

**Care Management Subcommittee
Recommendations
Presented to ULTCB on 2/21/2008**

The Unified Long Term Care Budget Work Group was established to develop a comprehensive, flexible and transparent process for effective and efficient budgeting and service delivery that:

- Encompasses both facility-based and home- and community-based long-term services and supports
- Is based on consumer choice and differing levels of service need
- Includes a seamless array of service delivery options
- Features a consolidated policymaking and budget authority to simplify decision making and maximize the state's flexibility

In order to meet its charge, the Unified Long Term Care Budget Work Group developed subcommittees to focus on specific topic areas; one of which was care management. The Care Management Subcommittee was charged with the following task:

This subcommittee will make recommendations as to the role of care management in a transformed system of long-term services and supports. Issues to be considered by this subcommittee include:

- What is the role of the care manager? (Gatekeeper, counselor, navigator, advocate, service authorizer, or some combination of all of these).
- Who should benefit from care management?
- How does the care management system for long-term services and supports integrate with existing managed care plans? This includes both Medicare managed care plans and the Medicaid ABD managed care plans.

The Care Management Subcommittee (members are listed in Appendix A) began meeting on November 8, 2007 and met five times to draft recommendations related to the areas mentioned above. The proposed recommendations provide a sound foundation for initiating the transformation of care management within a unified budget and may be applicable for all phases. Unfortunately the subcommittee lacked representation of key stakeholders affected by the later phases and therefore, if implemented, recommendations should be reevaluated as each phase is implemented.

CARE MANAGEMENT

The current method of providing long term services and supports is fragmented and unique to each delivery system; so one can imagine that the current framework for delivering care management is also unique and different to each system. The Unified Long Term Care Budget provides the opportunity to bring consistency and a standard purpose to care management. The current care management practices and definitions (see Appendix B) were discussed and

common goals and principles used for the foundation of building the care management component of the long term care system.

Philosophically, the care management system should reflect a seamless and coordinated transition of the consumer through various stages of the care management process from access to assessment to care planning and service delivery. The process should facilitate integrated and comprehensive delivery of appropriate services in the appropriate setting. The care management process includes provisions for continuous monitoring of the consumer's evolving needs and a timely response to same. The consumer's strengths, special abilities, and cultural, social, health needs are given consideration in the whole-person approach to care planning and service delivery. The delivery of high quality, efficient, timely consumer driven care which influences positive outcomes is critical.

A common definition for care management across systems and programs will further unite the long term care system and provide the framework and guiding principle for care management activities. The subcommittee recommends the following:

1. The Unified Long Term Care Budget Work Group should adopt the following definition for care management: Care Management is a holistic, collaborative, consumer-driven process for the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer's quality of life based on his/her capacity and preferences.
2. The subcommittee recommends that this definition for care management be adopted and implemented for all consumers receiving long-term care services and supports. This may include changing the definition of care management in waiver applications, the state plan, and any related administrative codes.

Fiscal Impact: Insignificant-may be negligible cost associated with staff time to revise administrative code, waivers and other documents to reflect definition.

ROLE OF THE CARE MANAGER:

The care manager, in a unified system of long-term services and supports, will wear many hats and fill many roles. Nationally the role of a care manager has evolved during the past two decades due in part to individuals with long-term care needs demanding more choice, control and authority in directing their own care and services. This movement towards consumer choice and direction will be supported by the care manager by focusing on managing the services and not managing the individual. Consumer choice and person centered planning should be the foundation from which care management activities occur.

Care managers will assume a variety of roles to support individuals in a long-term care system. Care management is not one strategy or approach; but reflects a continuum of approaches based on the consumer's capacity and the level of decision making, control and autonomy. The role of the care manager is guided by the purpose of care management which is to authorize and ensure

the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer's quality of life based on his/her capacity and preferences. In doing so the care manager may take on the role of an advocate, coach, teacher, facilitator, broker, negotiator, counselor, coordinator, assessor, evaluator, gate keeper, record keeper and/or researcher.

The individual is linked with a care manager upon being determined eligible for long term services and supports. The care manager will assist the individual through a variety of activities such as determining service needs through assessment, developing care plans, authorizing services, referring and linking to services and monitoring and follow up activities to ensure the individual's needs are being met, the individual is satisfied with the services and the individual continues to be eligible for services in the long term care system. The care manager will not assume a role as a direct service provider nor should the care management entity be permitted to provide any direct service. It is important for the care manager to be independent of providing any direct service or working for an entity that provides services therefore eliminating any potential conflict of interest.

The care manager's role must be adaptable to the variety of settings and programs providing long term care services and supports. This model of care management is based on the design of the current long term services and supports delivery system which consists of a community component (state plan, Medicaid waivers, PACE and other sources) and institutional components. There needs to be acknowledgement that some delivery systems have certain responsibilities inherent to their system; for instance nursing facilities are required by federal law to develop a written plan of care which describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met; or the requirement for the PACE program to provide a benefit package for all participants, regardless of the source of payment, which includes all Medicare-covered items and services and all Medicaid-covered items and services, as specified in the state's approved Medicaid plan. Therefore the role of the care manager must also be flexible to accommodate the varying responsibilities of the distinct components of the delivery system.

