# CASE MANAGEMENT PROGRAMS

Department of Social Services
Medical Services

# CASE MANAGEMENT PROGRAMS

## Health Homes

Assists in management of high risk high-cost population with multiple comorbidities

Must meet core services and develop a care plan

Providers must do quarterly and outcome measure reporting

Provides additional reimbursement to providers

## BabyReady

Mandatory program for pregnant women when specific criteria is met

Provides care coordination, person centered care plan, transitional care plan

Partner with DOH and Barrier to Care Initiative must be developed

Provides additional reimbursement to providers

## IHS Care Coordination

Provides additional care coordination services for IHS and Medicaid dual eligible individuals

Allows for a wider range of services that IHS can refer to outside entities with the same reimbursement methodology

Provides shared savings with providers and additional case management staff to IHS

# HEALTH HOME OVERVIEW

South Dakota
Department of
Social Services

# WHAT IS A HE

Partnership with Medicaid Providers to help manage the high risk, high-cost recipients.

Team Based approach that supports the whole person.

Designed to affect change in the Health Home recipient's health status and reduce utilization of high-cost services.

Based on the provision of the six Core Services outlined by CMS and defined by the Health Home Implementation Workgroup.

# PROVIDER INFRASTRUCTURE

**Two Types of Health Homes**

***Primary Care Provider***

Primary Care Physician

PA/Advance Practice Nurse

Working in a

Federally Qualified Health Center

Rural Health Clinic

Clinic Group Practice

IHS/Tribal 638

***Behavioral Health***

Mental Health Provider working in a Community Mental Health Center (CMHC)

**Team**

- Care Coordinator
- Primary Care Provider
- Pharmacist
- Support Staff
- Other services as needed
- Behavioral Health Specialist

- **<u>Any</u>** Medicaid Recipient who has…..
  - Two or more chronic conditions or one chronic and one at risk condition (Defined separately below)

    - **Chronic Conditions include:** Mental Illness, Substance Abuse, Asthma, COPD, Diabetes, Hypertension, Obesity Musculoskeletal and neck and back disorders
    - **At Risk Conditions include:** Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression and use of multiple medications (6 or more classes of drugs)

  - One Severe Mental Illness or Emotional Disturbance.
- Eligibility based on 15 months of claims data based on diagnosis.
- Recipients who meet the eligibility criteria are stratified into four tiers based on the recipient illness severity using the Chronic Illness and Disability Payment System (CDPS).

# SIX CORE SERVICES

- Six Core Services must be provided to the level appropriate for each recipient. More in-depth definitions at:
- https://dss.sd.gov/docs/medicaid/PCP_Core_Services_Specific.pdf

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care/follow-up
5. Patient and family support
6. Referral to community and social support services

# KEY ELEMENTS OF A CARE PLAN

- Care Plans are an integral part of serving recipients in Health Homes.
- Each clinic or Health System can choose a template for their Care Plan, but a Care Plan must be completed for each recipient in Health Homes.
- If behavioral health needs are identified in the assessment, Care Plan should include plan to address.
- Care Plans should be developed with active participation from the recipient and their supports if applicable.

- Health Home recipients will be required to obtain a referral prior to seeing a provider other than their designated provider.
- Health Homes should implement a process for obtaining resulting medical records, test results and/or procedure summaries when providing a referral.
- If the Health Home is the Community Mental Health Centers (CMHCs), the referral **must** start with CMHC.

# QUARTERLY CORE SERVICE REPORTING

- DSS uses a retrospective payment system for the HH program. Services will be provided and then after the quarter is complete, DSS will pay for all recipients where the Health Home has provided at least one core service within the quarter.
- DSS will upload all recipients enrolled in the clinic's Health Home o the DSS Online Portal each quarter.
- The Health Home will use the data provided to indicate if a core service was provided by clicking yes or no and submitting the report
- One Core Service must be provided within the quarter, or the Health Home will not be paid for any of the months in that quarter.

| Quarter | Submission Date |
|---|---|
| Jan – March | April 30 |
| April – June | July 31 |
| July – Sept | October 31 |
| Oct – Dec | January 31 |

# HEALTH OUTCOME MEASURE REPORTING

- Health Homes report outcome measures for each recipient for whom a core service is claimed.
- Each Health Home will submit data electronically at the individual level every 6 months.
- Vendor sends out a list of recipients to whom a core service was provided. Health Homes will need to submit data by a specified date https://dss.sd.gov/healthhome/outcomemeasures.aspx.
- Vendor will provide clinic level data back to the HH

| Period | Due Date |
|---|---|
| Jan- June | Set by Vendor |
| July – Dec | Set by Vendor |

# QUESTIONS?

# THANK YOU


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# BABYREADY OVERVIEW FOR SOCIAL WORKERS & CASE MANAGERS

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South Dakota Department of Social Services

# Overview

## BabyReady Program

- The BabyReady program is one of the Three Care Management programs
- BabyReady recipients, like PCP recipients, must acquire referrals to see other providers outside of their clinic
- BabyReady recipients, unlike the PCP program, are outreached by their assigned provider
- BabyReady program participation is not optional
  - The only way a recipient is not eligible for the program is if they select a non-participating BabyReady provider
- BabyReady recipients have access to a mom-centered personalized care team to help connect them with local resources, care plan development, education, and healthcare system navigation.

