Medical Care Advisory Committee

August 9, 2019

MISSISSIPPI DIVISION OF MEDICAID

MISSISSIPPI DIVISION OF MEDICAID

State Plan Amendment (SPA) Updates

SPA 18-0015 Disproportionate Share Hospital (DSH) Payments

- Approved 8/1/19, effective 10/1/18

SPA 19-0001 Targeted Case Management for Beneficiaries with Intellectual and/or Developmental Disabilities in Community-Based Settings

- Approved 5/9/19, effective 01/01/2019

SPA 19-0003 Non-emergency Transportation Broker Contract

- Approved 5/9/19, effective 02/01/2019

SPA 19-0004 Prescription Drug Limit Increase

- Approved 7/1/19, effective 7/1/2019

SPA Updates

SPA 19-0005 Home Health Visit Increase

- Approved 3/22/19, effective 7/1/19

SPA 19-0006 Post-Eligibility Treatment of Income

- Approved 5/13/19, effective 1/1/2019

SPA 19-0009 Transitional Medical Assistance (TMA)

- Approved 5/13/19, effective 1/1/2019

SPA 19-0010 Dental and Orthodontic Reimbursement

- Approved 5/9/19, effective 3/1/2019

SPA 19-0011 Preadmission Screening and Annual Resident Review (PASRR) in Nursing Facilities (NF)

- Approved 7/22/19, effective 7/1/2019

SPA Updates

CHIP SPA 19-0012 Managed Care

- Approved 7/25/19, effective 7/1/18

CHIP SPA 18-0010

- Submitted 1/9/2018, RAI Issued 11/9/18

CHIP SPA 19-0011 Mental Health Parity and Addiction Equity Act (MHPAEA)

- Submitted 5/7/19, RAI 5/23/19

SPA 19-0013 Outpatient Prospective Payment System(OPPS) Reimbursement

- Submitted 7/11/19, effective 7/1/19

SPA and Waiver Updates

SPA 19-0018 Treatment of Resources

- Submitted 7/8/19, effective 7/1/19

SPA 19-0020 All Patient Refined-Diagnosis Related Groups (APR-DRG) Reimbursement

- Submitted 7/30/19, effective 7/1/19

1115 Workforce Training Initiative

- Completeness letter received 1/22/18, CMS Review In Process

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Administrative Code Updates

- AC 19-032 Elderly and Disabled Waiver (Effective 8/1/19)
- AC 19-026 Electronic Signature (Effective 8/1/19)
- AC 19-009 Hyperbaric Oxygen Therapy (HBOT) (Effective 9/1/19)
- AC 19-033 Nursing Facility Discharges (Effective 9/1/19)
- AC 19-034 IL Waiver (Effective 9/1/19)
- AC 19-035 FQHC Mental Health Providers (Effective 9/1/19)
- AC 19-006 Pharmacy Limit (Effective 10/1/19)
- AC 19-029 Tribal Cost Sharing (Effective 10/1/19)

Administrative Code Updates

- AC 19-030 UR in ICF/IID (Effective 10/1/19)
- AC 19-038 Dental Services in Hospital and ASC Setting (Effective 10/1/19)
- AC 19-039 Dental Services in Hospital Setting (Effective 10/1/19)
- AC 19-040 Mass Adjustments (Effective 10/1/19)
- AC 19-041 Dental in the ASC Setting (Effective 10/1/19)
- AC 19-042 Incontinence Garments (Effective 10/1/19)

Old Business

- Pediatric Cardiac Care
- Dental Subcommittee - update

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Dental Subcommittee

- Dr. Mark Livingston- Update

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New Business

- Long Term Care – Opportunities for Improvement
- CCO- Pharmacy Best Practices and Management of High Utilizers

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MCAC information for August 2019

Coordinated Care Organizations: Clinical Best Practices and Management of High Utilizers

Magnolia Health Plan

And UnitedHealthcare

Questions to ask ourselves:

- What are the most common disease states that lead to high utilization of healthcare resources among Medicaid beneficiaries in Mississippi?
- What can be done to better MANAGE these disease states that can lead to both healthier members and decreased healthcare expenditures?
- How well are we carrying out these measures?
- What data do we have to see how well we compare to other surrounding states in these measures?
- What more can and should we be doing?

What are the most common disease states that lead to high utilization of healthcare resources among Medicaid beneficiaries in Mississippi?

- Diabetes Mellitus
- Hypertension
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease/Asthma
- Attention Deficit Hyperactivity Disease (ADHD) in children

What can be done to better MANAGE these disease states that can lead to both healthier members and decreased healthcare expenditures?

