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**State/Territory Name: South Dakota**

**State Plan Amendment (SPA) #: 24-0013**

This file contains the following documents in the order listed:


1) Approval Letter
2) CMS Form 179
3) Approved SPA Pages

# SD - Submission Package - SD2024MS0001O - (SD-24-0013) - Administration; Health Homes



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E 12th St., Room 355
Kansas City, MO 64106

## Center for Medicaid & CHIP Services

October 11, 2024

Heather Petermann
Director, Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57505

Re: Approval of State Plan Amendment SD-24-0013

Dear Heather Petermann,

On August 05, 2024, the Centers for Medicare and Medicaid Services (CMS) received South Dakota State Plan Amendment (SPA) SD-24-0013 to assure compliance with with federally mandated quality reporting requirements for the Child Core Set, the behavioral health quality measures on the Adult Core Set, and the Health Home Core Set outlined in 42 CFR 431.16 and 437.10 through 437.15. The amendment also implements an inflationary rate increase for health homes.

We approve South Dakota State Plan Amendment (SPA) SD-24-0013 with an effective date(s) of July 01, 2024.

If you have any questions regarding this amendment, please contact Tyler Deines at tyler.deines@cms.hhs.gov

Sincerely,

Ruth A. Hughes

Acting Director, Division of Program Operations

Center for Medicaid & CHIP Services

# SD - Submission Package - SD2024MS0001O - (SD-24-0013) - Administration; Health Homes



## Submission - Summary

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

CMS-10434 OMB 0938-1188

### Package Header

**Package ID** SD2024MS0001O

**SPA ID** SD-24-0013

**Submission Type** Official

**Initial Submission Date** 8/5/2024

**Approval Date** 10/11/2024

**Effective Date** N/A

**Superseded SPA ID** N/A

### State Information

**State/Territory Name:** South Dakota

**Medicaid Agency Name:** Department of Social Services

### Submission Component

(selected) State Plan Amendment

(selected) Medicaid

( ) CHIP

# Submission - Summary

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**Effective Date** N/A

**Superseded SPA ID** N/A

## SPA ID and Effective Date

**SPA ID** SD-24-0013

| Reviewable Unit | Proposed Effective Date | Superseded SPA ID |
|---|---|---|
| Health Homes Payment Methodologies | 7/1/2024 | SD-23-0017 |
| Health Homes Monitoring, Quality Measurement and Evaluation | 7/1/2024 | SD-19-0003 |
| Reporting | 7/1/2024 | New |

**Page Number of the Superseded Plan Section or Attachment (If Applicable):**

# Submission - Summary

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

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**Approval Date** 10/11/2024

**Effective Date** N/A

**Superseded SPA ID** N/A

## Executive Summary

**Summary Description Including Goals and Objectives** SPA implements an inflationary increase to the Health Home Per Member Per Month and Clinical Outcome Measure payment rates as appropriated by the state legislature during the 2024 legislative session effective July 1, 2024 and assures that the requirements for general and annual reporting of child and adult core sets are met.

## Federal Budget Impact and Statute/Regulation Citation

**Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| First | 2024 | $28478 |
| Second | 2025 | $113910 |

**Federal Statute / Regulation Citation**

42 CFR 447.201
42 CFR 431.16
42 CFR 437.10 through 437.15

**Supporting documentation of budget impact is uploaded (optional).**

| Name | Date Created | |
|---|---|---|
| No items available | | |

## Submission - Summary

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

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| **Superseded SPA ID** | N/A | | |

# Governor's Office Review

- (●) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

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

# SD - Submission Package - SD2024MS0001O - (SD-24-0013) - Administration; Health Homes



## Health Homes Payment Methodologies

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

CMS-10434 OMB 0938-1188

## Package Header

**Package ID** SD2024MS0001O

**SPA ID** SD-24-0013

**Submission Type** Official

**Initial Submission Date** 8/5/2024

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**Effective Date** 7/1/2024

**Superseded SPA ID** SD-23-0017

System-Derived

## Payment Methodology

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

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

**Describe below**

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

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

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

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

Total state funds available for the quality incentive payment are listed on South Dakota Medicaid's website effective July 1, 2024: http://dss.sd.gov/medicaid/providers/feeschedules/. The amount is divided into the small caseload incentive payment and the clinical outcome measure payment. The small caseload incentive payment amount is divided equally between each qualifying designated Health Home.

