MoHealth Net

Missouri Department of Social Services

Show-Me Healthy Kids

Care Management for All

July 1, 2022 Implementation

Agenda

- Overview of Care Management
- Eligibility, Enrollment, Tiers, and Care Management Assignments
- Member Care Planning and Coordination
- Care Management Activities

Overview of Care Management

Show Me Healthy Kids (SMHK) is comprised of an array of physical and behavioral health services designed to support the unique and complex needs of its members.

Services are delivered in a manner that:

- Integrates member care
- Supports resiliency and recovery
- Addresses member adversity & trauma
- Promotes appropriate use of community-based services
- Promotes early identification, prevention, & treatment of health care conditions

Contract Section: 3.7.1

Overview of Care Management

- Focus on improved health outcomes and member and family experiences.
- Includes Disease Management, Hospital Care Transition, and Transition of Care as appropriate.
- Utilizes a person-centered, integrated approach to meet the complex physical health, behavioral health and psychosocial needs of members and their families.
- Supports and augments care management activities performed by other entities (e.g., medical homes, health homes, local public health agencies).
- Closely coordinates with other case management providers, including Children's Division, Foster Care Case Management providers, Division of Youth Services, Department of Mental Health.

Contract Section: 2.12.1; 3.9.1

Care Management Principles

Specialty Plan Principles of Care Management

A focus on enhancing and coordinating a member's care across an episode or continuum of care.

Comprehensive care planning.

Provision of education to facilitate understanding of CM process.

Application of clinical knowledge to the member's condition.

Incorporation of shared goals.

Inclusion of member/family education.

Promotion of preventive service utilization.

Identification and planning interventions to ensure appropriate utilization.

Coordination of Transition of Care efforts.

Incorporation of Disease Management services.

Promote the provision of care management by local, community-based care management entities.

Use of health home providers or Local Community Care Coordination Program (LCCCP) providers.

Process to monitor service delivery.

Contract Section: 2.12.1a

Care Management Principles

Integrated	Identify and address the holistic (physical, behavioral, and psychosocial health) needs of each member in an integrated manner.
Member & Family-centered	Support the individualized goals of the member/family, respecting the member/family's preferences, values, and culture.
Well – Coordinated Care	• Care managers will communicate and collaborate with COA 4 children and youth's natural supports and multiple-serving systems. • Care managers will develop a common assessment and shared care plan that reflects the member/family's strengths and needs; to coordinate care transitions; to monitor the delivery and effectiveness of care; and to create a seamless experience of care to the greatest extent possible.

Contract Section: 3.9.3

Addressing the Impact of Trauma

Trauma Informed Care Definition

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), [1]trauma-informed care is a strengths-based approach to service delivery that, “realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization ”

Care Management Principle

Trauma Informed	All care management activities, including assessment and care planning shall be provided in accordance with the specified definition of trauma informed care*, incorporating the key principles of the Missouri Model.

Contract Section: 3.9.3.c; 2.4.1; [1]SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014

Addressing the Impact of Trauma

The Missouri Model

A Developmental Framework for Trauma-Informed (revised 2019) addresses the process of an organization moving along a continuum from trauma aware to trauma informed (https://www.cfechildwellbeing.org/becoming-trauma-informed).

All Care Management Activities Must Incorporate Five Key Principles of the Missouri Model

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

Contract Section: 2.4.2

Show-Me Healthy Kids Care Management Staff

SMHK CM staff will be composed of individuals with diverse specialties and experience necessary to capably deliver comprehensive, integrated CM services to meet the physical, behavioral, and psychosocial needs of Specialty Plan members.

Contract Section: 3.9.5

Training Requirements for Care Management Staff

Training List

Care management staff will receive adequate training in the topics below to support the COA 4 population.