The role of a care manager for an individual enrolled on the PACE program may be limited to assessing continuing eligibility, ensuring the consumer is in the setting of his/her choice and facilitating changes to other long term service delivery systems at the consumer's request. The role of a care manager for an individual in an institutional setting will focus on assessing continuing eligibility, appropriateness/satisfaction of placement, discussion of community options, facilitation if transitioning to the community, and oversight and monitoring of long term care Medicaid expenditures with the goal of promoting the best possible health outcomes.

The care manager's role for individuals in a community setting would include the responsibility of ensuring access to and coordination of health and supportive services; authorizing and managing all the services, including state plan services, received within the long term care system; assessing for continuing eligibility for long-term care services; and monitoring and follow up activity related to service needs.

With these concepts in mind the subcommittee recommends the following related to the role of the care manager:

1. The role of the care manager is to:
 - a. Coordinate and collaborate with all available funding sources
 - b. Assess ongoing eligibility for long term care services and supports
 - c. Assess service needs; authorize, as appropriate, and monitor the provision of quality, culturally competent health and supportive services
 - d. Use available resources efficiently and effectively.
 - e. Maximize the individual consumer's quality of life based on his/her capacity and preferences.
2. Care management activities should be guided by the principles of consumer direction and person centered planning.
3. The care manager and care management entity should be independent from entities providing other services within the long term care system.
4. Care managers should be utilized for all long term services and supports whether provided in an institutional or community setting and the role of the care manager must be flexible to adapt to the unique characteristic of each delivery system.

Fiscal Impact: There would be additional cost associated with providing care management to every individual in the long term care system but the cost savings achieved, particularly by managing state plan home health services, may offset the cost at the same time ensuring that individuals receive appropriate services in the most appropriate setting.

WHO SHOULD BENEFIT FROM CARE MANAGEMENT?

Every individual accessing long term care services and supports (i.e. the services and supports included in the unified long-term care budget) would benefit from some degree of care management. This means individuals in institutions such as the nursing facility or intermediate care facility for individuals with mental retardation and/or developmental disabilities and individuals in the community; on waivers, on the PACE program and/or receiving state plan services would receive some level of care management.

Care management services must be responsive to the evolving needs of the consumer and flexible to change as the consumer's needs change. Some individuals may benefit from limited care management services in which the care manager periodically assesses continuing eligibility for services, ensure needs are being met and confirms the consumer's satisfaction with the services. Other individuals may need care managers to be more involved with ongoing assessment and care planning to address ongoing changes. The degree of involvement of the care manager would be dependent on multiple factors such as the consumer's capacity and interest in managing his/her own care; the care setting; the type, amount, frequency and duration of services; consumer's functional abilities; available informal support system; and other items.

The Care Management Subcommittee recommends:
The state should establish protocols and standardized criteria to guide the degree of care management.

Fiscal Impact: Establishing protocols and guidelines in and of themselves would be minimal cost; actual implementation of the guidelines may be used as a tool to contain costs by providing a structure from which the care managers can operate.

COORDINATION WITH MANAGED CARE PLANS

The last area the Care Management Subcommittee was asked to consider was how does the care management system for long-term services and supports integrate with existing managed care plans? This includes both Medicare managed care plans and the Medicaid ABD managed care plans.

House Bill 66 mandated the statewide expansion of the Medicaid managed care program for the entire Covered Families and Children (CFC) population and a portion of the Aged, Blind and Disabled (ABD) population. Excluded from the ABD population are individuals who are dually eligible (Medicare/Medicaid), children, waiver consumers, consumers in institutions and consumers with a Medicaid spend-down. At the same time Ohio is experiencing an emergence in Medicare Special Needs Plans.

The subcommittee explored the current role of managed care and possible coordination efforts. Two presentations were arranged which discussed managed care and a local initiative which currently coordinates long term service delivery with a managed care delivery system. The Ohio Association of Health Plans provided an overview of the Medicare Special Needs Plans and an overview of the current state of Medicaid managed care in Ohio. Area Agency on Aging 10B provided an overview of their Integrated Care Management Program which is a partnership between the Area Agency on Aging and Summa Health Providers to coordinate services provided by their two delivery systems.

Managed care plans share similar goals to the care management system for long term services and supports. Both value the right care in the right place, the least restrictive setting and care management as a central strategy for management and oversight of the delivery of cost effective, person centered, quality services. Area Agency on Aging 10B reported from their experience that coordinating with a managed care plan benefits individuals by building on the existing strengths of both systems blending models to address acute and chronic medical needs including psycho-social and functional needs.

