Ohio Department of Job and Family Services

Care Management Program Requirements

For the ABD/CFC Managed Care Programs

For the Provider Agreement Effective July 1, 2010 to June 30, 2011

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Introduction

Beginning in April 2008, the Medicaid managed care plans (MCPs), the Ohio Association of Health Plans, and the Ohio Department of Job and Family Services (ODJFS) convened a workgroup to develop criteria to identify members who would benefit the most from care management services. During the subsequent months, the discussion evolved to include other potential program enhancements that would allow MCPs to design care management (CM) interventions to meet the needs of members with special health care needs. In other words, the program enhancements would allow MCPs to match resources to the member's need, and more effectively and efficiently administer their CM programs. The revamped approach described in the current provider agreement acknowledges that disease management protocols are a viable strategy for managing the care of members and allows the MCPs more flexibility in the design of their CM programs. It is expected that the MCP's care management program will continue to improve health outcomes, increase the member's quality of life, and assist the member in successfully navigating the complex health care system.

Purpose

The purpose of this document is to clarify the minimum expectations for the MCP's care management program regarding the completion of the identification, assessment, and care treatment plan for members assigned to the low-, medium-, or high-risk stratification levels. This document is referenced in Appendix G of the Provider Agreement. The MCPs are expected to comply with the requirements in this document and the Provider Agreement. All of these elements must be submitted and approved as part of the Care Management Program submission.

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LOW RISK STRATIFICATION LEVEL

Mechanisms to Identify Members Potentially Eligible for Care Management	Identification Criteria for Assigning Members to Risk Stratification Levels for Care Management	Health Assessment	Care Treatment Plan:	Member Enrollment in Care Management Program	Minimum Frequency of Contact between the MCP and Member
The MCP must implement the following identification mechanisms: (a) A review of administrative data (Emergency Department (ED), Inpatient Hospital Stays, and pharmacy [including poly-pharmacy combinations]). (b) A review of members who are enrolled in the Controlled Substance and Member Management Program. ------------------------------ The MCP may implement the following identification mechanisms: (a) Provider/Member self-referrals (b) Telephone interviews (c) Home visits (d) Information reported by the Managed Care Enrollment Center (e) Health (risk) assessment/questionnaires (f) ODJFS Referrals (g) MCP Referrals (e.g., from internal MCP operations.)	The MCP must indicate the criteria to be used by the MCP to identify members for the low-risk level. The strategy will be reviewed by ODJFS as part of the care management program submission.	-The health assessment completed by the MCP must at a minimum: (a) Include a review of administrative claims data. (b) Identify the severity of the member's health condition or disease state (c) Be reviewed by a qualified health care professional appropriate for the member's condition. -The health assessment completed by the MCP may also address access to care barriers. -The MCP must ensure that the health assessment is completed, or contributed to, by a	-The care treatment plan is developed by the MCP for the member. -Elements of a care treatment plan must include: (a) Goals and actions that address health care conditions, disease state(s), or access to care barriers identified in the health assessment; (b) Member level interventions that assist members in obtaining services, providers and programs related to the health care conditions identified in the health assessment; (c) Continuous review, revision, and contact follow up, as needed, to ensure the care treatment plan is adequately monitored, including: i. Identification of gaps between care	-The care management steps of identification, assessment and care treatment plan development must be completed within 90 days of enrollment or identification of the member's health care condition. -For the low-risk level, the MCP may choose to implement an "opt out" option. The member is automatically enrolled in the care management program unless the member contacts the MCP and requests disenrollment. -The MCP may obtain verbal or written confirmation of the member's care management status in the care management record.	Annually

		health care professional as specified in the Provider Agreement, Appendix G.	recommended and care received; and ii. Re-evaluation of a member's risk stratification level with adjustment to the level of care management services provided. -The treatment plan may address the following disease management strategies: (a) Health education for the member; (b) Member self-reporting of data; (c) Member self-management techniques; (d) Reporting feedback to the provider on member compliance with treatment plan; and (e) Member compliance with appointments.		

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MEDIUM RISK STRATIFICATION LEVEL