Overview of the respective roles and responsibilities.
Overview of the SP's CM program and CM responsibilities.
Trauma-informed care and other evidence based and promising practices.
Covered benefits for SP members and network providers.
Informed consent, assent, and alternative consenter requirements.
Social determinants of health and available community services and resources.
Specialty Plan information systems, operational processes and workflows.
Missouri's Psychotropic Medication Settlement, and the role of the Center for Excellence.
DYS and CD specific resources available to or in support of the member.
DYS and CD residential programs, levels of care, and services.

Contract Section: 3.9.6

Eligibility, Enrollment, Tiers, and Care Management Assignments

Specialty Plan Care Management

All Specialty Plan members are eligible for CM and will be assigned by the Specialty Plan to a CM tier.

Initial assessment is completed within 14 days of enrollment to identify the CM tier.

CM tiers are re-evaluated based on risk factors:

- Admission to an inpatient behavioral health setting
- A newly diagnosed condition
- A change in service utilization levels
- The prescription of a psychotropic medication or newly identified psychosocial need

The Specialty Plan will allow and consider request from caregivers or other supports to assign higher intensity tier of CM services.

Contract Section: 3.9.8

Care Management Tiers

CM tiers will be used to align with the level of CM needed by the member. The criteria and threshold for each tier will determine if a member needs higher or lower care management services.

Health risk factors when determining a member's tier level include:

- Information from the enrollment broker's health risk assessment screening
- Acuity, chronicity, and complexity of the member's physical and behavioral health conditions
- Comorbidities
- Trauma history
- Pregnancy and related risk factors
- Multi-system involvement
- Polypharmacy
- Psychotropic medication prescription(s)
- Elevated blood lead levels
- High-cost and high-utilization
- Residential placement
- Psychosocial needs

Contract Section: 3.9.8

Member Care Planning and Coordination

Care Plans

Care Plans include member/family centered activities, measurable, defined goals, interventions and evaluation of progress. Support staff integration will be done through activities including, case conferences, development of multidisciplinary approaches, and shared care plans.

SMHK will provide a copy of the care plan to CD using a state-determined method.

All care management activities, including assessment and care planning shall be provided in accordance with the definition of trauma informed care, incorporating the key principles of the Missouri Model.

