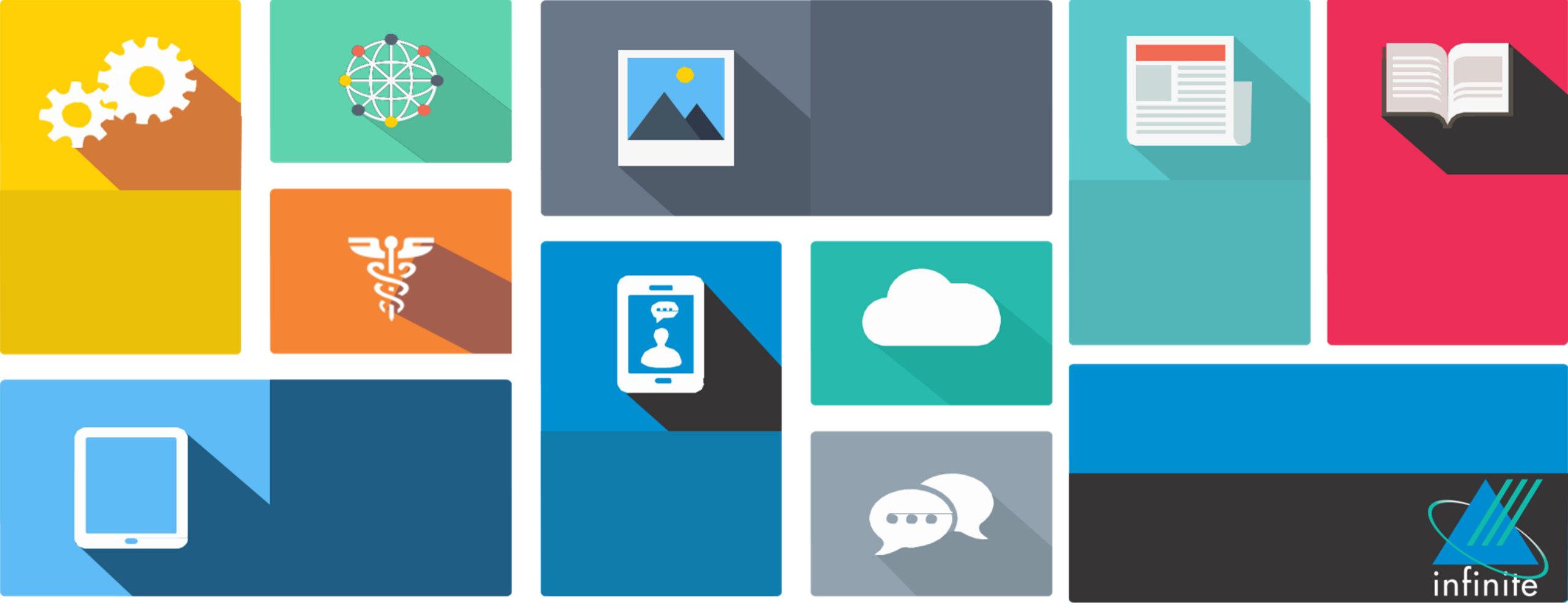

Care Management

Medical/Care Management

The system for Health plans and their providers to achieve and maintain both **high quality and cost effectiveness**.

Care management is a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminate duplication, and helping patients and caregivers more effectively manage Complex and Chronic health conditions.

- An effective health plan must be able to manage both the cost and the quality of healthcare services.
- Without adequate quality management, it may not be able to meet the healthcare and service quality needs of members, providers, purchasers, and regulatory and accrediting bodies.
- Without adequate cost management, a health plan may not be able to maintain its financial viability.

Care management activities can be divided into three broad categories:

- Utilization Management
- Clinical Practice Management
- Quality Management.

keys to successful care management

- **In-person encounters:** Person-to-person encounters, including home visits, are necessary features of effective care management. Care management relying solely on telephone encounters has not shown success.

- **Training and personnel**: Programs with specially trained care managers who have a relatively low workload are most successful. Most care managers are registered nurses (RNs) who work as part of a multidisciplinary team.

- **Physician involvement:** Placing care managers with physicians in primary care practices may help facilitate physician involvement.

- **Informal caregivers:** Patients with complex health care needs, particularly those with physical or cognitive functional decline, often need the assistance of informal caregivers to actively participate in care management.

- **Coaching:** Coaching involves teaching patients and their caregivers how to recognize early warning signs of worsening disease.

Utilization Management

Utilization management is "the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called ‘utilization review’.”

- ***Prospective review*** is conducted at the onset of a service or treatment and is also referred to as precertification or prior authorization. This review is performed before care is rendered in order to eliminate or reduce unnecessary services. Prospective review may have the impact of not authorizing or limiting care that had been recommended by the evaluating provider(s).

