DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

Region VIII

November 22, 2013

[SD13-0008:HH: LJ]

Kim Malsam-Rysdon, Secretary
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291

Re: South Dakota State Plan Amendment (SPA) Transmittal Number 13-0008

Dear Ms. Malsam-Rysdon:

The Centers for Medicare & Medicaid Services (CMS) Denver Regional Office has completed its review of South Dakota State Plan Amendment (SPA) Transmittal Number 13-0008. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The State plan pages for this SPA were submitted and approved through the Medicaid Model Data Lab. To qualify for enrollment in a health home, Medicaid participants must:

1. Have two or more chronic diseases or has one chronic condition and is at risk for another. Chronic diseases include: Asthma, COPD, Diabetes, Heart Disease, Hypertension, Substance Abuse, Obesity, Musculoskeletal and Neck/Back disorders. At-risk conditions include: Pre-Diabetes, tobacco use, cancer hypercholesterolemia, depression, and use of 6+ chronic medications. Or;

2. Have a single occurrence of a diagnosis for Severe Mental Illness or Emotional Disability, limited to schizophrenia, bipolar, major depression, mood disorders, Ethyl Alcohol-related psychotic disorders, anxiety, personality/social disorders, Attention Deficit Hyperactivity Disorder.

This SPA designates the following as health home providers: physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, Federally Qualified Health Centers (FQHCs), advanced practice nurses, or physician assistances when the provider has signed the attestation, taken the initial health home training and meets the provider standards.

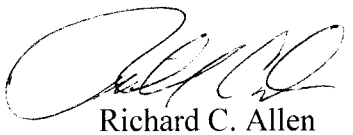
We are approving this SPA with an effective date of July 2, 2013, and have included the approved State plan pages with this letter. In accordance with the statutory provisions at Section 1945(c) (1) of the Social Security Act, for payments made to health home providers under this amendment, during

the first eight fiscal quarters that the SPA is in effect - July 2, 2013 through June 30, 2015, the Federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on July 1, 2015.

This approval is based on the State's agreement to collect and report information required for the evaluation of the health home model. States are also encouraged to report on the CMS' recommended core set of quality measures.

If you have any questions concerning this amendment or require further assistance, please contact Laurie Jensen at 303-844-7126 or Laurie.Jensen@cms.hhs.gov.

Sincerely,



Richard C. Allen
Associate Regional Administrator
Divisions of Medicaid & Children's Health Operations

CC: Kirby Stone, Medicaid Director
Ann Schwartz
Amy Stewart

Transmittal Number: SD-13-0008 Supersedes Transmittal Number: SD-13-0008 Approved Effective Date: Jul 2, 2013 Approval Date: Nov 21, 2013
Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

SD-13-0008

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

☐ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:
South Dakota Health Homes

State Information

State/Territory name:	**South Dakota**
Medicaid agency:	Department of Social Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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The primary contact for this submission package.

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The secondary contact for this submission package.

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Title: Managed Care Program Manager

Telephone number: (605) 773-3495

Email: Kathi.Mueller@state.sd.us

The tertiary contact for this submission package.

Name:

Title:

Telephone number:

Email:

Proposed Effective Date

07/02/2013 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
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.

Federal Budget Impact

	Federal Fiscal Year		Amount
First Year	2013	$	2035791.00
Second Year	2014	$	8143163.00

Federal Statute/Regulation Citation

Affordable Care Act of 2010, Section 2703

Governor's Office Review

No comment.

Comments received.
Describe:

No response within 45 days.

Other.
Describe:

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Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

Public notice was not required and comment was not solicited

Public notice was not required, but comment was solicited

Public notice was required, and comment was solicited

Indicate how public notice was solicited:

- [ ] **Newspaper Announcement**
- [x] **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

  Date of Publication:

  07/01/2013 (mm/dd/yyyy)
- [x] **Email to Electronic Mailing List or Similar Mechanism.**

  Date of Email or other electronic notification:

  06/28/2013 (mm/dd/yyyy)

  Description:
  An email, including the proposed SPA, was sent to the members of the Health Home Workgroup.
- [x] **Website Notice**

  Select the type of website:
  - [x] Website of the State Medicaid Agency or Responsible Agency

