of health home services.

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Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

South Dakota has taken care to ensure the reimbursement model is designed to only fund Health Home Services that are not covered by any of the currently available Medicaid funding mechanisms. Quality assurance reviews by our vendor are in place to help ensure that there's no duplication of payment. Additionally, upon enrollment and annually thereafter, each Health Home receives training on the definition and criteria of a core service. This training specifies that a core services may not have already been billed to South Dakota Medicaid using a fee for service, encounter, or daily rate.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Health Home Payment Calculation Methodology with Example	6/4/2026 4:55 PM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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South Dakota Health Home
Quality Incentive Payment Methodology

Health Home Composite Scoring

- South Dakota worked with our stakeholder group to weigh each measure appropriately. The measure weights range from 12 to 25 and total 100.
- Once measure weights were assigned, the past year's and the current year's outcomes were compared for improvement or attainment. Each measure is reviewed for additional points, either 0.5 points for improvement or 1.0 point for attaining and/or exceeding the target.
- Caseload Severity Scores were assigned by the average number of recipients in each tier who had received a core service every month. Caseload Severity Score Tier calculations are as follows: [number of recipients in Tier 1*0.25] + [number of recipients in Tier 2 * 0.50] + [number of recipients in Tier 3 * 0.75] + [number of recipients in Tier 4 * 1.00].
- Measure Total was calculated using the following equation:
  (Weight * Improvement or Attainment) * Caseload Severity Score = Measure Total Score
- The Clinic Composite Score is the sum of all Measure Total Scores.

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**

Distribution of Incentive Dollars

- Dollars per point were assigned by taking the Clinical Outcome Payment Dollars (Payment Pool = $556,500) divided by the combination of all Clinic Composite Scores.
- The Clinical Outcome Payment is calculated by multiplying Clinic Composite Score * Dollars per point.
- Small Clinic Payment (Payment Pool = $75,000) is equally divided amongst the clinics that qualify. No changes are being made to the small clinic payment pool or methodology.
- A Health Home's total payment is the sum of the Clinical Outcome Payments and Small Clinic Payment.

Example: Distribution of Incentive Dollars Total $556,500

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	$85,297.36	$25,000.00	$110,297.36
2	2110.00	$60.01	$126,621.62	$25,000.00	$151,621.62
3	1820.75	$60.01	$109,263.65	$0.00	$109,263.65
4	1220.75	$60.01	$73,257.51	$25,000.00	$98,257.51
5	1450.75	$60.01	$87,059.86	$0.00	$87,059.86
Totals	8023.63	$60.01	**$481,500.00**	**$75,000.00**	**$556,500.00**

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | SD2018MS0006O | SD-19-0003 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID	SD2018MS0006O	**SPA ID**	SD-19-0003
Submission Type	Official	**Initial Submission Date**	1/31/2019
Approval Date	4/30/2019	**Effective Date**	1/1/2019
Superseded SPA ID	SD-13-008-X System-Derived		

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive Care Management is the development of an individualized care plan developed by the designated provider with active participation from the recipient and all health care team members. As part of developing each recipient's individual care plan, the health home will use a standardized tool to conduct an assessment. Each recipient will be screened for both mental health and substance abuse issues. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR. The designated provider is responsible for providing for all of the recipient's health care needs or taking responsibility for appropriately arranging care (monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive services) with other qualified professionals. The designated provider should provide same day appointments, timely clinical advice by telephone during office hours, and document clinical advice in the medical record. Comprehensive care management services may include but are not limited to the following:
a. Designated provider uses clinical information and claims history to assess potential level of participation in care management services;
b. Designated provider assesses preliminary service needs including behavioral health; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes;
c. Care Coordinator monitors individual and population health status and service use to determine adherence to or variance from treatment plan;
d. Care Coordinator develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
e. Care Coordinator provides education to recipients on how to access care during office hours, appropriate utilization of urgent care and emergency room visits, specialty services and support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The State of South Dakota is in development stages of a Health Information Exchange (HIE). The HIE is a HIPAA compliant portal that will be accessible to Health Home providers and will enable providers to access the information listed below. Until the HIE is operational, South Dakota Medicaid will electronically provide monthly claims data for each recipient to each Health Home. The data will be provided in a HIPAA compliant manner. The data will supplement the Health Home's Electronic Health Record (required for Health Home Providers) and enable the provider to:
a. Analyze paid claims submitted for a recipient over the past two years (diagnosis code, CPT codes, drug claims);
b. View dates and providers of inpatient hospital, emergency room, and other services;
c. Review laboratory and clinical trait data; and
Health Home providers will also utilize an electronic health record, as feasible, to facilitate interdisciplinary collaboration among all providers;
d. Review prescription drugs filled.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