Mechanisms to Identify Members Potentially Eligible for Care Management	Identification Criteria for Assigning Members to Risk Stratification Levels for Care Management	Health Assessment	Care Treatment Plan:	Member Enrollment in Care Management Program	Minimum Frequency of Contact between the MCP and Member
The MCP must implement the following identification mechanisms: (a) A review of administrative data (Emergency Department (ED), Inpatient Hospital Stays, and pharmacy [including poly-pharmacy combinations]). (b) A review of members who are enrolled in the Controlled Substance and Member Management Program. The MCP may implement the following identification mechanisms: (a) Provider/Member self-referrals (b) Telephone interviews (c) Home visits (d) Information reported by the Managed Care Enrollment Center (e) Health (risk) assessment/questionnaires (f) ODJFS Referrals (g) MCP Referrals (e.g., from internal MCP operations like the 24/7 nurse advice line.)	The MCP must indicate the criteria to be used by the MCP to identify members for the medium-risk level. The strategy will be reviewed by ODJFS as part of the care management program submission.	-The health assessment completed by the MCP must at a minimum: (a)Include a review of administrative claims data. (b)Identify the severity of the member's health condition or disease state (c)Be reviewed by a qualified health care professional appropriate for the member's condition. -The health assessment completed by the MCP may also address access to care barriers. -The MCP must ensure that the health assessment is completed, or	-The care treatment plan is developed by the MCP for the member. -Elements of a care treatment plan must include: (a) Goals and actions that address health care conditions, disease state(s), or access to care barriers identified in the health assessment; (b) Member level interventions that assist members in obtaining services, providers and programs related to the health care conditions identified in the health assessment; (c) Continuous review, revision, and contact follow up, as needed, to ensure the care treatment plan is adequately monitored, including: i. Identification of gaps	The care management steps of identification, assessment and care treatment plan development must be completed within 90 days of enrollment or identification of the member's health care condition. -For the medium-risk level, the MCP may choose to implement an "opt out" requirement. The member is automatically enrolled in the care management program unless the member contacts the MCP and requests disenrollment. -The MCP may obtain verbal or written confirmation of the member's care	Semi-annually

		contributed to, by a health care professional as specified in the Provider Agreement, Appendix G.	between care recommended and care received; and ii. Re-evaluation of a member's risk stratification level with adjustment to the level of care management services provided. -The treatment plan may address the following disease management strategies: (a) Health education for the member; (b) Member self-reporting of data; (c) Member self-management techniques; (d) Reporting feedback to the provider on member compliance with the treatment plan; and (e) Member compliance with appointments.	management status in the care management record.	

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HIGH RISK STRATIFICATION LEVEL

Mechanisms to Identify Members Potentially Eligible for Care Management	Identification Criteria for Assigning Members to Risk Stratification Levels for Care Management	Health Assessment	Care Treatment Plan:	Member Enrollment in Care Management Program	Minimum Frequency of Contact between the MCP and Member
The MCP must implement the following identification mechanisms: (a) A review of administrative data (Emergency Department (ED), Inpatient Hospital Stays, and pharmacy [including poly-pharmacy combinations]). (b) Members who are enrolled in the Controlled Substance and Member Management Program. ------------------------------ The MCP may implement the following identification mechanisms: (a) Provider/Member self-referrals (b) Telephone interviews (c) Home visits (d) Information reported by the Managed Care Enrollment Center (e) Health (risk) assessment/questionnaires (f) ODJFS Referrals (g) MCP Referrals (e.g.,	-The MCP must, at a minimum, include the following criteria for identifying high-risk members: (a) One (1) inpatient hospital readmission within 90 days (within a rolling 12-month period); or (b) Three (3) or more acute inpatient hospitalizations (within the a rolling 12 month period); or (c) Two (2) or more ED visits within 180 days (within a rolling 12 month period) with a primary diagnosis of any of the following conditions: Asthma, Coronary Artery Disease, Congestive Heart Failure, Diabetes, Non-Mild Hypertension, Chronic Obstructive Pulmonary Disease, Severe Mental Disorder, or Substance	-The health assessment completed by the MCP must: (a) Evaluate the member's health condition or disease state, and identify if the member has comorbidities, or complex health conditions; (b) Include a comprehensive review of the following components: i. the member's medical condition, including physical, behavioral, social and psychological needs. ii. documentation of clinical history iii. current medications iv. caregiver	-The care treatment is developed by the MCP for the member. -Elements of a care treatment plan must include: (a) Goals and actions that address health care conditions, disease state(s), or access to care barriers identified in the health assessment; (b) Member level interventions that assist members in obtaining services, providers and programs related to the health care conditions identified in the health assessment; (c) Continuous review, revision, and contact follow up, as needed, to ensure the care treatment plan is adequately monitored, including: i. Identification of gaps between care	- The care management steps of identification, assessment and care treatment plan development must be completed within 90 days of enrollment or identification of the member's health care condition. -For the high-risk level, the MCP must obtain and document verbal or written confirmation of the member's care management status in the care management record. -For the high-risk level, an opt-out option is not permissible.	Quarterly

from internal MCP operations.)	Abuse; **or** d) Two (2) or more preventable ED visits (as defined by the NYU algorithm) within the year (within a rolling 12 month period). This identification criteria will include only those ED visits that have primary diagnoses codes that the NYU algorithm assigns a probability of being primary care treatable and/or preventable/avoidable, excluding those diagnoses that have a probability of only being non-emergent. -The MCP may develop identification criteria in addition to the above for the high risk stratification level.	resources v. access to care barriers (c) Be completed, or contributed to, by a-health care professional as specified in the Provider Agreement, Appendix G.	recommended and care received; and ii. Re-evaluation of a member's risk stratification level with adjustment to the level of care management services provided. -The care treatment plan must be individualized and must include the following: (a) Short and long term goals (b) Communication plan with the member and provider. (c) Collaboration with other service providers or care managers.		