    Date of Posting:

    06/28/2013 (mm/dd/yyyy)

    Website URL:

    http://dss.sd.gov//healthhome/index.asp
  - [ ] Website for State Regulations

    Date of Posting:

    (mm/dd/yyyy)

    Website URL:
  - [ ] Other
- [ ] **Public Hearing or Meeting**
- [ ] **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

- [ ] **Access**

  Summarize Comments

  Summarize Response
- [ ] **Quality**

  Summarize Comments

  Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

Service Delivery

Summarize Comments

Summarize Response

Other Issue

Issue
Issue Name:
48 vs 72 hour followup after recipient transitions from a facility
Summarize Comments
Concern was raised that the current practice is contact within 72 hours following transition. Documentation was provided that neither 482.43 (c)(3) or 482.43(c)(5) contain a requirement. Additionally, documentation was provided that included text from the Survey and Certificaiton Letter 13-32 dated May 17,2013. In this letter, CMS indicates that hospitals may consider using follow-up phone calls within 24-72 hours, but that this was not required, nor was a specific time limit provided. In the absence of any CMS federal requirement for the followup to be 48 hours, South Dakota agrees with providers that 72 hours is more reasonable.
Summarize Response

Issue
Timeline changed from 48 to 72 hours followup contact in the transitional care.

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Submission - Tribal Input

☐ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☑ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes
Name of Indian Tribe: All nine tribes in South Dakota Date of consultation: 06/28/2013 (mm/dd/yyyy) Method/Location of consultation: South Dakota follows a standard Tribal Consultation process for all SPAs. Through that process, input is sought from the elected leaders and other representatives of all nine tribes. Input is also sought from Indian Health Services, Urban Indian Health, and other tribal health programs. The draft SPA and other pertinent information are sent via email and recipients are imvited to provide input within 30 days. The Health Home initiative and proposed SPA were discussed in the Division of Medical Services' quarterly Medicaid Tribal Consultation meetings on October 25, 2012, January 3, 2013, May 30, 2013, and July 11, 2013. An email soliciting tribal input was sent to tribal leaders, tribal representatives, Indian Health Services, Urban Indian Health and other interested parties on June 28, 2013. A conference call focused on Health Homes was held with Indian Health Services on January 7, 2013.

☑ **Indian Health Programs**

Indian Health Programs
Name of Indian Health Programs: All Indian Health Programs Date of consultation: 06/28/2013 (mm/dd/yyyy) Method/Location of consultation: South Dakota follows a standard Tribal Consultation process for all SPAs. Through that process, input is sought from the elected leaders and other representatives of all nine tribes. Input is also sought from Indian Health Services, Urban Indian Health, and other tribal health programs. The draft SPA and other pertinent information are sent via email and recipients are invited to provide input within 30 days. The Health Home initiative and proposed SPA were discussed in the Division of Medical Services' quarterly Medicaid Tribal Consultation meetings on October 25, 2012, January 3, 2013, May 30, 2013, and July 11, 2013. An email soliciting tribal input was sent to tribal leaders, tribal representatives, Indian Health Services, Urban Indian Health and other interested parties on June 28, 2013. A conference call was held with Indian Health Services on January 7, 2013.

☐ **Urban Indian Organization**

Urban Indian Organizations

Name of Urban Indian Organization:

South Dakota Urban Indian Health

Date of consultation:

06/28/2013 (mm/dd/yyyy)

Method/Location of consultation:

South Dakota follows a standard Tribal Consultation process for all SPAs. Through that process, input is sought from the elected leaders and other representatives of all nine tribes. Input is also sought from Indian Health Services, Urban Indian Health, and other tribal health programs. The draft SPA and other pertinent information are sent via email and recipients are invited to provide input within 30 days.

The Health Home initiative and proposed SPA were discussed in the Division of Medical Services' quarterly Medicaid Tribal Consultation meetings on October 25, 2012, January 3, 2013, May 30, 2013, and July 11, 2013. An email soliciting tribal input was sent to tribal leaders, tribal representatives, Indian Health Services, Urban Indian Health and other interested parties on June 28, 2013. A conference call was held with Indian Health Services on January 7, 2013.