- Diabetes Mellitus
    1. HbA1c testing and monitoring control
    2. Monitor for retinopathy (annual eye exams)
    3. Monitor for kidney damage
    4. Blood pressure control

Diabetes Mellitus (MHP data)

Measurement Year	2012	2016	2017	2018
Hgb A1c testing	73.73%	86.16%	86.62%	88.8%
Hgb A1c control	31.35%	36.99%	39.66%	45.01%
Annual eye exam	60.26%	69.45%	67.57%	68.37%
Nephropathy Screen	82.12%	91.65%	92.94%	90.51%

Diabetes Mellitus (UHC data)

Measurement Year	2012	2016	2017	2018
Hgb A1c testing	73.24%	87.10%	84.33%	84.43%
Hgb A1c control	20.44%	35.04%	35.22%	46.23%
Annual eye exam	42.82%	63.50%	51.94%	55.72%
Nephropathy Screen	75.18%	93.67%	92.24%	89.78%

What can be done to better MANAGE these disease states that can lead to both healthier members and decreased healthcare expenditures?

- Hypertension
    1. Controlling Blood Pressure
    2. Monitoring of patients on persistent medications

        ACE Inhibitors or ARBs

        Diuretics

Hypertension (MHP Data)

Measurement Year	2012	2016	2017	2018
BP Control	46.9%	42.4%	41.36%	45.26%
Monitor ACE/ARB	87.29%	88.81%	89.07%	89.50%
Monitor Diuretic	86.93%	88.57%	88.66%	89.68%

Hypertension (UHC Data)

Measurement Year	2012	2016	2017	2018
BP Control	Not Available	47.69%	42.58%	53.53%
Monitor ACE/ARB	Not Available	Not Available	Not Available	Not Available
Monitor Diuretic	Not Available	Not Available	Not Available	Not Available

What can be done to better MANAGE these disease states that can lead to both healthier members and decreased healthcare expenditures?

- Cardiovascular Disease
    1. Persistent use of Beta Blocker treatment after Heart Attack
    2. Statin therapy

        Received a prescription

        Adherence

Cardiovascular Disease (MHP data)

Measurement Year	2012	2016	2017	2018
Beta Blocker following Heart Attack	60.00%	55.81%	62.71%	58.00%
Received Statin RX	Not a measure yet	64.59%	69.43%	71.95%
Statin 80% adherence	Not a measure yet	39.02%	38.70%	44.41%

Cardiovascular Disease (UHC Data)

Measurement Year	2012	2016	2017	2018
Beta Blocker following Heart Attack	Denominator <30	64.29%	39.13%	65%
Received Statin RX	Not a measure yet	65.19%	64.12%	66.67%
Statin 80% adherence	Not a measure yet	36.49%	47.55%	40.88%

What can be done to better MANAGE these disease states that can lead to both healthier members and decreased healthcare expenditures?

- Chronic Obstructive Pulmonary Disease/Asthma

  COPD- dispensing of medications following an exacerbation

    Systemic corticosteroid

    Bronchodilator

  Persistent Asthma

    medication compliance with asthma controller medications

Chronic Obstructive Pulmonary Disease/Asthma (MHP Data)

Measurement Year	2012	2016	2017	2018
COPD corticosteroid	40.69%	38.15%	40.69%	41.53%
COPD bronchodilator	75.62%	74.01%	74.61%	77.06%
Asthma				
Medication compliance 50%	52.66%	49.82%	45.65%	50.25%
Medication compliance 75%	27.79%	22.73%	19.82%	24.25%
Asthma medication ratio	52.88%	51.90%	66.10%	67.23%

Chronic Obstructive Pulmonary Disease/Asthma (UHC Data)

Measurement Year	2012	2016	2017	2018
COPD corticosteroid	27.88%	32.40%	41.81%	41.33%
COPD bronchodilator	60.62%	67.17%	70.62%	76.77%
Asthma				
Medication compliance 50%	50.19%	51.38%	55.00%	50.47%
Medication compliance 75%	26.25%	23.69%	28.58%	23.91%
Asthma medication ratio	41.96%	62.44%	70.13%	71.62%

What can be done to better MANAGE these disease states that can lead to both healthier members and decreased healthcare expenditures?

- Attention Deficit Hyperactivity Disease (ADHD) in children

  Appropriate Follow-up/Evaluation

    Upon initiation

    Maintenance

Attention Deficit Hyperactivity Disease (ADHD) in children (MHP data)

Measurement Year	2012	2016	2017	2018
Follow up care for children prescribed ADHD medication				
Initiation phase	34.4%	56.71%	58.51%	57.06%
Continuation and Maintenance phase	22.27%	66.37%	69.14%	70.50%

How well does Mississippi compare?

- What data do we have to see how well we compare to other surrounding states in these measures?