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

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

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

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

1. Measures that showed successful implementation of the Health Home Model, where the clinic had complete control over the outcome.

2. Measures were also selected which required recipient compliance.

South Dakota worked with our stakeholder group to weight each measure appropriate. The weights of the 10 measures totaled 100.
Once weights were assigned, the past year's and the current year's outcomes were compared for each of the measures and if they improved from the previous year, they were awarded a 0.5 points for the measure and if the met or exceeded the target, they were awarded a 1.00 point for the measure.

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

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

The severity score was calculated as follows [number of recipients in Tier 1*0.25] + [number of recipients in Tier 2 * 0.50] + [number of recipients in Tier 3 * 0.75] + [number of recipients in Tier 4 * 1.00].

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

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

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

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

Payments made in error will be recovered via a supplemental recovery mechanism and will appear on the provider's

remittance advice. The agency will notify the provider in writing explaining the error prior to the recovery. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

| | |
|---|---|
| **Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided** | Each of the four tiers will have an individual per member per month (PMPM) payment. South Dakota will update the tier of each active recipient annually. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. Health Home services will be provided by Community Mental Health Centers (CMHC) and Primary Care Providers (PCP). The agency's rates are effective January 1, 2024 for services provided on or after that date. All rates are posted on the agency website at https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The state developed fee schedules are the same for both governmental and private providers. |

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

## Health Homes Payment Methodologies

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

# Package Header

| | | | |
|---|---|---|---|
| **Package ID** | SD2024MS0001O | **SPA ID** | SD-24-0013 |
| **Submission Type** | Official | **Initial Submission Date** | 8/5/2024 |
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| **Superseded SPA ID** | SD-23-0017<br>System-Derived | | |

# Agency Rates

**Describe the rates used**

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

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# Rate Development

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

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

**Comprehensive Description** Each of the four tiers will have an individual per member per month (PMPM) payment. PMPM payments were based on the estimated Uncoordinated Care Costs (UCC) for the eligible recipients. UCC includes the following: non-emergent ER usage, all cause readmission and ambulatory sensitive conditions. These estimates were developed from FY 2012 claims data and will serve as the baseline. In order to receive the PMPM payment, designated providers must provide at a minimum one core service per quarter. Core services provided must be documented in the EHR and responses must be submitted online following each quarter through the DSS online provider portal. The agency's rates are effective July 1, 2024 for services provided on or after that date. All rates are posted on the agency website at https://dss.sd.gov/medicaid/providers/feeschedules/dss/. The state developed fee schedules are the same for both governmental and private providers.

# Health Homes Payment Methodologies

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

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## Assurances

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

**Describe below how non-duplication of payment will be achieved**

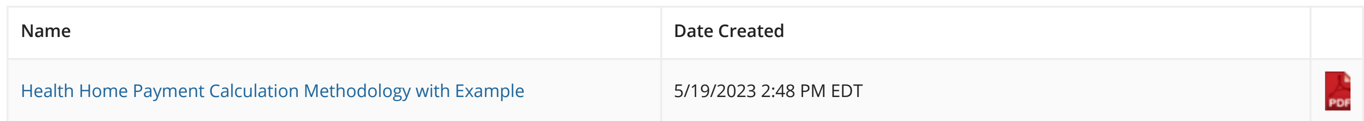
South Dakota has taken care to ensure the reimbursement model is designed to only fund Health Home Services that are not covered by any of the currently available Medicaid funding mechanisms. Quality assurance reviews by our vendor are in place to help ensure that there's no duplication of payment. Additionally,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

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

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

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

## Optional Supporting Material Upload



| Name | Date Created | |
|---|---|---|
| Health Home Payment Calculation Methodology with Example | 5/19/2023 2:48 PM EDT | PDF |

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

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# SD - Submission Package - SD2024MS0001O - (SD-24-0013) - Administration; Health Homes



## Health Homes Monitoring, Quality Measurement and Evaluation

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

CMS-10434 OMB 0938-1188

### Package Header

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| **Superseded SPA ID** | SD-19-0003<br>System-Derived | | |

### Monitoring

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

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

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

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

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

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

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

# Health Homes Monitoring, Quality Measurement and Evaluation

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## Quality Measurement and Evaluation

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

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