Indicate the key issues raised in Indian consultative activities:

☑ **Access**

Summarize Comments

Concerns were raised by representatives from Indian Health Service about the definition of Designated provider. Originally the definition contained a requirement that providers be licensed by the State of South Dakota. Many providers that work at the Indian Health Service Units are licensed, but not by the State of South Dakota.

Summarize Response

The definition of designated provider was adjusted so that the providers were required to be licensed and IHS was added to the list of clinic types where designated providers could work.

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

Service delivery

Summarize Comments

Summarize Response

Other Issue

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Submission - SAMHSA Consultation

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of Consultation	
Date of consultation: 11/20/2012 (mm/dd/yyyy)	

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Health Homes Population Criteria and Enrollment

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 Abuse Disorder**
- ☑ **Asthma**
- ☑ **Diabetes**
- ☑ **Heart Disease**
- ☑ **BMI over 25**

Other Chronic Conditions	
COPD, Hypertension, Musculoskeletal and Neck and Back Disorders.	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☑ **Mental Health Condition**
- ☑ **Substance Abuse Disorder**
- ☑ **Asthma**
- ☑ **Diabetes**
- ☑ **Heart Disease**
- ☑ **BMI over 25**

Other Chronic Conditions	
COPD, Hypertension, Musculoskeletal and 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 or more 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-9 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.

Geographic Limitations

☑ **Health Homes services will be available statewide**

If no, specify the geographic limitations:

By county

Specify which counties:

By region

Specify which regions and the make-up of each region:

By city/municipality

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

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

Describe the process used:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

☐ **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.**

◉ **Other**

Describe:

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

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- [x] **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.**
- [x] **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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

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**

Describe the Provider Qualifications and Standards:

☑ **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**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards:

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
Name: Advanced Practice Nurses Provider Qualifications and Standards: 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.
Name: Physicians' Assistants Provider Qualifications and Standards: 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

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

Physicians

Describe the Provider Qualifications and Standards:

Nurse Care Coordinators

Describe the Provider Qualifications and Standards:

Nutritionists

Describe the Provider Qualifications and Standards:

Social Workers

Describe the Provider Qualifications and Standards:

Behavioral Health Professionals

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

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.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes 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 or clinic group practice.

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.

Provider Standards

The State's minimum 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;

Coordinate and provide access to preventive and health promotion services including prevention of mental illness and substance use disorders;

Coordinate and provide access to mental health and substance abuse services

Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from transfer from a pediatric to an adult system of health care

Coordinate and provide access to chronic disease management including self-management support to individuals and their families.

Coordinate and provide access to individual and family supports including referral to community, social support and recovery services.

Coordinate and provide access to long-term care supports and services

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.

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

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.

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Health Homes Service Delivery Systems

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

- [ ] **Fee for Service**
- [ ] **PCCM**

PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.

The PCCMs will be a designated provider or part of a team of health care professionals.

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

- [ ] **Fee for Service**
- [ ] **Alternative Model of Payment (describe in Payment Methodology section)**
- [ ] **Other**

Description:

- [ ] **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

- [ ] **Risk Based Managed Care**

The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:

- [ ] **The current capitation rate will be reduced.**
- [ ] **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

- [ ] **Other**

Describe:

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

Yes

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

No

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

Other Service Delivery System:

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

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Health Homes Payment Methodologies

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

Fee for Service

Fee for Service Rates based on:

Severity of each individual's chronic conditions

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

Capabilities of the team of health care professionals, designated provider, or health team.

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

Other: Describe below.

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Per Member, Per Month Rates

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

South Dakota has developed the following payment structure for designated Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications and attestations. Failure to meet such requirements is grounds for revocation of Health Home Status and termination or recovery of Health Home payments. The payment methodology for Health Homes is in addition to the existing fee for services, encounter or daily rate payments for direct services and is structured as follows.

Per Member Per Month (PMPM) Payment

South Dakota intends to reimburse Health Home Services using a PMPM. 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. Health Home Services as described in the six core service definitions (Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support and Referral to Community and Social Services) may or may not require face-to face interaction with a health home patient. However, when these duties do involve such interaction, they are not traditionally clinic treatment interactions that

meet the requirements of the currently available billing codes. South Dakota Medicaid recognizes that health home transformation requires financial support to clinic leadership and administrative functions so that recipients receive services in a data driven population focused and person centered environment. The criteria required to receive a monthly PMPM payment is.