The Behavioral Health Professional is a designated provider for the Community Mental Health Centers. Health Home designated providers have the overall accountability and responsibility for the Health Home recipient's care. This will include but is not limited to the development and ongoing oversight/implementation of the recipient's individualized care plan, encouraging the recipient, family members and other providers to play an active role in the care plan, provide information and education to the recipient and family members, and work with recipient, family members on establishing goals and then working with the recipient and family members to achieve the established goals.

As a designated provider the Behavioral Health professional would take the lead in providing the clinic aspects of the care plan. They will use clinical information and claims history to assess potential level of participation in care management services;

As a designated provider the Behavioral Health Professional will assesses preliminary service needs including behavioral health; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

The Care Coordinator serves as a focal point within the Health Home team and facilitates the core services of Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and provides referral to community and support services as necessary.

The Care Coordinator plays the following roles
a. Monitors individual and population health status and service use to determine adherence to or variance from treatment plan;
b. Develops and disseminates reports that indicate progress toward meeting outcomes for recipient satisfaction, health status, service delivery and costs; and
c. Provides education to recipients on how to access care during office hours, appropriate utilization of urgent care and emergency room visits, specialty services and support services.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

Physicians must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a designated provider the Physician would take the lead in providing the clinic aspects of the care plan. They will use clinical information and claims history to assess potential level of participation in care management services;

As a designated provider the Physician will assess preliminary service needs including behavior health; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes.

☑ Physician's Assistants

Description

Physicians' Assistants must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a designated provider the Physician's Assistants would take the lead in providing the clinic aspects of the care plan. They will use clinical information and claims history to assess potential level of participation in care management services;

As a designated provider the Physician's Assistants will assess preliminary service needs including behavior health; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes.

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Advanced Practice Nurses	Advanced Practice Nurses must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Nursing. As a designated provider Advance Practice Nurses would take the lead in providing the clinic aspects of the care plan. They will use clinical information and claims history to assess potential level of participation in care management services; As a designated provider Advance Practice Nurses will assess preliminary service needs including behavior health; develops a treatment plan, which will include recipient's goals, preferences and optimal clinical outcomes.

Care Coordination

Definition

Care coordination is the implementation of an individualized care plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. The Health Home Care Coordinator in collaboration with the designated provider and the other applicable members of the health team is responsible for the management of the recipient's overall care plan. The Health Home should share key clinical information (problem list, medication list, allergies, and diagnostic test results) with other providers involved in the care of recipients. If a recipient is being served in the primary care setting and has behavioral health needs, the care management team will ensure that a behavioral health provider is part of the team. Vice versa if a recipient with a severe mental illness has co morbid physical conditions the care management team will ensure that a primary care provider is part of the team. DSS will use its staff nurses to conduct a random sample of case reviews to monitor that care coordination is being provided. Specific activities may include, but are not limited to the following:

a. Care Coordinator monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
b. Care Coordinator coordinates and/or arranges services for the recipient;
c. Care Coordinator conducts referrals and follow-up monitoring;
d. Care Coordinator supports the recipient's compliance with treatment recommendations;
e. Care Coordinator participates in hospital discharges and home visits; and
f. Designated provider and Care Coordinator communicate with other providers and recipient/family members.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The State of South Dakota is in development stages of a Health Information Exchange (HIE). The HIE is a HIPAA compliant portal that will be accessible to Health Home providers and will enable providers to access the information listed below. Until the HIE is operational, South Dakota Medicaid will electronically provide monthly claims data for each recipient to each Health Home. The data will be provided in a HIPAA compliant manner. The data will supplement the Health Home's Electronic Health Record (required for Health Home Providers) and enable the provider to:
a. Analyze paid claims submitted for a recipient over the past two years (diagnosis code, CPT codes, drug claims);
b. View dates and providers of inpatient hospital, emergency room, and other services;
c. Identify clinical issues that impact a recipient's care and receive best practice information;
d. Identify approved or denied medical pre-authorizations;
e. Retrospectively review medication adherence;
f. Offer medication compliance education; and
g. Review laboratory data and clinical trait data.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

The Behavioral Health Professional is a designated provider for the Community Mental Health Centers. Health Home designated providers have the overall accountability and responsibility for the Health Home recipient's care. This will include but is not limited to the development and ongoing oversight/implementation of the recipient's individualized care plan, encouraging the recipient, family members and other providers to play an active role in the care plan, provide

information and education to the recipient and family members, and work with recipient, family members on establishing goals and then working with the recipient and family members to achieve the established goals.

As a designated provider the Behavioral Health professional will communicate with other providers and recipient/family members. This can also be done by the Care Coordinator.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

The Care Coordinator serves as a focal point within the Health Home team and facilitates the core services of Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and provides referral to community and support services as necessary.

The Care Coordinator plays a major role in the Care Coordination Core Services. This included the following roles:
a. Monitors and evaluates the recipient's continuing needs, including health maintenance, prevention and wellness, long term care services and supports;
b. Coordinates and/or arranges services for the recipient;
c. Conducts referrals and follow-up monitoring;
d. Supports the recipient's compliance with treatment recommendations;
e. Participates in hospital discharges and home visits; and
f. Communicate with other providers and recipient/family members. This can also be done by designated providers

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

Physicians must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a designated provider the Physician will communicate with other providers and recipient/family members. This can also be done by the Care Coordinator.

☑ Physician's Assistants

Description

Physicians' Assistants must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a designated provider the Physician's Assistants will communicate with other providers and recipient/family members. This can also be done by the Care Coordinator.

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Advanced Practice Nurses	Advanced Practice Nurses must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Nursing. As a designated provider Advance Practice Nurses will communicate with other providers and recipient/family members. This can also be done by the Care Coordinator.

Health Promotion

Definition

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. The Health Home care manager or health coach will provide health promotion activities. Specific activities may include, but are not limited to the following:
a. Care Coordinator provides health education to recipients and their family members specific to the recipient's chronic and/or behavioral health conditions;
b. Care Coordinator develops disease specific self-management plans;
c. Care Coordinator provides education regarding the importance of immunizations and screenings, child physical and emotional development; and
d. Care Coordinator promotes healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home Providers will utilize their electronic health record to record and track recipient health promotion activities and, based on recipient needs, provide educational material electronically as appropriate. Health Homes will provide reporting via the Electronic Health Record.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☑ Nurse Care Coordinators

Description

The Care Coordinator serves as a focal point within the Health Home team and facilitates the core services of Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and provides referral to community and support services as necessary.

The Care Coordinators performs the following functions in the Health Promotion Core Service:
a. provides health education to recipients and their family members specific to the recipient's chronic and/or behavioral health conditions;
b. develops disease specific self-management plans;
c. provides education regarding the importance of immunizations and screenings, child physical and emotional development; and
d. promotes healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care services are a process to connect the designated provider team and the recipient to needed services available in the community. A defined member of the designated provider care team has overall responsibility and accountability for coordinating all aspects of transitional care including transitions to home, long term care, rehab and other settings. The Health Home will be responsible for working with settings to ensure this information is being provided to the Health Home. At the time that HIE becomes operational, HIE will be used to make this notification. A follow-up contact will be required within 72 hours. Specific activities may include, but are not limited to the following:
a. Care Coordinator facilitates interdisciplinary collaboration among providers during transitions;
b. Designated provider encourages the PCP's, recipients and family/caregivers to play a central and active role in the formation and execution of the care plan;
c. Care Coordinator provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
d. Care Coordinator collaborates with physicians, nurses, mental health professional, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community; and
e. Care Coordinator shifts the use of reactive care and treatment to proactive health promotion and self-management.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