Comparison of Magnolia Health Plan Metrics to other Centene Medicaid plans **2018**

Measure	GA	TX	MO	FL	SC	LA	MS
ADHD initiation phase	44.50%	44.80%	**37.9%**	45.70%	53.1%	49.8%	**57.06%**
Hgb A1c testing	79.30%	89.10%	**74.70%**	86.6%	**89.30%**	84.90%	88.08%
Hgb A1c *poor control* (>9)	58.90%	44.50%	**60.30%**	47.00%	**42.30%**	53.8%	47.93%
Diabetes Nephropathy screen	88.6%	**92.70%**	**83.70%**	91.2%	90.80%	88.40%	90.51%

Comparison of UHC Health Plan Metrics to other Medicaid plans **2018**

Measure				FL		LA	MS (UHS)
ADHD initiation phase							**Not Available**
Hgb A1c testing				36.13%		86.13%	84.43%
Hgb A1c *poor control* (>9)				42.09%		38.69%	45.50%
Diabetes Nephropathy screen				92.21%		91.97%	89.78%

Comparison of Molina Health Plan Metrics to other Molina Medicaid plans **2018**

Measure	MS (2020)	SC	TX	FL	MI	OH	IL
ADHD initiation phase	62.50	45.46	49.05	45.69	48.91	56.11	47.03
Hgb A1c testing	68.27	86.42	84.29	87.69	85.86	82.27	82.33
Hgb A1c *poor control* (>9)	96.15	74.62	76.88	52.10	52.36	83.83	88.50
Diabetes Nephropathy screen	78.53	90.15	92.38	92.89	91.07	86.86	86.74

What more **can** we and **should** we be doing?

- Continue efforts to educate providers and members on quality care measures

  Quick Reference Guides

  Quality Coordinator visits to individual providers and facilities

Explore adding quality measures in to value-based contracts with provider groups and facilities

- In 2019, the Division of Medicaid has established quality targets for all Coordinated Care Organizations and failure to meet the specified targets will result in a **financial penalty**.

New Business (cont.)

- Provider Satisfaction Surveys
- Care Management Utilization
  - Magnolia Health Plan
  - UnitedHealthcare
  - Molina Health Plan

Care Management
Frequently Asked Questions

Magnolia Health Plan

What is the **PURPOSE** of Care Management?

- **Transforming the health of our community one member at a time.**
- **Achieving Improved Health Outcomes at the lowest cost possible.**
  - Making sure our members get the **RIGHT CARE** at the **RIGHT PLACE** at the **RIGHT TIME**

Both of these goals are accomplished through **Care Coordination** (member/provider/subspecialists/all available resources/healthplan),and **Member Education and Empowerment**

Elements of Care Management

- Preventative Medicine
- Care Gap Closure
- Population Health Management
- Social Determinants of Health
- Care Coordination
- Provider Collaboration
- Disease Management
- Complex Case Management
- Emergency Room Diversion

Are you achieving the defined purpose and how? *Yes, Specific Areas*

- **ER Diversion**

With continual education, re-education and follow-up of high ER Utilizers, we are seeing a steady decrease in the number of ER visits/month from March 2019-June 2019.

- **Prevention of Hospital Readmissions**

Successful contact with members within 3 days of discharge was up to 61.4% in June, our highest rate ever!

- **Improving Birth Outcomes**

Smart Start for Your Baby showers quarterly hosted 255 pregnant members in 2018 providing education, support, care management referral when requested or high risk identified

- Makena Work Group- collaboration with Care Management, Provider Relations, Operations
  ongoing- July percentage of Magnolia members who meet criteria receiving Makena 91%
- In 2018 of the 188 Magnolia members that received Makena, 75% of the babies born were healthy

- **Improving Member Satisfaction with Care Management**

Care Management Member Satisfaction Surveys scoring for 2018 as 98% satisfied. The goal was 90% or greater.

Are you achieving the defined purpose and how? *Yes, Specific Areas (cont.)*

- **Foster Care**

In two years we have given out over 1200 Foster Care Comfort Bags to children being remanded into CPS Custody with nothing but the clothes on their back. Magnolia Care Management has also trained every CPS Case worker and Leader in the state by region. Training includes Trauma Care, EPSDT Requirements and Preventative Health.

- **Addressing Social Determinants of Health needs of our members**

Magnolia has an extensive Community Resource Data Base for Member Support, Advocacy, Nutritional needs, Disease Support and Support groups. It is recorded by County in Mississippi allowing Care Managers quick assess to available resources. These Social Determinants of Health are vital to our members.

Every day our Care Management team utilizes this Data Base in attempts to meet needs that will transform the health of our community one member at a time.

- **Standardized communication templates for EVERY Care Management member encounter to improve health outcomes**

E6-Excellent Encounters Every time through Education, Encouragement and Empowerment.

Who is eligible for Care management services in MS for your CCO? How many in your CCO are eligible for care management?

