



ABOUT MEDICAID HEALTH HOMES



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What is a Medicaid Health Home?

A Medicaid Health Home, or Health Home, provides a comprehensive system of care coordination for Medicaid recipients with chronic conditions.

“Health Home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the ‘whole-person’ across their lifespan.²⁰”

A Health Home is a federally defined initiative in the Affordable Care Act (ACA). It is a person-centered system that offers coordinated care to Medicaid recipients with multiple chronic conditions.

“The goal is to achieve improved outcomes and better services for Medicaid recipients.²¹”

Health Homes share many characteristics with Patient-Centered Medical Homes, but Health Homes are customized to meet the specific needs of Medicaid recipients with chronic medical conditions or behavioral health conditions.¹⁸ While most of the services provided by a Health Home are similar to those provided by a Patient-Centered Medical Home, Health Homes are designed to serve a different population (Medicaid recipients) as required by the ACA.

The Health Home initiative aims to:

- Reduce inpatient hospitalization and emergency room visits
- Increase integration between physical and behavioral health services
- Enhance transitional care between institutions and the community

Why is South Dakota implementing Health Homes?

“South Dakota is implementing Health Homes to improve health outcomes and experience of care for eligible Medicaid recipients, while also realizing cost savings from better coordinated care for that population”

The work began as a recommendation of the Medicaid Solutions Workgroup, convened by Governor Dennis Daugaard in 2011. The workgroup was tasked with identifying ways Medicaid could realize cost savings and better serve recipients.

The final Report of the Medicaid Solutions Workgroup can be found here:

<https://dss.sd.gov/docs/healthhome/finalmedicaidsolutionsreport.pdf>

In April 2012, the Department of Social Services convened a Health Home Workgroup to guide the process of evaluating and implementing Health Homes. Information considered included federal requirements, other states' Health Home models, SD Medicaid diagnostic and claims data, and other research.²¹

Who is eligible to receive Health Home services?

In South Dakota, Medicaid recipients are eligible to participate in a Health Home if they have:

- Two or more chronic conditions
- One chronic condition and are at risk for a second chronic condition
- A severe mental illness or emotional disturbance

See the table below for definitions of these conditions.

Chronic conditions	Mental health condition, substance use disorder, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal and neck/back disorders
At-risk conditions	Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6 or more classes of drugs)
Severe mental illness	Disorders that affect mood, thinking, and behavior such as depression, anxiety disorders, schizophrenia, eating disorders, and addictive behaviors
Emotional disturbance	Referring to children, a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects performance: ²³ <ul style="list-style-type: none"> • An inability to learn that cannot be explained by intellectual, sensory or health factors • An inability to build or maintain satisfactory interpersonal relationships • Inappropriate types of behavior or feelings under normal circumstances/ a general pervasive mood of unhappiness or depression • A tendency to develop physical symptoms or fears associated with personal or school problems

Eligible individuals can be referred to a Health Home by the state, a health care provider, or a hospital. Individuals may choose among the available, qualified Health Home providers and may change providers or disenroll at any time. However, individuals may only receive Health Home services from one provider in a given period of time.

Enrollment must be documented by the provider, and that documentation should, at a minimum, indicate:

- The individual has received the required information explaining the Health Home program
- The individual has consented to receive the Health Home services
- The effective date of enrollment

What are the six core services that must be provided by a Medicaid Health Home?

Health Homes must provide six federally mandated Core Services:²²

1. **Comprehensive Care Management:** Providing initial and ongoing assessment and care management services that integrate primary, behavioral, and specialty health care and community support services. It uses a broad person-centered care plan which addresses all clinical and non-clinical needs, promotes wellness, and supports the management of chronic conditions to achieve optimal health outcomes.

Services include, but are not limited to:

- Conducting outreach to gather information from the enrollee, the enrollee's support member(s), and other healthcare providers
 - Completing a comprehensive needs assessment
 - Developing a comprehensive person-centered care plan
2. **Care Coordination:** Facilitating and monitoring services identified in a person-centered care plan to manage chronic conditions for optimal health outcomes to promote wellness.

Services include, but are not limited to:

- Implementing the person-centered care plan
 - Continuously monitoring progress toward goals identified in the person-centered care plan through contacts with enrollee, enrollee's support member(s), and healthcare providers
 - Supporting the enrollee's adherence to prescribed treatment regimens and wellness activities
 - Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting
 - Communicating and consulting with other providers and the enrollee and enrollee's support member(s) as appropriate
 - Sharing centralized information to coordinate integrated care by multiple providers through use of electronic health records (EHRs)
 - Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress towards goals
3. **Health Promotion:** Educating and engaging a patient in making decisions that promote his/her maximum independent living skills and ability to make lifestyle choices that foster good health. This includes proactive management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems.