1. The member has been determined eligible for the health home program through claims data.
2. The member is eligible for Medicaid when services were provided.
3. The member has been assigned to or chosen a Health Home and has not opted out of the Health Home Program.
4. At a minimum, one of the Core Services has been provided to the recipient every quarter and services are documented in the EHR
5. The Health Home will report every quarter that they have provided a core service to each recipient on their caseload. This can be done by using the monthly caseload report or submitting the recipient id, name and Y or N on a core services being provided in another format.

Using the most recent fifteen months of Medicaid claims data, recipients will be determined eligible and tiered using the Chronic Illness and Disability Payment System (CDPS). CDPS stratifies each diagnostic category into hierarchical levels of severity that demonstrate the level of future risk of healthcare needs of a recipient with a diagnosis within a given category.

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. Future adjustments to PMPM payments will be made based on claims data analysis and cost reports submitted annually by Health Homes demonstrating actual costs for the recently completed state fiscal year.

Health Home services will be provided by Community Mental Health Centers (CMHC) and Primary Care Providers (PCP). "The agency's rates were set on July 2, 2013 and are effective for services on or after that date. All rates are posted on the agency website at https://dss.sd.gov//healthhome/pmpmpayments.asp. The state developed fee schedules are the same for both governmental and private providers.

Throughout the planning phase, South Dakota worked to compare the six core services to services already being provided and reimbursed by Medicaid in order to avoid duplication.

Assurances

- SD has an active PCCM program. Recipients currently in the PCCM program who are eligible in Health Homes will be removed from the PCCM program and placed in Health Homes. While providers can be both a PCCM provider and a Health Home provider, providers will only receive a Health Home payment or a PCCM payment for each recipient. Providers may be both a PCCM provider and a Health Home Provider, but they will receive only one type of payment for each recipient.
- South Dakota assures that all governmental and private providers are reimbursed according to the same rate schedule.
- South Dakota assures that it shall reimburse Health Home providers directly except when there is employment or contractual arrangements

Incentive payment reimbursement

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

PCCM Managed Care (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 PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

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.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☐ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

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

Categorically Needy eligibility groups

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

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. 10
Scope of benefit/service

The benefit/service can only be provided by certain 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 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

Description

Medical Specialists

Description

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.

☑ **Physicians' 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**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Advanced Practice Nurses

Description

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 benefit/service

- **The benefit/service can only be provided by certain 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 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

Description

Medical Specialists

Description

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.

Physicians' 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

Description

☐ **Social Workers**
Description

☐ **Doctors of Chiropractic**
Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**
Description

☐ **Dieticians**
Description

☐ **Nutritionists**
Description

☐ **Other (specify):**
Name
Advanced Practice Nurses
Description
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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **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**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**
Description

☐ **Nutritionists**
Description

☐ **Other (specify):**
Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

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, the State will notify the Health Home of recipient's hospitalization. Nurses will also be available to provide technical assistance to the discharge planning team about placement options. 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 benefit/service

☐ **The benefit/service can only be provided by certain 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 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**

Description

☐ **Medical Specialists**

Description

☑ **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.

☐ **Physicians' 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**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Advanced Practice Nurse

Description

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 benefit/service

☑ **The benefit/service can only be provided by certain 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 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

Description

Medical Specialists

Description

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.

Physicians' 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

Description

Social Workers

Description

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

☑ **Other (specify):**

Name

Advanced Practice Nurse

Description

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, if relevant

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 benefit/service

☐ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **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**
Description

☐ **Medical Specialists**
Description

☐ **Physicians**
Description

☐ **Physicians' Assistants**
Description

☐ **Pharmacists**
Description

☐ **Social Workers**
Description

☐ **Doctors of Chiropractic**
Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**
Description

☐ **Dieticians**
Description

☐ **Nutritionists**
Description

☐ **Other (specify):**
Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS 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.

Medically Needy eligibility groups

All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.

Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.

All Medically Needy receive the same services.

There is more than one benefit structure for Medically Needy eligibility groups.