- **All** Magnolia Health Plan members with any need physical, behavioral or Social Determinate Of Health is eligible for Care Management Services at some level. Members with chronic and high risk illness are where we seek to go first for improved outcomes and quality of life.

Magnolia Care Management evaluates and stratifies risk scores to assist member to best level of care management services for them. They must be agreeable to participation.

How many individuals who are eligible are participating and who are they? What percentage is that of total eligible? What percentage is that of total enrollment?

- There are different levels of Care Management
- **Complex Case Management**: members who have high utilization of ER And or Inpatient stays. Catastrophic Diseases such as Cancer, Transplant.
- **Care Management**: Typically at a lower risk and more stable but have a Chronic 5 diagnosis: Diabetes, Cardiovascular Disease, Chronic Respiratory Diseases, Cancer, Stroke.
- **Disease Management**: Members who are stabilized but benefit from Health Coaching and Healthy Lifestyle Choices and education. Smoking Cessation and Weight Loss Programs are in this category.
- **Care Coordination**: Social Workers manage these members for: Benefit education, assistance with doctor appointments, transportation, social determinants of health, DME needs and Needy Meds. Program.

How many individuals who are eligible are participating and who are they? What percentage is that of total eligible? What percentage is that of total enrollment? (cont.)

- Currently there are 5589 Magnolia Health Plan Medicaid/MSCAN members enrolled in Care Management Services
- Current Medicaid/Magnolia Population is 204,106. That is 3% of the population in Care Management Services.
- Because the duration of care management varies based on several issues, we anticipate that in calendar year 2019 we will have over 10,000 members enrolled in Care Management Services at some level. This represents 5% of the Magnolia MSCAN population

How do individuals become enrolled in care management?

- Self Referral
- Provider Referral
- Utilization Management Referral
- Claims Referral
- High Risk CM Referral
- State Agency Referral
- Caregiver Referral

magnolia health

magnolia health

PROVIDER REFERRAL FORM FOR CARE MANAGEMENT & DISEASE MANAGEMENT PROGRAMS

Provider Information:	
Contact Name:	
Referral Date:	
Phone:	
Fax:	
Email:	

Member Information:	
Name:	
Date of Birth:	
Medicaid ID #:	
Street Address:	
City, State, Zip:	
Phone:	

PROVIDER: Please place check by all applicable diagnoses for this member:			
	Asthma		Kidney Disease
	Congestive Heart Failure		Obesity
	Coronary Heart Disease		Prematurity & Developmental Delays
	COPD		Sickle Cell Disease
	Cystic Fibrosis		Depression
	Diabetes		Smoking Cessation
	Hemophilia		Pregnancy ; must submit *Notification of Pregnancy* (NOP) form
	HIV/AIDS		
	Hypertension		Schizophrenia
	Autism		Developmental Delays
	Substance Use Disorder (SUD)		Other (please list in space below):

PROVIDER: Please provide responses, as applicable, for this member:	
	Number of Emergency Room visits during previous 6 months
	Number of inpatient hospital admissions during previous 12 months

PROVIDER: Once form is completed, please mail or fax to:	
Mail:	Magnolia Health Attn: Medical Management 111 East Capitol Street, Suite 500 Jackson, MS 39201
Fax:	866-901-5813
Phone:	To speak to a care manager regarding your request call 1-866-912-6285.

Why isn’t everyone case managed?

- All members receive care coordination in Welcome Packets, Newsletters and Website Notifications.
- Members must agree to Case Management services
- Many members do not need direct Care Management as they have stable conditions and do not have Rising Risk or worsening disease processes.
- With the average Care Manager carrying a case load of about 100 members, we would need over 2,000 care managers alone which is neither cost effective or reasonable

What services to Care Managers provide?

- Care Coordination, Education, Encouragement, Empowerment and Participation in one's own health by our members.
- Complex Case Management
- Population Health Management
- Care Coordination
- Disease Management
- Social Determinants of Health
- Provider Collaboration
- Care Gap Closure
- Preventative Medicine
- Emergency Room Diversion

How do you track progress and outcomes?

