

**Department of Human Services
Health Care Reform Review Committee
Representative George Keiser, Chairman
March 19, 2014**

Chairman Keiser, members of the Health Care Reform Review Committee, I am Julie Schwab, Director of Medical Services for the Department of Human Services (Department). I appear before you to provide information regarding existing care coordination programs for Medicaid, Medicaid Expansion, and the Children's Health Insurance Program (CHIP) to utilize coordinated care.

Medicaid Primary Care Case Management Program (PCCM)

The Primary Care Case Management (PCCM) program functions statewide and certain Medicaid populations are required to enroll in the PCCM program. Recipients either choose or are assigned a Primary Care Provider (PCP). The PCCM program functions to provide adequate access to primary care; to provide coordination and continuity of health care services, to avoid duplication of services, to focus on delivering high quality care, and to ensure efficient and effective health care services.

The PCCM program requires all non-emergent health care services be received from the clients PCP. If specialty or hospital services are required, a referral from the client's PCP is required prior to the appointment. Some services do not require a referral. As of December 2013, approximately 40,667 individuals were enrolled in the Medicaid PCCM program.

Medicaid Health Management Program (Disease Management)

The North Dakota Department of Human Services (DHS) released a Request for Proposal (RFP) for the delivery of the disease management services and contracted with U.S. Care Management (USCM) to assist with the delivery of services.

In October 2007, DHS began offering a disease management program for Medicaid recipients who had asthma, diabetes, chronic obstructive pulmonary disease, or congestive heart failure.

Effective October 1, 2011, North Dakota Medicaid transitioned the disease management program to a Health Management program. The Health Management program made available the opportunity for physicians, nurse practitioners, clinics, and health teams to offer health management services to Medicaid recipients.

With the transition in October 2011, providers, clinics and health teams (including Federally Qualified Health Centers, Rural Health Clinics and Indian Health Services) have the option of providing additional care coordination services in the form of a health management program for individuals with certain chronic diseases (asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease). Providers, clinics and health teams may qualify for an additional per member, per month payment for providing services as outlined in the North Dakota Medicaid's Health Management program design.

The Health Management program is comprised of an integrated package that may include: dedicated care coordinator, high risk screening and assessment, triage, referral system which includes tracking referrals and results, recall system for appointments, pharmacy review, inpatient and discharge transitions, education, and emergency department diversion.

Benefits to the Recipient if enrolled in the Health Management Program

- Nurse care management services (recipient's care plan).
- Coordinated, communication, and integrated local service systems and supports by building collaborative relationships with local social, community, and state service agencies.
- Individualized care plans (to include identifying needs, implementation, and evaluation) in collaboration with the participant, family (if appropriate), and personal primary care provider.
- Education and training is provided to enhance the participant's understanding of the participant's condition(s) as well as the appropriate management of the participant's condition(s). This includes education about self-management, appropriate use of resources, how to navigate the health care system, and how the nurse care manager will work with the participant and their primary care provider to promote and coordinate the plan of care.
- Provide participant with pre-visit preparations, reminders, and recall visits.
- Contact and follow up with participants who have not kept appointments.
- Continuous access to a designated clinic staff, or an on-call provider (toll-free), or toll-free health information line staffed by licensed nurses within the United States.

There are approximately 300 Medicaid recipients participating in the health management program.

Medicaid Expansion

The Medicaid expansion request for proposal (RFP) required primary care and coordination of health care services. The RFP required that the Sanford Health Plan (SHP) implement procedures to:

- Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- Coordinate the services the SHP furnishes to the enrollee with the services the enrollee receives from any other provider.
- Share with other SHP providers serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the state) so that those activities need not be duplicated.
- To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements
- The RFP required that the SHP implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the individual that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.
- For enrollees determined to need a course of treatment or regular care monitoring, the SHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

Children's Health Insurance Program (CHIP) – Healthy Steps Care Coordination

BCBSND identifies Healthy Steps enrollees with special health care needs through use of a health risk assessment, provider referral and through review of claims data. Case management services are offered to Healthy Steps enrollees with special health care needs to assist in care coordination and to obtain necessary medical services. Nurse case managers assess, facilitate and advocate for options and services to meet CHIP enrollee's needs to promote quality and cost effective outcomes. CHIP enrollees are educated on availability of and procedures to access services. The Case Management processes have been reviewed by the External Quality Review Audit and were found to satisfy all requirements outlined in this section.

BCBSND MediQHome provides primary care physicians with all necessary information to coordinate Healthy Steps enrollees care. Procedures ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. BCBSND routinely monitors provider quality and efficiency via MediQHome.

MediQHome provides information to physicians for managing the most costly, common chronic conditions, including:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Coronary Artery Disease
- Congestive Heart Failure

- Diabetes
- Adolescent Diabetes
- Childhood Diabetes
- Hypertension
- Child/Adolescent Hypertension
- Metabolic Syndrome

The information is provided to BCBSND so that they may work with providers to best meet the services prescribed by evidence-based medicine best practices. The Healthy Steps program covers clinic services, inpatient and outpatient hospitalization, prescriptions, mental health services, preventive well-child exams, immunizations, dental, and vision services.

This concludes my testimony. I am happy to answer questions.