South Dakota Medicaid requires hospitals to report any Medicaid inpatient stay of 6 days or more. Hospitals provide information about diagnoses, condition and plan of treatment, as well as anticipated discharge date. Registered Nurses with SD Medicaid track all reported stays until discharge. If the notification is for a Health Home recipient, Registered Nurses will collaborate with the Health Home Program Manager and Clinic Care Coordinators. The Health Home care coordinator will:
a. Perform the required continuity of care coordination between inpatient and outpatient services;
b. Work with the hospital personnel to coordinate the hospital discharge and avoid readmission; and
c. Update recipient's care plan in the electronic health record.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

The Behavioral Health Professional is a designated provider for the Community Mental Health Centers. Health Home designated providers have the overall accountability and responsibility for the Health Home recipient's care. This will include but is not limited to the development and ongoing oversight/implementation of the recipient's individualized care plan, encouraging the recipient, family members and other providers to play an active role in the care plan, provide information and education to the recipient and family members, and work with recipient, family members on establishing goals and then working with the recipient and family members to achieve the established goals.

As a Designated Provider the behavorial Health Professional encourages the PCP's, recipients and family/caregivers to play a central and active role in the formation and execution of the care plan;

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

The Care Coordinator serves as a focal point within the Health Home team and facilitates the core services of Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and provides referral to community and support services as necessary.

The Care Coordinator supports this Core Service by performing the following functions

a. Facilitates interdisciplinary collaboration among providers during transitions;
b. Provides comprehensive transitional care activities, including, whenever possible, participating in discharge planning;
c. Collaborates with physicians, nurses, mental health professional,

social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community; and
d. Shifts the use of reactive care and treatment to proactive health promotion and self-management.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

Physicians must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a Designated Provider the Physician encourages the recipients and family/caregivers to play a central and active role in the formation and execution of the care plan.

☑ Physician's Assistants

Description

Physicians' Assistants must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a Designated Provider the Physician's Assistant encourages the recipients and family/caregivers to play a central and active role in the formation and execution of the care plan.

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Advanced Practice Nurse	Advanced Practice Nurses must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Nursing. As a Designated Provider the Advanced Practice Nurse encourages the recipients and family/caregivers to play a central and active role in the formation and execution of the care plan.

Individual and Family Support (which includes authorized representatives)

Definition

Recipient and family support services reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes. A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate. This includes assessing the barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments. Specific activities may include, but are not limited to the following:
a. Care Coordinator advocates for recipients and families;
b. Care Coordinator identifies resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community;
c. Care Coordinator coordinates transportation to medically necessary services; and
d. Designated provider or Care Coordinator provides information on advance directives in order to allow recipients/families to make informed

decisions.
Health Homes will provide information in a variety of ways including electronic, telephonic, in person, or group settings.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The Health Home providers' Electronic Health Records will incorporate documentation of all care management interventions, including provisions of Individual and Family Support Services. The following is a list of the types of Individual and Family Support Services documented in the Electronic Health Record. All of these activities can be used in queries and reports.
a. Referrals to community resources and social supports;
b. Conducting medication education;
c. Providing recipient tool kits to include self- management tool kits; and
d. Scheduling support (including transportation services).
Health Homes will provide reporting via the Electronic Health Record.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

The Behavioral Health Professional is a designated provider for the Community Mental Health Centers. Health Home designated providers have the overall accountability and responsibility for the Health Home recipient's care. This will include but is not limited to the development and ongoing oversight/implementation of the recipient's individualized care plan, encouraging the recipient, family members and other providers to play an active role in the care plan, provide information and education to the recipient and family members, and work with recipient, family members on establishing goals and then working with the recipient and family members to achieve the established goals.

As a designated provider, the Behavioral Health Professional works to ensure that information on advance directives is provided to the recipient in order to allow recipients/families to make informed decisions.This may also be done by the care coordinator.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

The Care Coordinator serves as a focal point within the Health Home team and facilitates the core services of Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and provides referral to community and support services as necessary.