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Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
The State will use claims data to measure hospital readmissions for the same or similar diagnoses within 30 days

Using claims data, the State will track avoidable hospital readmissions by calculating Ambulatory Care Sensitive Conditions (ACSC) readmissions/1000: (# of readmissions with a primary diagnosis consisting of an Agency for Healthcare Research and Quality (AHRQ) ICD-10 code for ambulatory care sensitive conditions/member months) x 12.
Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
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 savings using a pre-/post period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service or tier. It will be broken out for each primary care health home. The data source will be Medicaid paid claims and the measure will be PMPM Medicaid expenditures. Savings calculations will be trended for inflation and will truncate the claims of high cost outliers annually that exceed three standard deviations of the mean. Savings calculations will include the cost of PMPM payments received by health home providers.
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.

Quality Measurement

- [x] **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**
- [ ] **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.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

- [x] **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Hospital Admissions

Measure Specification, including a description of the numerator and denominator.
Numerator = Total number of inpatient Health Home admissions during the past twelve months/Denominator = the average number of Health Home recipients during the same twelve month period x the result by 1,000.

Data Sources:
Claims

Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- (●) **Annually**
- **Continuously**
- **Other**

Emergency Room Visits

Measure:

Emergency Room Visists

Measure Specification, including a description of the numerator and denominator.
Numerator = Total number of Health Home recipient emergency room visits during the past twelve months/Denominator = the average number of Health Home recipients during the same twelve month period x the result by 1,000.

Data Sources:
Claims

Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- (●) **Annually**
- **Continuously**
- **Other**

Skilled Nursing Facility Admissions

Measure:

Skilled Nursing Facility Admissions

Measure Specification, including a description of the numerator and denominator.
Numerator = Total number of Skilled Nursing Facility Health Home admissions during the past twelve months/Denominator = the average number of Health Home recipients during the same twelve month period x the result by 1,000
Data Sources:
Claims
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- **Annually**
- **Continuously**
- **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:
Hospital Admission Rates
The State will use claims data to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency) for the participating Health Home sites. Hospital admission rates will be measured as a pre-program measure and then compared to Health Homes sites annually. On-site reviews will be completed periodically.
Chronic Disease Management
Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

PCP and CMHC Health Home Outcome Measures have been established that address Clinical Care, Experience of Care and Quality of Care. These outcome measures were selected to address the presence and efficiency of Chronic Disease Management, Coordination of Care and the other Core Services. Performance results are reported every six months with the ability to review performance at the recipient, Health Home and overall program level. Additionally, SD Medicaid nurses will complete a random sample medical record review.
Coordination of Care for Individuals with Chronic Conditions
Clinical data received from providers on health home enrollees will provide the best picture for this evaluation.

PCP and CMHC Health Home Outcome Measures have been established that address Clinical Care, Experience of Care and Quality of Care. These outcome measures were selected to address the presence and efficiency of Chronic Disease Management, Coordination of Care and the other Core Services. Performance results are reported every six months with the ability to review performance at the recipient, Health Home and overall program level. Additionally, SD Medicaid nurses will complete a random sample medical record review.
Assessment of Program Implementation
The State will monitor program implementation in collaboration with Health Home Providers. The State has formed a Health Home Implementation Workgroup made up of representatives from each provider type – health system PCP sites, independent clinics, CMHCs, FQHCs, and IHS. This group will meet quarterly, or more often if warranted. The group will meet to assess implementation, address operating issues and opportunities, and discuss on-going communication needs. The group will meet several times during implementation and continue as needed.
Processes and Lessons Learned
The State and Health Home providers will continue to monitor progress and identify opportunities for improvement as a continuous quality improvement effort. The State will elicit feedback from providers and recipients. As Health Homes mature, the State will track change and assess what elements of practice transformation are working and which are not. Critical attention will be paid to critical success factors that have been achieved by others and barriers to practice transformation.
Assessment of Quality Improvements and Clinical Outcomes
The State will utilize quality process and outcome measures to assess quality improvements and clinical outcomes. As appropriate aggregated clinical information will be shared to promote best practices and to positively affect future outcomes.
Estimates of Cost Savings
The State will use the same method as that described in the Monitoring section.

If no, describe how cost-savings will be estimated.

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