# Provider Enrollment & Enhanced Payments

## Provider Enrollment

To enroll as a BabyReady clinic, the clinic must complete an application and Barriers to Care Initiative form.

- An addendum must be completed and signed by each individual provider listed on the application.

## Enhanced Payment Services

| Code | Description | Fee |
|---|---|---|
| NA | Care Coordination PMPM | $ 42.31 |
| NA | Barriers to Care PMPM | $ 10.00 |
| S0280 | Person-centered Care Plan | $ 100.00 |
| S0281 | Transitional Care Plan | $ 50.00 |
| G9151 | Prenatal Care Enhanced Payment | $ 200.00 |
| G9152 | Postpartum Visit Enhanced Payment | $ 100.00 |

# Recipient Eligibility

Pregnant Medicaid-eligible recipients less than 32 weeks gestation are eligible for the BabyReady Program.

Providers may submit a BabyReady Opt-In and Selection form for those 32 weeks or more and have not yet delivered.

Recipients will be transitioned from the program to the PCP program 3 months after the end of their pregnancy.

- Miscarriages are included

# Care Coordination Services

## Care Coordination

The provider must have sufficient staffing to provide the required care coordination services for recipients on the providers' caseload. Care coordination staffing may be at the health system or clinic level but must be available to assist women served by individual participating providers. All care coordination services must be documented.

- Care coordination staff may include RNs, LPNs, CHWs, SW's or other staff qualified and trained to deliver a specific care coordination service.
- Care coordination services may include:
    - Person-Centered Care Plan
    - Health Education and Promotion
    - Health System and Resource Navigation
    - Transitional Care Coordination
        - Transitional Care Plan

# Care Plans

The Person-Centered and Transitional Care plan can be developed by a member of the Care Management team and signed off on by the provider

## Person-Centered Care Plan

Person-Centered Care Plan Elements:

- Measurable goals related to treatment, wellness and recovery including intended outcomes;
- Preferences and Strengths related to treatment, wellness, and recovery goals;
- An emergency/natural disaster/crisis plan;
- Key community and/or social services that address identified needs;
- Planned care coordination interventions; and
- Documentation of key providers included in care plan development and/or key care team members.

## Transitional Care Plan

The Transitional Care Plan should contain the following information:

- Identification of the recipients PCP provider and their scheduled appointment to establish care;
- Identification of the newborns PCP and their scheduled well child visit(s);
- Any necessary specialty appointments that need to be made;
- Documentation that the PCP has recipient's medical records or access to their records; and
- Identification any known follow up needed with regards to labs, imaging, etc.

# DOH Collaboration

**DOH:**

Assigns a nurse(s) to each enrolled clinic

Provides participating providers with promotional materials regarding these programs and training upon request to facilitate this requirement.

Follows-up on recipients receiving in-home services as needed

**Provider:**

Share relevant health and social determinants of health information with the DOH nurse

Promotes and refers recipients to the DOH programs which support pregnant women.

- Bright Start,
- Pregnancy Care, and
- Women, Infants & Children (WIC) Program.

# Barriers to Care Initiatives

## Barriers to Care Initiatives

Providers (clinic level or system level) would select and implement one of the following initiatives:

- Initiatives to improve initiation and attendance at prenatal and postpartum visits
- Initiatives to reduce transportation barriers that prevent women from receiving prenatal and postpartum care.
- Initiatives to address social determinants of health that impact the woman's and unborn child's health or
- Initiatives to facilitate childcare during appointments and deliveries or to facilitate the provision of services with children present at the clinic or facility.
- Other initiatives to address barriers of care as determined by the provider

# THANK YOU


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South Dakota Department of Social Services

# Care Coordination and IPA Nurses

2025

South Dakota Department of Social Services

# Care Coordination

- In 2016, Health and Human Services changed national Medicaid funding policy to cover more services for IHS and Medicaid eligible American Indians with 100% federal funds when going outside of IHS for services
- This was to allow for a wider range of services to be provided
- For the services to be reimbursed with 100% federal funds specific criteria have to be met
  - Care Coordination Agreement
  - Referral for outside services by the IHS provider
  - Medical record sharing
- IHS must maintain responsibility for the patient's care by reviewing the outside records and taking any necessary action if needed
- Due to this policy change, the State of SD and Great Plains IHS met and discussed how to best utilize this change in funding