- ***Concurrent reviews*** performed during the course of treatment or episode of care. Intervention occurs at varied intervals and may encompass case management activities such as care coordination, discharge planning, and care transitioning. Concurrent review may have the impact of curtailing an existing episode of care.

- ***Retrospective review*** is conducted after the service has been completed and assesses the appropriateness of the procedure, setting, and timing in accordance with specified criteria. Such reviews often relate to payment and may result in denial of a claim. Financial risk for a retrospective denial is often borne by the provider.

Clinical Practice Management

- Clinical Practice Management involves the development and implementation of parameters for the delivery of healthcare services to plan members
- Based on the concept of Evidence based care.
- Caregivers (Nurses, Physicians and Care managers) are involved in coordination of care, maintaining patient's Care plans for managing the Complex health conditions.
- Care plans are generated based on the health condition and risk level – Health problem, Interventions and Goals are added and evaluated over a period of time.
- Periodic assessment is done to track member's progress
- Clinical documentation is done in the form of Progress notes, reports and medication details

Quality Management & HEDIS

- Quality Management (QM) is an organization-wide process of measuring and improving the quality of the healthcare and services a health plan's members receive.

- The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
- HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.
- An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrolees

HEDIS Structure

- The 90 HEDIS measures are divided into six "domains of care":
  1. Effectiveness of Care
  2. Access/Availability of Care
  3. Experience of Care
  4. Utilization and Relative Resource Use
  5. Health Plan Descriptive Information
  6. Measures Collected Using Electronic Clinical Data Systems

- Measures are added, deleted, and revised annually. For example, a measure for the length of stay after giving birth was deleted after legislation mandating minimum length of stay rendered this measure nearly useless.

Data Collection

- HEDIS data is collected through surveys, medical charts and insurance claims for hospitalizations, medical office visits and procedures.
- Clinical measures use the **administrative** or **hybrid** data collection methodology, as specified by NCQA.
- **Administrative** data are electronic records of services, including insurance claims and registration systems from hospitals, clinics, medical offices, pharmacies and labs.
- For example, a measure titled **Childhood Immunization Status** requires health plans to identify 2-year-old children who have been enrolled for at least a year. The plans report the percentage of children who received specified immunizations.
- Plans may collect data for this measure by reviewing insurance claims or automated immunization records.

Reporting

- HEDIS results must be audited by an NCQA-approved auditing firm for public reporting.
- NCQA has an on-line reporting tool called Quality Compass that is available for a fee of several thousand dollars.
- It provides detailed data on all measures and is intended for employers, consultants and insurance brokers who purchase health insurance for groups.
- NCQA's web site includes a summary of HEDIS results by health plan. NCQA also collaborates annually with U.S. News & World Report to rank HMOs using an index that combines many HEDIS measures and accreditation status.
- The "Best Health Plans" list is published in the magazine in October and is available on the magazine's web site.

HEDIS Measures

- https://www.ncqa.org/hedis/measures/

Referral Management

- The definition of referral management is managing the process by which patients are transitioned to the next step in their care. This transition usually occurs at a critical moment for a patient: An escalation in care or a change in diagnosis.
- Normally referral management takes place in the context of a primary care provider sending a referral to a specialist, but also happens from specialist to specialist or from inpatient settings/emergency room discharge to a provider.

HIPP (Health Insurance Premium Payment Program)

- HIPP is a Medicaid program that allows a recipient to receive free private health insurance paid for entirely by their state's Medicaid program
- HIPP is for families who have one or more individuals with expensive health care costs, typically due to complex or chronic medical conditions.
- It is a program that can save both states and families money by shifting some of the costs for care to private insurance plans.
- States choose to pay the monthly cost of health insurance premiums, that your medical costs will then be primarily covered by your private insurance plan instead of Medicaid.
- Examples: Kids with complex medical issues, Kidney failure, Carcinoma, HIV patients

MTMP (Medication Therapy Management Program)

- MTMP aims to improve outcomes by helping people to better understand their health conditions and the medications used to manage them.
- This includes providing education on the disease state and medications used to treat the disease state, ensuring that medicines are taken correctly, reducing waste due to unused medicines, looking for any side effects, and providing education on how to manage any side effects.
- CMS required Medicare Part D plans to include these services.
- It is a free service for members enrolled in Part D who meet three eligibility criteria.
- Enrolees must have at least two chronic conditions, take multiple drugs covered by Part D, and are predicted to exceed a preset amount in annual out of pocket costs for their covered Part D drugs.
- Example: Chronic Obstructive Pulmonary Disease (COPD), Depression, Diabetes, End-Stage Renal Disease (ESRD), High cholesterol (hyperlipidemia), Osteoporosis, Hypertension

Thank You