Services include, but are not limited to:

- Educating the patient about his/her chronic condition
 - Teaching self-management skills
 - Conducting medication reviews and regimen compliance
 - Assisting the patient with resources that address exercise, nutrition, stress management, substance use reduction/cessation, tobacco cessation, self-help recovery resources, and other wellness services based on the patient's needs and preferences
4. **Comprehensive Transitional Care:** Facilitating services for the patient and family/caregiver(s) when the patient transitions between levels of care (e.g., hospital, nursing facility, rehabilitation facility, community-based group home, family or self-care) or when a patient elects to transition to a new Health Home provider. Health Homes should establish a written protocol on the care transition process to set up real-time sharing of information and care transition records for Health Home patients.

Services include, but are not limited to:

- Establishing relationships with hospitals, residential settings, rehabilitation settings, long-term services and support providers, etc. to promote a smooth transition if the patient is moving between levels of care and back into the community
- Developing systems for prompt notification and ongoing communication of the patient's admission to and/or discharge from an emergency room, in-patient residential, rehabilitative, or other treatment setting
- Participating in discharge planning with the hospital or other treatment settings to ensure goals of the patient's person-centered care plan are met
- Communicating and providing education to the patient, the patient's support member(s), and the providers located at the settings to and from which the patient is transitioning

- Developing a systematic protocol to assure timely access to follow-up care post-discharge that includes at a minimum all of the following:
 - Receipt of summary of care record from the discharging entity
 - Medication reconciliation
 - Reevaluation of the care plan to include and provide access to needed community support services
 - Plan to ensure timely scheduled appointments
5. **Individual and Family Support:** Coordinating information and services to assist the patient’s support member(s) in maintaining and promoting quality of life, with particular focus on community living options.
- Services include, but are not limited to:*
- Providing education and guidance in support of self-advocacy
 - Providing caregiver counseling or training, including skills to: provide specific treatment regimens to help the individual improve function, obtain information about the individual’s disability or conditions, and navigate the service system
 - Identifying resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization, and adaptive skills
 - Providing information and assistance in accessing self-help, peer support, respite services, etc.
6. **Referral to Community and Support Services:** Referring a patient and the patient’s support member(s) to community-based resources that can meet the needs identified on the patient’s person-centered care plan.
- Services include, but are not limited to:*
- Providing referral and information assistance to individuals in obtaining community-based resources and social support services
 - Identifying resources to reduce barriers to achieving the patient’s highest level of function and independence
 - Monitoring and follow-up with referral sources, patient, and patient’s support member(s) to ensure appointments and other activities, including employment and other social community integration activities, were established and patients have engaged in services

Who can provide Health Home Services?

To serve Medicaid recipients with complex health care needs resulting in high costs to Medicaid, states have flexibility in who is eligible to be a Health Home provider.

“South Dakota has two types of Health Homes -- those led by Primary Care Providers and those led by a Community Mental Health Center.²¹”

Each Health Home is led by one or more designated providers. Designated providers for Health Homes include:

- Providers licensed by the state of South Dakota practicing as a primary care physician (e.g. family practice, internal medicine, pediatrician or OB/GYN), physician’s assistant, or advanced practice nurse practitioner. Providers may work with a Federally Qualified Health Center, Rural Health Clinic, Indian Health Service, or clinic group practice
- Mental health professionals working in a Community Mental Health Center

“Each designated provider leads an individualized team of health care professionals and support staff to meet the needs of each Medicaid recipient.”

A designated provider team may include a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff and other services as appropriate and available.¹⁸

What do providers need to do to become a Health Home provider?

*Providers who would like to serve as a designated Health Home provider should:*²¹

- Read the eligibility criteria on the South Dakota Department of Social Services (DSS) website:
<https://dss.sd.gov/sdmedx/includes/providers/becomeprovider/>
- If a provider feels they meet the required provider standards, complete an application on the DSS website:
<https://dss.sd.gov/healthhome/application.aspx>.
 - Health Home application training can be viewed here:
<https://dss.sd.gov/healthhome/application.aspx>.
 - Direct questions about the application to the contact person on the website.

DSS reviews completed applications to ensure each provider meets the standards. If the application is approved, DSS provides onsite training to the Health Home.

What are the costs associated with becoming a Health Home?

There is no fee to become a Health Home. There may be some internal costs for providers related to implementation of the program.²¹

How are providers reimbursed for Health Home services?

Health Home providers are paid a per-member, per-month (PMPM) payment based on the tier of the recipients to cover the cost of providing the six core services required by Health Homes.

Find more information here:

<https://dss.sd.gov/healthhome/pmpmpayments.aspx>