# Care Coordination Investments

- Increase use of telehealth services to support emergency departments and support increased access to primary and specialty care consultation and treatment in through Indian Health Service and Tribal Programs
- Develop a formal Community Health Worker/Community Health Representative program under the Medicaid State Plan.
- Expand support for prenatal and postpartum care to support healthy birth outcomes
- Expand capacity for mental health and chemical dependency services through Indian Health Service and Tribal Programs.
- Expand Medicaid eligible providers of behavioral health and substance use disorder (SUD) treatment services.
- Add evidence-based behavioral health services and supports for children and families, including supporting the provision of functional family therapy as a Medicaid state plan service.
- Embed nurses and mid-level practitioner within I.H.S. to help support care coordination efforts and connections back to communities as a way to fully use funding I.H.S. cannot receive directly
- Funds being reinvested by enrolled providers that receive shared savings payments

# Care Coordination Agreements

- Current agreements in place in SD since 2017-2019

  - Avera
  - Sanford
  - Monument
  - Dialysis Management Group
  - Bennett County Hospital
  - Mobridge Regional Hospital
  - Black Hills Surgical Hospital
  - Children's Home Society

  - Brookings Health System
  - Abbott House
  - Aurora Plains Academy
  - Lutheran Social Services
  - Our Home
  - Avantara Nursing Facilities

# Intergovernmental Personnel Act (IPA) Agreements

- IPA Agreements create a partnership between the State of South Dakota and Indian Health Service facilities to increase access to care, strengthen continuity of care and care coordination to improve the health of Medicaid-eligible American Indians.

- Goals include:
  - Reducing the cost to IHS for completing care coordination and enhancing IHS case management resources
  - Coordinating patient care and managing medical records between outside facilities and IHS
  - Reducing the State's general fund expenditures for Medicaid-eligible American Indians
  - Coordinating access to and ensuring follow-up to specialty services, PCP, and long-term care services
  - Assist IHS in other case management duties to enhance patient outcomes

# IPA Nurses

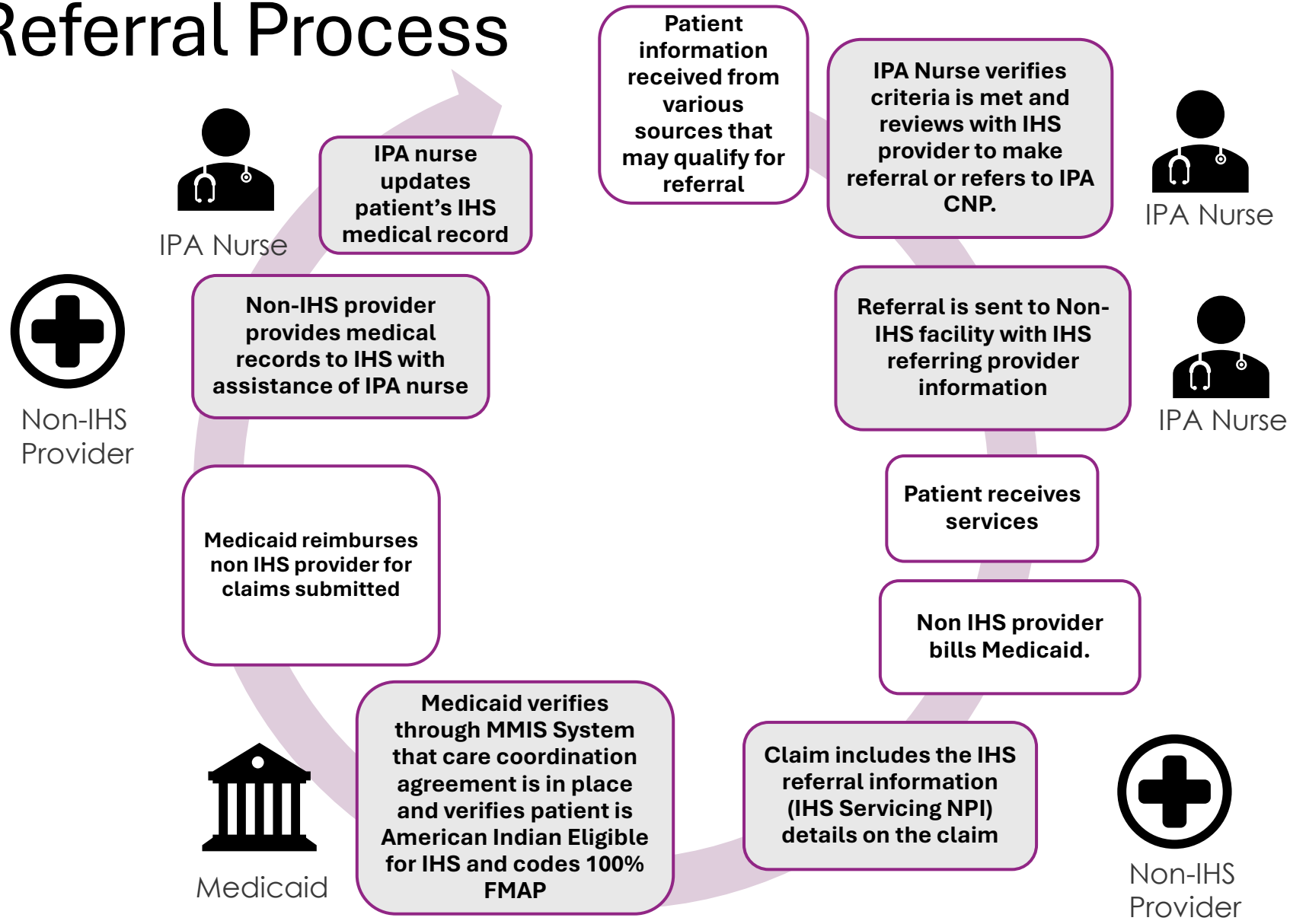
- The State of South Dakota has been able to hire nursing staff to work in and assist IHS facilities with case management duties and the Medicaid Care Coordination referrals