- Quality is tracked by HEDIS measures and DOM specific quality expectations
- Birth Outcomes are tracked monthly
- Claims review tracks compliance with certain things such as flu shots
- ER utilization, Inpatient readmissions and Medication adherence are tracked to determine Care Management effectiveness
- Health Risk Assessments are tracked
- Resource referrals are tracked to see how effectively we are meeting our members' Social Determinants of Health needs
- Care Manager performance is monitored for production, audited for effective member outreach and outcomes

Medicaid
Whole Person Care
Mississippi
Overview High Risk Case Management

August, 2019

OPTUM®

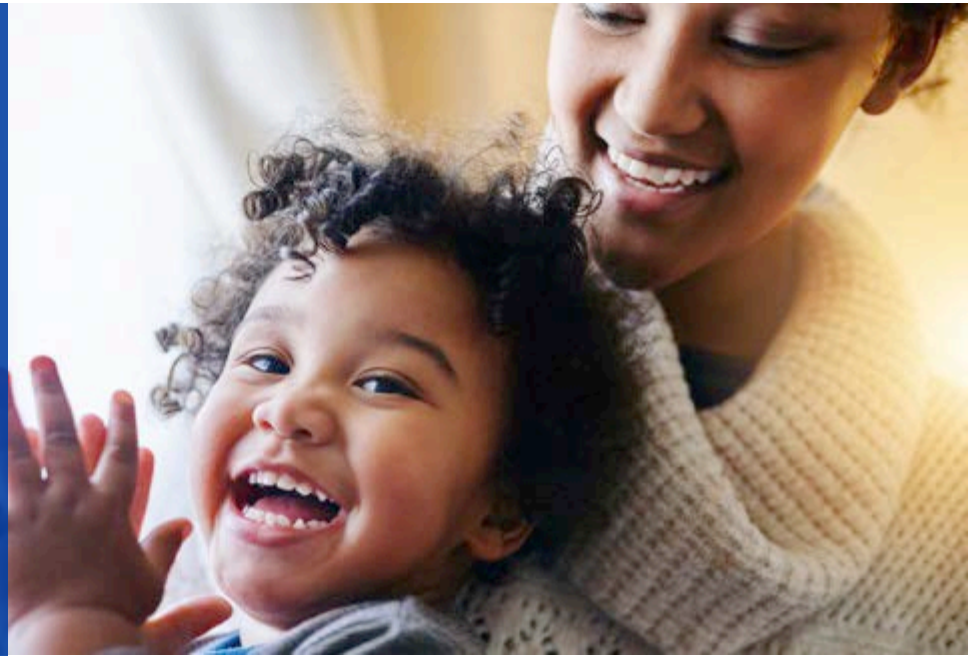
UnitedHealthcare®

UNITEDHEALTH GROUP

Whole Person Care.

UnitedHealthcare Community Plan

Whole Person Care is holistic, integrated care management and coordination that addresses members' medical, behavioral and social needs.



Our care teams **address social factors** that effect members' health, including:

- ✓ Lack of housing
- ✓ Food insecurity
- ✓ Utility needs
- ✓ Violence
- ✓ Transportation

Helping to impact people's health and well-being.

UnitedHealthcare Community Plan

Our care teams use a compassionate, high-touch approach to address members' clinical, behavioral and social needs.

Clinical.

- Acute (serious) care
- Chronic conditions
- Clinically fragile
- Women's health

Behavioral health.

- Depression
- Serious mental illness
- Substance use

Social determinants.

- Food deprivation
- Homelessness
- Poverty
- Social isolation
- Transportation

Whole Person Care

UnitedHealthcare COMMUNITY & STATE

Whole Person Care *includes* **high risk case management, transition case management** and care **coordination program serving C&S members**. The Whole Person Care program is augmented to address state contractual requirements. Our care managers work with members and their family to achieve improved health outcomes.

- Program objective:
  - Connect members to the appropriate level of care
  - Engage members and remove barriers to self care, therapeutic intervention, and social supports - with the intent to prevent unnecessary acute admissions and emergency department visits
  - Ensure appropriate engagement with and support for highest risk members
  - Educate in chronic condition management, behavioral health and substance use disorders

    Success metrics:
  - Reduction in utilization (inpatient, readmission, ER, improved community tenure)
  - Enhanced quality (HEDIS measures)
  - Reduction in total cost of care

Our approach.

UnitedHealthcare Community Plan

Our person-centered systems of care honor and respect the voice of each individual.

Identify at-risk members:

- Use analytics and predictive modeling to focus on clinical, behavioral, social and economic barriers.

Local, personal care:

- Serve 1 member at a time in the communities where they live.
- Compassionate care coordinators are supported by local teams who provide tailored care plans.

Enhanced experience through a single contact:

- Having just 1 connection to care programs and community resources reduces confusion and frustration.