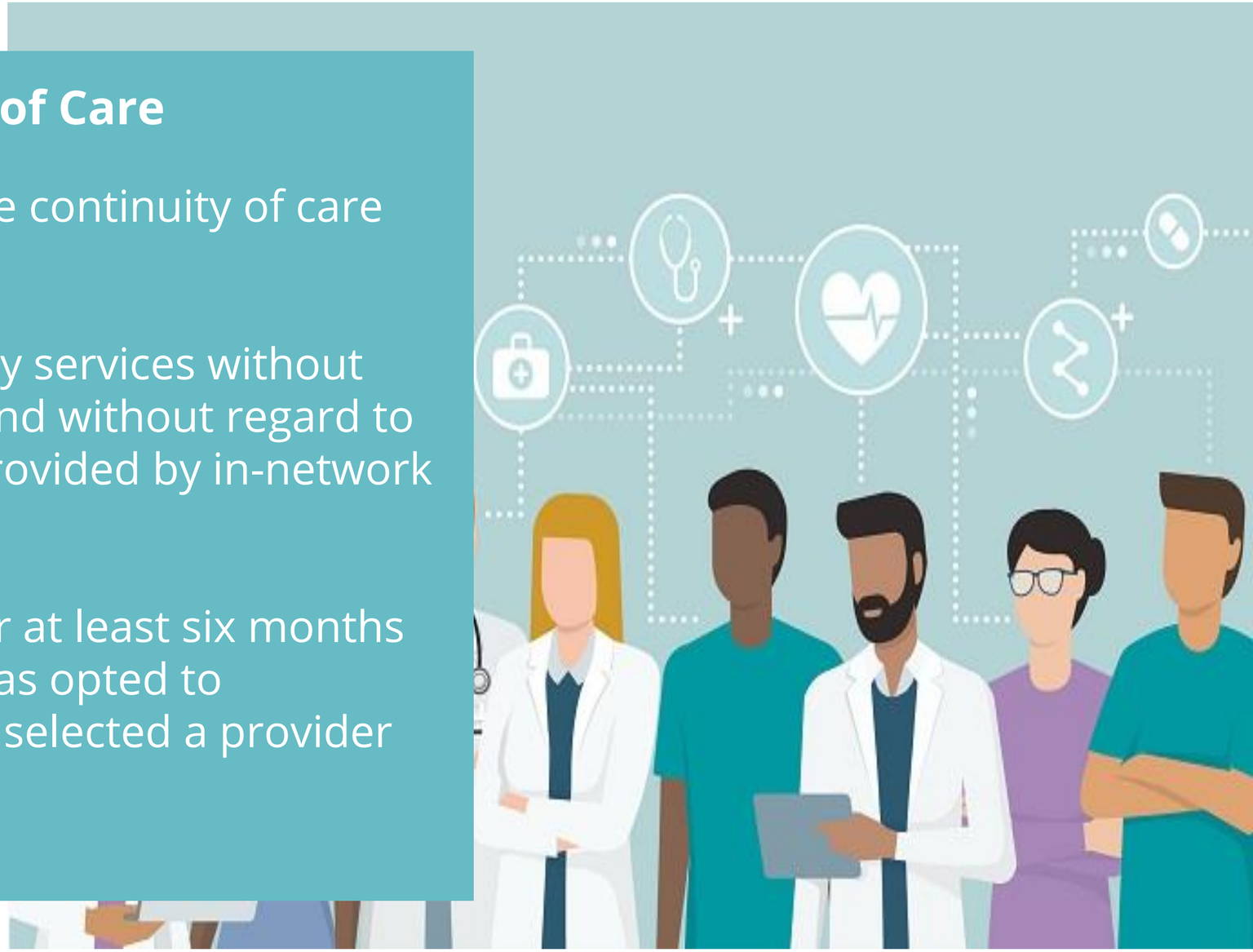
- Safety
- Choice
- Empowerment
- Trustworthiness
- Collaboration

Contract Section: 3.9.15.a; 3.9.2.e; 2.4.2

Member Care Planning and Coordination

Member Transition of Care

- The Specialty Plan will ensure continuity of care for members.
- Continue medically necessary services without any form of prior approval and without regard to whether such services are provided by in-network or out-of-network providers.
- Continue services as such for at least six months unless the member/family has opted to discontinue such services or selected a provider that is in-network.



Contract Section: 3.9.16.a

Member Care Planning and Coordination

Member Transition of Care: Age and Eligibility Transitions

SMHK will ensure continuity of care for COA 4 members experiencing age or eligibility transitions. The transition of care requirements include:

Anticipating and assisting with critical age transitions, including pediatric/child to adult transitions and transitions required as a result of aging out or loss of Specialty Plan eligibility.

Ensuring educational resources and assistance are offered in planning for age transitions at least six months prior to critical age transitions.

Providing necessary information to inform choices when making transition-related decisions due to aging out or losing Specialty Plan eligibility.

Discussing legal considerations, financial needs, employment, education, living arrangements, and social needs should be part of transition planning.

The Specialty Plan’s assistance will support and not duplicate/conflict with CD, DYS, and DMH.

Contract Section: 3.9.16.a

Assent, Informed Consent, and Alternative Consenters

Assent, informed consent and alternative consenter requirements apply to COA 4 members in the Specialty Plan.

The Specialty Plan will work with the state agency and CD to develop policies and procedures that operationalize requirements related to assent for members 12 and older, informed consent, and alternative consenters. The following considerations for the Specialty Plan's care management policies and procedures will apply:

- Timely access to medical records to support informed consent decisions when applicable;
- Resources/support for CD and FCCM case managers to facilitate understanding of medications prescribed, including coordination of roles of Specialty Plan and Center for Excellence in Child Well-Being to support informed consent;
- Specialty Plan participation in calls between CD/FCCM case managers and foster and/or biological parents when applicable.