- Three RNs work in the high referral service units and also assist at other units
  - Samantha Hall, RN - Pine Ridge IHS and assists Fort Thompson and Fort Yates
  - Cassie Long, RN - Rosebud IHS and assists Lower Brule and McLaughlin
  - Lillian Jefferson, RN - Cheyenne River IHS and assists Sisseton and Wagner

- IPA Nurse Practitioner, Leslie Wilson, CNP, work with all nine service units to assess patients and provide IHS referrals for those that have not been evaluated at an IHS recently or to establish care with NICU babies

- General email set up to contact the IPA team at CCAReferral@state.sd.us

# IPA Nurse Referral Process




**Where does the patient information come from?**

- State Review Team for PRTF referrals
- LTSS Medical Review Team Nurses
- Behavioral Health
- IHS Case Management/Discharge tracking
- Prior Auth Nurses (6 day tracking) for prolonged hospitalizations and possible transitions to another level of care
- PRTFs or SNFs directly
- NICUs directly
- SD Medicaid Reports

# IPA Nurse Duties

## RN

- Referrals
  - Maintain IHS EHR with new progress notes, immunizations, procedures, and preventative care measures
  - Monitor and review Medicaid billing claims
- Care Coordination
- Health Homes
  - Contact patients for follow-up
  - Schedule follow-ups
  - Assist with mandatory reports and core measures
- STI tracking
- Immunizations
  - update EHR thru SDIIS
  - assisting with Maven information, tracking, contact information
  - coordinating events, assisting with chart reviews from SDIIS to EHR
- Case Management
  - ER transfers, receiving discharge summaries, contacting patient's for follow up, scheduling, scanning records
  - Medicaid Referrals for outside facilities
- Contact for IHS and Care Coordination facilities for available State and IHS resources

## CNP

- Establish (reestablish) care with patients in person and via telemedicine and document visit in the IHS EHR
- NICU Referrals
  - Baby is seen while at the NICU and new patient paperwork is filled out by the parent(s)/guardian
  - Discuss needs or assistance that could be available through State of SD (DOH, DHS,DSS- Medicaid, Economic Assistance etc.)
  - Offer additional information on substance use disorders if applicable
  - Public Health Nurse Consults
  - Follow post discharge to ensure follow-up appt attended and all other specialty follow-ups
- Psychiatric Residential Facilities and Substance Use Disorder Facilities
  - Care coordination agreements are with facilities that treat children
  - Available to assist with care coordination at discharge
- Long Term Care
  - Assist with any needs at discharge for shorter term stays
  - Keep them connected with their primary IHS
- Contact for IHS and Care Coordination facilities for available State and IHS resources

# Shared Savings

- Savings are used to accomplish the following:
  - Address service gaps in Medicaid primarily focusing on American Indians as discussed at South Dakota Healthcare Solutions Coalition
  - Increase rates for Medicaid providers
  - Shared Savings with participating providers
    - A portion of the savings each care coordination facility generates each year is paid out yearly
    - Additional information can be found on the DSS website then click on Medicaid – DSS Statistical Information – FMAP Savings Report Data’

# Questions?

dss.sd.gov

IPA Team Email

CCAReferral@state.sd.us