Whole Person Care Focus

UnitedHealthcare Community Plan

Program Description

- Whole Person Care is a population health model where members are engaged in their health and well being
- Whole Person Care is not driven by diagnosis
- Whole Person Care addresses the medical, behavioral, social determinants of health and functional needs of our members
- Members receive care in the most effective and efficient way, based on each person's goals, needs and cultural preferences
- Care teams consist of non-clinical and clinical experts, based in local markets, with support resources to address

Engagement Strategy

- Field & Telephonic based member outreach
- Local based care team model:
  - Community Health Workers
  - RN High Risk Case Managers
  - Behavioral Health Advocates
  - Peer Support Specialists
  - Pharmacist
  - Medical Director

Target Population

- Members are identified through:
  - Internal algorithm
  - Direct Provider/Member Referrals
  - Inpatient Transitions in care
  - Health Plan Referrals

Interventions

- Assessments completion to identify members' needs, address barriers, identify medical and behavioral needs, connect member to Social Services, community resources
- Development of Plan of Care or Health Action Plan to close barriers in care
  - Connect member to provider, specialists
  - Assess barriers in medication adherence
  - Complete behavioral and/or substance abuse assessments (as needed)
  - Pharmacy Consult
  - Weekly integrated interdisciplinary rounds
- Coach on gaps in care

Local, personal care: Community.

UnitedHealthcare Community Plan

Our approach:

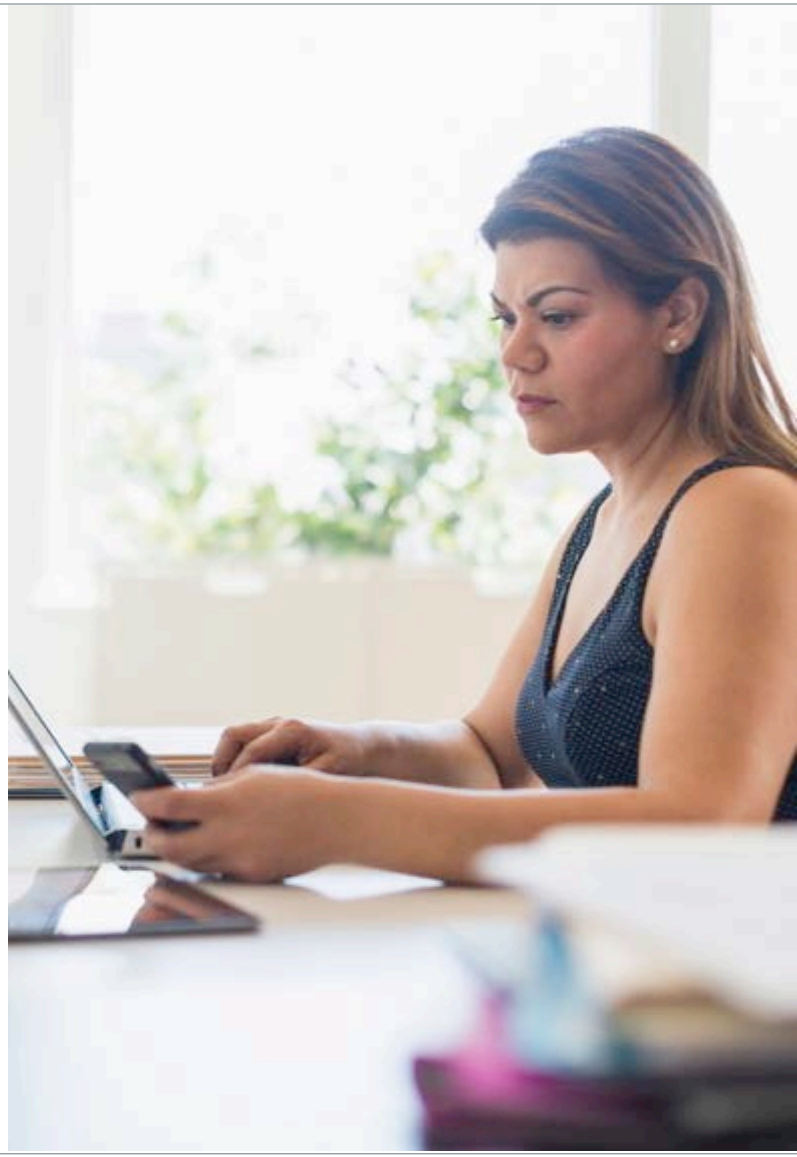
- Complete “Access to Care” assessment.
- Address social needs.
- Educate on importance of seeing primary care physician or specialist regularly.
- Identify member’s health care goals and develop action plan.
- Establish recurring communication with member.

Local, personal care: Hospital.

UnitedHealthcare Community Plan

Our approach:

- Connect with member at bedside, if possible.
- Ask if they have a safe location to go to after discharge.
- Address any social determinants of health.
- Assist with scheduling practitioner appointments within 7 days of discharge.
- Educate on the importance of follow-up visits and following discharge instructions.
- Confirm completion of any follow-up appointments.



How do we achieve goals in Whole Person Care high risk case management?

