482-000-8 Care Management Requirements

Note: For purposes of this guide, the term plan is defined to mean physical health plan.

Overview

Care management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes.

The Department expects the plans participating in the Nebraska Health Connection (NHC) to provide proactive medical case management to the managed care client.

Care management is an integral part of managed care as part of the administrative requirements for utilization management and quality assurance activities, and is included in the Department's managed care policies and contractual agreements.

Each plan is required to comply with the Department's Quality Strategy (see 482-000-12). The health plans are required to provide care management separate from, but integrated with utilization management and quality improvement activities.

The major components of care management are assessment, planning, facilitation, coordination, and evaluation. The major activities of care management include advocacy, communication, problem solving, collaboration, and empowerment. Disease management programs must focus on diseases that are chronic or very high cost and include comprehensive health education.

Desired Outcomes

The NHC will offer managed care clients expanded choices, increased access to care, greater coordination and continuity of care, cost-effective health services, and better health outcomes through effective care management and disease management. Achievement of the best possible health outcomes for NHC clients will be measured by defined care management/health risk assessment outcomes indicators through the Department's Quality Strategy.

Departmental Expectations

The Department's expectation is for the NHC to provide a proactive approach in a client/family-centered manner to achieve and maintain the maximum health status possible for each client enrolled in the NHC. A proactive approach assures that the client experiences a seamless, integrated health care delivery system that is culturally competent.

A) Each health plan must conduct a Health Risk Assessment and offer Care Management activities to the following groups of clients at a minimum:
   1. Clients falling under the Medicaid eligibility category of the Aged, Blind and Disabled, i.e., AABD.
   2. Special Needs clients.
   3. Children who are in Foster Care Placement.
   4. Clients with chronic and/or special health needs.
   5. Clients at risk for poor health outcomes.
   6. Children with positive results from lead testing.
   7. Clients discharging from the hospital.
   8. Clients in Lock-In status.
   9. Clients with multiple missed medical appointments.
   10. Clients with screening results indicating referral treatment without follow up.
   11. Clients requesting case management activities.
   12. Clients whose PCP has made a referral for care management activities.

B) Any client identified for care management activities through the Health Risk Assessment must be offered care management services. Clients declining care management activities must have this documentation in the client record.

   When a client is identified and accepting of care management, the care manager must:
   1. Review the client's needs;
   2. Initiate a care coordination plan in collaboration with the client, the PCP, any Specialists, family member(s), and all other members of the health care team;
   3. Establish a care coordination plan that identifies goals to achieve and maintain optimal health outcomes, interventions, and duration of the plan; and
   4. Monitor progress towards goals.

In addition to the medical needs, the care coordination plan should consider the client's need for social, educational, and other non-medical services as well as the strengths o of the family/caregiver. All case information must be documented in the client record.

C) Disease Management. Disease management programs may be provided in conjunction with care management or separate from. Disease management programs must focus on diabetes, asthma, hypertension, and obesity at a minimum. The disease management program must empower the client, in concert with the medical home, any Specialists, and other care providers, to effectively manage disease and prevent complications through adherence to medication regimens, regular monitoring of vital signs and healthful diet, exercise and other lifestyle choices. The disease management program must engage clients in self-management strategies to improve their health. The program must assess the disease processes and its affect on life events and educates the member on disease self-management. All case information must be documented in the client record.

D) Children who are DHHS wards and in out-of-home placement. Care Management for children who are in foster care placement must involve coordination with the child's Child and Family Service Specialist (or designee). Care Management must also include identifying and responding to the child's health care needs including mental health and dental health needs. The case management plan must include an outline of:

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
2. How health needs identified through screenings will be monitored and treated;
3. How medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;
4. Steps to ensure continuity of health care services; and
5. The oversight of prescription medications.

E) Lock-in requirements per 471NAC 2-004 Client Lock-In. When the Department identifies a client for Lock-in status, care management staff (or other designee) must assist the client with designating their (Primary Care Physician) PCP as their lock-in provider and notify the Department (see 482-000-8).

F) HEALTH CHECK (Early and Periodic Screening, Diagnosis and Treatment Program)(EPSDT) Outreach. Per 471 NAC 33, the EPSDT program's objectives are ensuring the availability and accessibility of required health care resources and helping Medicaid-eligible children and their parents or caretakers effectively use them. Care coordination must include:

1. Provision of effective outreach/education activities which informs parents (or caretakers) of the benefits of having their children receive HEALTH CHECK screening, diagnosis, and treatment services;
2. Provision of consumer education to parents (or caretakers) which assists in making responsible decisions about participation in preventive health care and appropriate utilization of health care resources;
3. Assurance of continuing and comprehensive health care beginning with the screening through diagnosis and treatment for conditions identified during screening;
4. Provision of assistance to families in making medical and dental appointments and in obtaining needed transportation; and

5. Establishment of case management of screening services to monitor and document that all HEALTH CHECK (EPSDT) services are delivered within established time frames.

G) Client request in change of PCP. Client requests to change PCP's must be made to the health plan that the client is enrolled in. Care management staff (or other designee) are responsible for processing PCP transfer requests received from the client and assisting in identifying a new PCP which is enrolled provider in that plan.