The Care Coordinator supporst this core service in the following manner
a. Advocates for recipients and families;
b. Identifies resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community;
c. Coordinates transportation to medically necessary services; and
d. Provides information on advance directives in order to allow recipients/families to make informed decisions.
This may also be done by the designated provider.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

Physicians must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a designated provider, the Physician provides information on advance directives in order to allow recipients/families to make informed decisions.This may also be done by the care coordinator.

☑ Physician's Assistants

Description

Physicians' Assistants must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Medical and Osteopathic Examiners.

As a designated provider, the Physician's Assistant provides information on advance directives in order to allow recipients/families to make informed decisions.This may also be done by the care coordinator.

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Advanced Practice Nurse	Advanced Practice Nurses must be enrolled as Medicaid providers. This may be individual provider enrollment or enrollment of the entity for which the person works. Additionally, these providers must be licensed by the South Dakota Board of Nursing. As a designated provider, the Advanced Practice Nurse provides information on advance directives in order to allow recipients/families to make informed decisions.This may also be done by the care coordinator.

Referral to Community and Social Support Services

Definition

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. The Health Home designated provider has responsibility for identifying available community-based resources and manages appropriate referrals. Specific activities may include, but are not limited to the following:
a. Care Coordinator coordinates or provides access to recovery services and social health services available in the community (may include support groups, housing, personal need and legal services);
b. Care Coordinator provides assistance to obtain and maintain eligibility for health care, disability benefits, etc.;
c. Care Coordinator supports effective collaboration with community based resources; and
d. Care Coordinator and/or assess long-term care and other support services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

The Health Home providers' Electronic Health Records will incorporate documentation of all care management interventions, including referrals to community and social support services.
The Health Home will provide reporting via the Electronic Health Record.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

The Care Coordinator serves as a focal point within the Health Home team and facilitates the core services of Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and provides referral to community and support services as necessary.

The Care Coordinator plays the primary role in this core service by performing the following function:
a. Coordinates or provides access to recovery services and social health services available in the community (may include support groups, housing, personal need and legal services);
b. Provides assistance to obtain and maintain eligibility for health care, disability benefits, etc.;
c. Supports effective collaboration with community based resources; and
d. Assesses the need for long-term care and other support services.

- ☐ Nurses
- ☐ Medical Specialists
- ☐ Physicians
- ☐ Physician's Assistants
- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☐ Other (specify)

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | SD2018MS0006O | SD-19-0003 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID SD2018MS0006O

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Initial Submission Date 1/31/2019

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Superseded SPA ID SD-13-008-X

System-Derived

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

15 months of claims data for every currently eligible Medicaid recipient is reviewed monthly to determine eligibility for participation in a Health Home. Those who are eligibile are run through the Chronic Illness and Disability Payment System (CDPS) and assigned a prospective risk score. Recipients are then tiered based on the risk score.