UnitedHealthcare COMMUNITY & STATE

1. Member-centric care model

- Integrated care coordination team (medical, behavioral, social, specialty)
- Single point of contact to coordinate overall care – for members
- Incorporation of specialists

2. Single technology platform for Behavioral Health and Medical Case Management

3. Expanded Identification Stratification into Rising Risk population

- Identifies the **impactable** members **predicted** to likely be in the top 15% of costs unless an intervention is made

4. Supports all populations and stratifications under a single leadership and oversight structure including:

- *Persistent Super Utilizers* - Highest cost members and/or individuals with chronic and/or complex illnesses
- *Rising Risk* – expanded, newly managed population
- *Transition Case Management* – Medical and Behavioral health
- *Direct Referrals* – receive from Health Plan, Providers, other sources
- *Maternity/Healthy First Steps – support this program*

Enhanced experience through a single contact.

UnitedHealthcare COMMUNITY & STATE

- Primary care team member supported by clinical experts.
- Weekly case rounds with medical and behavioral health physician.
- Review of member challenges to adjust care plans as needed.

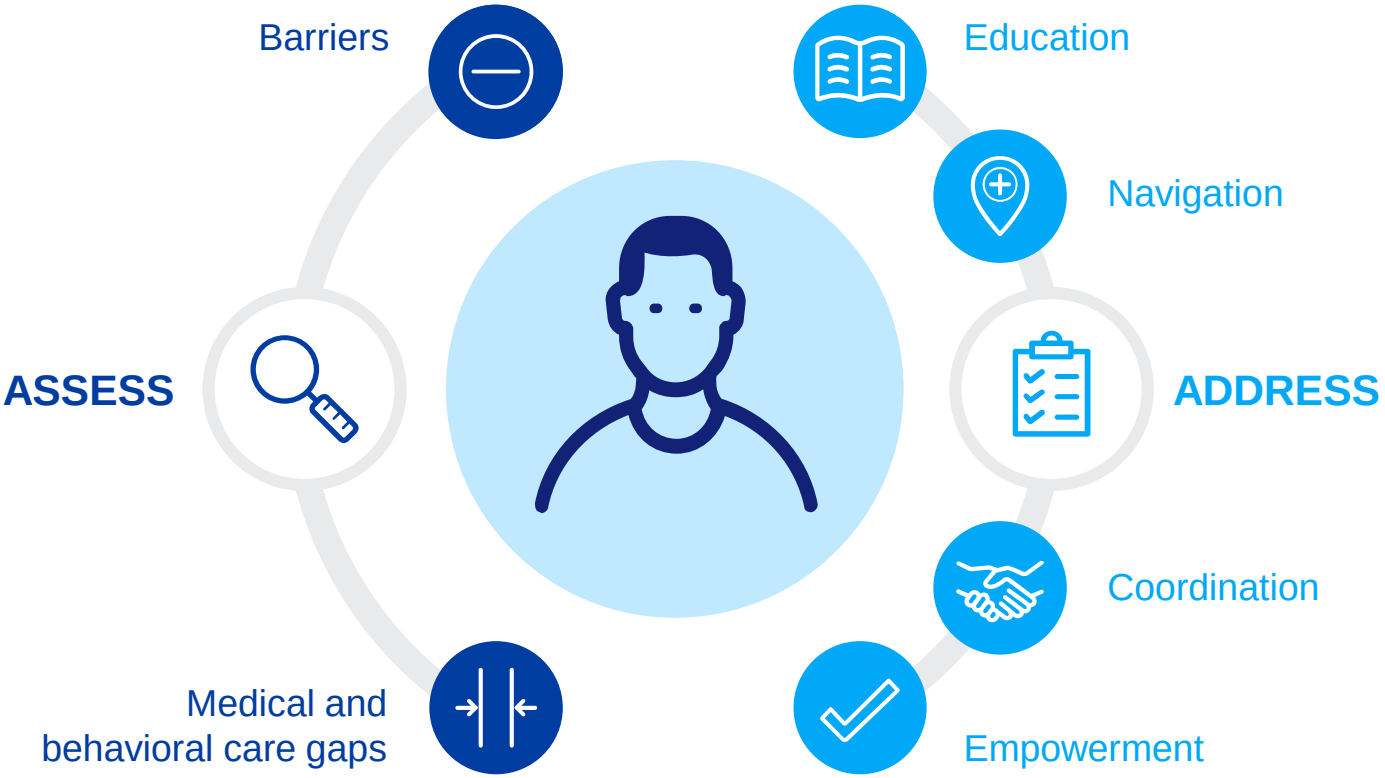
An interdisciplinary, member-focused care team with 1 goal: improving members' health.

- Registered nurses
- Primary care physicians
- Member's network of family, friends and loved ones
- Peer-support specialists
- Medical officer
- Community health workers
- Behavioral health workers
- Pharmacists

Care coordination.

UnitedHealthcare Community Plan

Our experienced team provides data-driven, evidence-based care coordination for all high-risk members.



Identifying members most at risk.