Contract Section: 3.9.15.b

Care Management Activities

Collaboration and Coordination

- Outreaching to members/families/ resource providers to coordinate care
- Communication exchange with PCPs and other member-serving entities
- Coordinating with other member-serving entities
- Monitoring care plan services
- Assist members with access resources and services
- Supporting transfer of care for members
- Assist with services for permanency planning

Crisis Planning

- Developing crisis and safety plans
- Arranging assessments for members as needed
- Assist with discharge planning to prevent readmissions and other adverse outcomes

Educational Resources

- Providing health education, disease management, and wellness/prevention coaching
- Educating providers about resources through Missouri's Child Psychiatry Access Project (MUPC), the Center for Excellence in CHILD Well-Being, and other regional resources
- Educating members/families/resource providers about benefits

Contract Section: 3.9.10

Care Management Coordination and Accountability

SMHK will have primary accountability to ensure the CM needs of its members are met (whether CM is provided by SMHK or other entities). For example:

Medical Home

DYS and CD Case Management

Primary Care Health Homes and CMHC Health Homes

Contract Section: 3.9.9

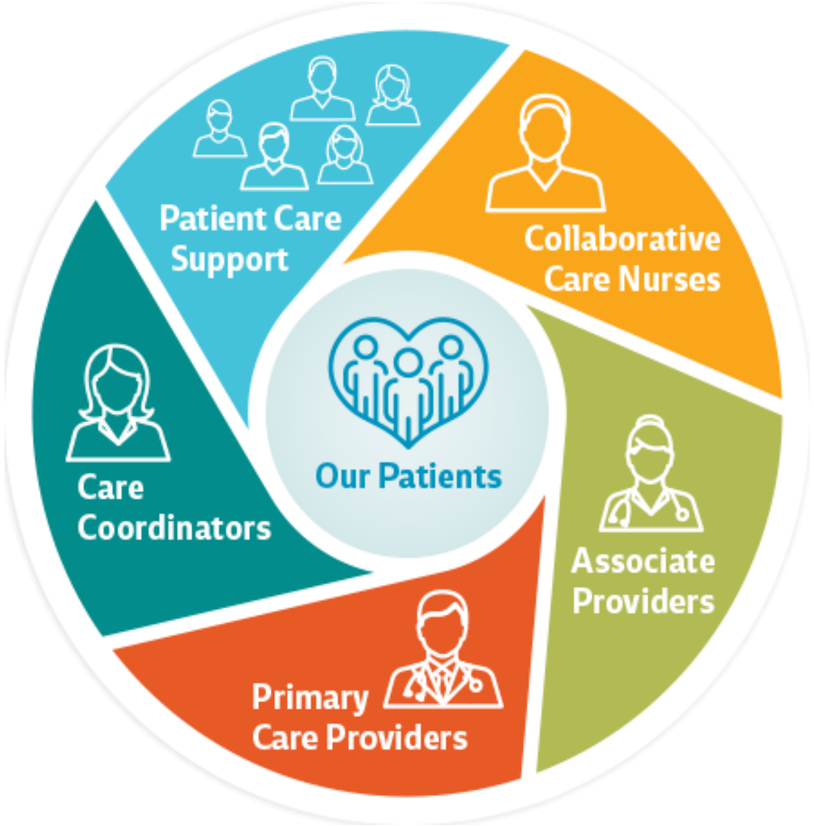
Avoiding Duplication and Overlap

Primary Care and Behavioral Health Homes (HH)

The Health Plan will coordinate services for members who are in Physical and Behavioral Health Homes by preforming the following:

- Identifying any care gaps or areas of duplication

- Serve as the primary source of CM for conditions other than or beyond those included in the state Health Home Behavioral Health programs.



Contract Section: 2.12.1.f.1