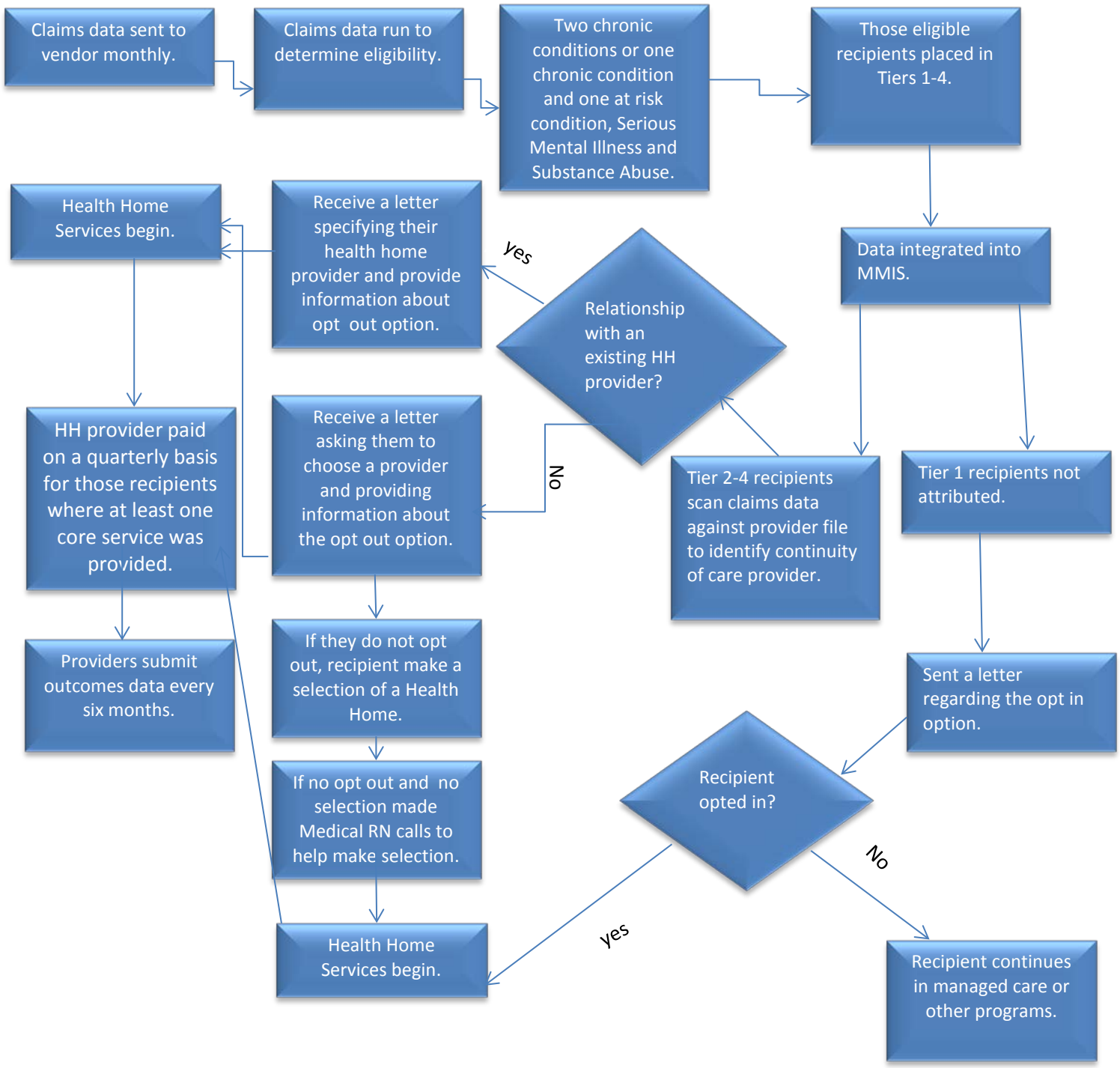
Those recipients in Tier 1 are not automatically attributed but are sent a letter regarding their eligibility and the steps to choose to participate. If the recipient chooses to participate, he/she would select a provider.

The claims for those recipients in Tiers 2-4 are reviewed to identify a continuity of care provider. If there is provider continuity and the provider is a Health Home, the recipient is assigned to the Health Home and sent a letter naming their Health Home provider and the information about opting out or choosing a different provider. If there is no continuity of care Health Home, the recipient is sent a letter asking them to choose a provider and the information about opting out.

Prior to the recipient's first Health Home visit, the Health Home reviews the EHR for existing recipient information. When the recipient arrives for the appointment an assessment, screens and routine tests are conducted and medications reviewed. The designated provider, recipient and Care Coordinator develop the recipient's plan of care for all conditions. The Care Coordinator establishes regular contact with the recipient. The plan of care and goals are documented in the EHR. Depending on the recipient's needs, other health or community services may be referred to and coordinated. This could include, but is not limited to, mental health professional, pharmacist, community education, etc. The Care Coordinator follows-up with the recipient as agreed upon. Based on the plan of care, future appointments, etc. are established.