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Our blended identification and stratification (ID/Strat) process includes:

- ✓ Behavioral health
- ✓ Medical
- ✓ Pharmacy
- Social determinants of health

This helps us identify individuals for intervention using:

- ✓ Condition-specific triggering events
- ✓ HEDIS measures
- Utilization and/or risk markers

Referral sources:

- Direct referrals
- Health assessment
- High-cost claimants
- Hospital discharges
- NurseLine
- Predictive model
- Hotspotting

Projected Volumes: Whole Person Care
High Risk Case Management

UnitedHealthcare®

POPULATION - COHORT	2019 Projected Volumes
Persistent Super Utilizers (PSU)	4,237
Non-PSU Transition Care Management (TCM)	1,262
Behavioral Intensive (includes standard)	4,188
TCM - Transition Care Management	985
HRA/Other (includes Direct Referrals)	723
Chronic Conditions: 13.1.8. Diabetes (adult and pediatric); Asthma (adult and pediatric); Cardiovascular (adult and pediatric); Chronic Kidney Disease (adult and pediatric). NOTE: Transplant is handled by Transplant CM team.	1,750
Severe Mental Illness (SMI)	780
Rising Risk: Consists of those who are likely to be in the top 15% of health care costs in the next 12 months and who are most likely to become future Persistent Super Utilizers; Rising Risk Specialty = End Stage Renal Disease, Sickle Cell Disease, Heart Failure, Advanced Illness	1,390
Hotspotting	400
Inpatient Discharge (BH) - formerly SMI Pilot. BH Inpatient discharges 100% managed	1,500
Mississippi Youth Program – Around-the-Clock (MYPAC)	173
Psychiatric Residential Treatment Facility (PRTF)	244
30-day readmission - Require 100% contact (Built into Non-PSU TCM)	1,262

Molina
Care Management Overview

What is the purpose of care management?

Are you achieving the designed purpose and how?

- The purpose of Care Management is provide care coordination services to individuals with chronic medical and behavioral health conditions, particularly those beneficiaries whose conditions are unmanaged. Beneficiaries that may benefit from Care Management interventions often present with multiple gaps in care including but not limited to, underutilization of primary care services, overutilization of Emergency Departments, medication barriers, social issues and low health literacy.

- Care Management is effective in closing gaps in care. Goals are achieved when care management staff are able to successful engage beneficiaries and their providers. In addition, care management staff work with both internal and community partners to address care gaps.

Who is eligible for care management in MS for your CCO? How many in your CCO are eligible for care management?

- All MSCAN beneficiaries covered by Molina Healthcare of Mississippi are eligible to participate in Care Management. Beneficiaries are identified for Care Management by Molina Healthcare of Mississippi on a continuous basis and may also be referred by their provider or through self-referral for services.

How many individuals who are eligible are participating and who are they? What percentage is that of total eligible? What percentage is that of total CCO enrollment?

- As noted above, all members are eligible for Care Management interventions. On average**,** Molina Healthcare of Mississippi serves between 4-6% of our total membership in Care Management programs. This rate excludes our Health Management program, Level I of four Care Management programs.

How do individuals become enrolled in care management?

- Members are identified for Care Management enrollment many different ways. Upon enrollment with Molina Healthcare of Mississippi all individual historical health information (when available) is reviewed and a risk score is assigned, beneficiaries are also screened upon enrollment into MSCAN any may be referred to a Level I-IV Care Management program.

- In addition to initial risk profiles and screening, monthly reporting and predictive modeling is used to identify members for Care Management interventions.

Why isn’t everyone case managed?

- While we believe all members can benefit for a Care Management interventions it is not practical and may not be cost effective.

- Staffing a care management team to serve all members would be costly as Care Management clinical teams typically work with a member anywhere from 30-90+ days. This timeframe may be exceeded, particularly when a beneficiary is unable to be reached, has poor follow-up with primary care, high utilization of Emergency Departments, poor medication adherence, and/or social barriers.

What services do care managers provide?

- Care Management primary responsibility is to coordinate a beneficiary's care across the continuum (medical and behavioral) through communication with beneficiaries, caregivers and providers.

- Care Management staff provide education regarding chronic conditions through telephonic and/or face-to-face communication, complete initial and ongoing health assessments and developed of individualized care plans that address medical, behavioral, and social conditions.

How do you track progress and outcomes?

- Data is pivotal to showing the efficacy of Care Management interventions and developing targeted interventions as populations evolve. Gap closures, Care Management engagement rates, reduction in readmissions and Emergency Department are a few ways we track progress and outcomes.

Any other pertinent information regarding care management?

- Care Management is essential in connecting members to care, closing gaps, and addressing social barriers to health outcomes.

- ✓Next Meeting
- ✓Adjournment

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