Name	Date Created	
Health Home Flow Chart revised	11/16/2018 11:29 AM EST	

Health Home Attribution and Payment Flow Chart



Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Administration, Health Homes | SD2024MS0001O | SD-24-0013 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID	SD2024MS0001O	**SPA ID**	SD-24-0013
Submission Type	Official	**Initial Submission Date**	8/5/2024
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Superseded SPA ID	SD-19-0003		
	System-Derived		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

Historical claims data will be used to establish a base cost for the HH program. Anticipated costs for those HH-eligible members in the future performance period for each program are estimated by applying anticipated percent decreases in the presence of HH interventions to the expected service category costs. The projected costs in the future performance period are then compared to anticipated costs to estimate program savings.

The state will annually perform an assessment of cost avoidance using a pre/post comparison, comparing trends among HH enrollees with a comparison group that is not enrolled in the program. We use a propensity score match to identify subsets of HH enrollees and non-HH enrollees that are alike in their observable characteristics such as past costs, Medicaid enrollment, sex, age and number of conditions and therefore are well suited for comparison. This quasi-experimental design allows us to isolate the effects of the program from other potential variables influencing costs. We compare the average per person per month (PMPM) change in costs for each of the groups in the pre-enrollment period and post-enrollment period to determine the extent to which costs were avoided by enrolling individuals in the Health Home program and providing core services related to coordination of care and chronic disease management. The data source to identify the change in PMPM costs is a paid claims file, merged with enrollment data and a file indicating which recipients received a Health Home core service. Overall cost avoidance calculations are trended over time and estimated for various categories of service.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

To facilitate the exchange of health information in support of care for recipients receiving or in need of Health Home services, several methods of health information technology (HIT) will be utilized initially and enhanced as Health Homes mature. The State of South Dakota is in development stages of a Health Information Exchange (HIE). The HIE is a HIPAA compliant portal that will be accessible to Health Home providers and will enable providers to access recipient administrative and clinical data for the development and ongoing refinement of individual care plans, comprehensive care management, and care coordination. Until the HIE is operational, South Dakota Medicaid will electronically provide claims history to each Health Home. The data will be provided in a HIPAA compliant manner, supplement the Health Home's Electronic Health Record (required for Health Home Providers) which enables the providers to provide the six core services.

Each Health Home is required to have an Electronic Health Record (EHR). Through that EHR and other electronic communication tools providers are utilizing, Health Home recipients may have access to on-line records, treatment plans and educational materials. In some cases these functions may be available through mobile devices. These tools and others in various stages of development may be used by the Health Home and the Health Home recipient to record and monitor progress against the agreed upon care plan. The EHR also facilitates communication and monitoring of referrals to other needed providers and/or community based services.

It is the responsibility of the Health Home Providers to secure the information needed to effectively deliver the required Health Home Services. Each Health Home site may accomplish this in a different manner. Methods of doing this include but are not limited to HIE, claims data, information sharing agreements and using their own Health system's EHR more effectively.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Administration, Health Homes | SD2024MS0001O | SD-24-0013 | MIGRATED_HH.South Dakota Health Homes

Package Header

Package ID	SD2024MS0001O	**SPA ID**	SD-24-0013
Submission Type	Official	**Initial Submission Date**	8/5/2024
Approval Date	10/11/2024	**Effective Date**	7/1/2024
Superseded SPA ID	SD-19-0003		
	System-Derived		

Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [x] The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

Medicaid State Plan Administration

General Administration

Reporting

MIGRATED_HH.South Dakota Health Homes

Package Header

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Submission Type	Official	**Initial Submission Date**	8/5/2024
Approval Date	10/11/2024	**Effective Date**	7/1/2024
Superseded SPA ID	New		
	User-Entered		

A. General Reporting

The agency submits all reports in the form and with the content required by the Secretary and complies with any provisions that the Secretary finds necessary to verify and assure the correctness of all reports.

☑ 1. The agency assures that all requirements of 42 CFR 431.16 are met.

B. Annual Reporting on the Child and Adult Core Sets

☑ 1. The agency assures that all requirements of 42 CFR 437.10 through 437.15 are met.

☑ 2. The agency reports annually, by December 31, on:

a. All measures on the Child Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

b. All behavioral health measures on the Adult Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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