Ohio's Medicaid managed care plans point out that they also provide some long term services and supports as they have recently become responsible for the first two months of nursing facility services for their members, and provide services such as nursing and personal care typically associated with long term care needs. It is imperative that the diverse systems that play a role in the care management process develop a mechanism to enhance care coordination for consumers and efficiently manage the cost of care.

In order to be effective the system must first be able to identify the common consumers and then have a structure from which to work. Because the nuances of funding source standards, benefit/services coverage, eligibility, resources, etc., a comprehensive plan is required. This plan could lead to the design/execution of a Memorandum of Understanding (MOU) which defines the 'terms of engagement' between the managed care and long term care delivery systems including the development of a shared health care record, data sharing, end-to-end care coordination, and monitoring.

Our recommendations are broad based and emphasize effective collaboration between the systems to execute care management as described in the principles previously outlined in this document.

Recommendations:

1. Develop a mechanism to identify the common consumers enrolled on the Medicare or Medicaid managed care plans and receiving long term care services and supports.
2. Use a memorandum of understanding, or similar vehicle, between Medicare or Medicaid managed care plans and care management entities to support coordination of services and benefits.
3. Explore the potential of using computerized HIPAA compliant personal health care record.

Fiscal Impact: Minimal administrative costs associated with state staff time devoted to working through the recommendations.

Summary of Recommendations

1. The Unified Long Term Care Budget Work Group should adopt the following definition for care management: Care Management is a holistic, collaborative, consumer-driven process for the provision of quality culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer's quality of life based on his/her capacity and preferences.
2. The subcommittee recommends that this definition for care management be adopted and implemented for all consumers receiving long-term care services and supports. This may include changing the definition of care management in waiver applications, the state plan, and any related administrative codes.
3. The role of the care manager is to:
 - a. Coordinate and collaborate with all available funding sources
 - b. Assess ongoing eligibility for long term care services and supports
 - c. Assess service needs; authorize, as appropriate, and monitor the provision of quality, culturally competent health and supportive services
 - d. Use available resources efficiently and effectively.
 - e. Maximize the individual consumer's quality of life based on his/her capacity and preferences.
4. Care management activities should be guided by the principles of consumer direction and person centered planning.
5. The care manager and care management entity should be independent from entities providing other services within the long term care system.
6. Care managers should be utilized for all long term services and supports whether provided in an institutional or community setting and the role of the care manager must be flexible to adapt to the unique characteristic of each delivery system.
7. The state should establish protocols and standardized criteria to guide the degree of care management.
8. Develop a mechanism to identify the common consumers enrolled on the Medicare or Medicaid managed care plans and receiving long term care services and supports.
9. Use a memorandum of understanding, or similar vehicle, between Medicare or Medicaid managed care plans and care management entities to support coordination of services and benefits.
10. Explore the potential of using computerized HIPAA compliant personal health care record.

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Appendix A

Care Management Committee List

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Current Care Management Definitions

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
PASSPORT	AGE	Age 60+ NF LOC	28,000	AAA or CSS	From Waiver Instructions page 109 case management usually entails (but is not limited to) conducting the following functions: <ul style="list-style-type: none"> • Evaluation and/or re-evaluation of level of care; • Assessment and/or reassessment of the need for waiver services; • Development and/or review of the service plan; • Coordination of multiple services and/or among multiple providers; • Linking waiver participants to other Federal, state and local programs; • Monitoring the implementation of the service plan and participant health and welfare, • Addressing problems in service provision; • Responding to participant crises
Choices	AGE	Age 60+ NF LOC	224	AAA or CSS	Same as above
Assisted Living	AGE	Age 21+ NF LOC	300	AAA or CSS	Same as above
Ohio Home Care	ODJFS	Up to age 60 NF LOC	7,730	CareStar	OAC 5101:3-45-01 (J) defines case management services as administrative activities that link, coordinate and monitor the services and resources provided to a consumer enrolled on an ODJFS-administered waiver. ODJFS may

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
					contract with other entities to perform one or more of these functions.
Transitions Waiver	ODJFS	ICFMR LOC previously on the Home Care Waiver	3,000	CareStar	Same as Ohio Home Care
Transitions II Aging Carve out	ODJFS	Age 60 + and previously enrolled on Home Care	1,270	CareStar	Same as Ohio Home Care
Level One Waiver	DMR	ICFMR LOC	4,800	County Boards of MRDD	<p><u>5101:3-48-01 Medicaid coverage of targeted case management services provided to individuals with mental retardation and developmental disabilities.</u></p> <p>(7) “Targeted case management” means services which will assist individuals in gaining access to needed medical, social, educational and other services as described in this rule in accordance with section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective January 1, 2006. Targeted case management is also referred to as medicaid case management.</p> <p>(D) Reimbursable activities.</p> <p>(1) Medicaid services listed in paragraph (D) are reimbursable only if provided to or on behalf of a medicaid eligible individual as defined in paragraph (C) of this rule and by qualified providers as defined in paragraph (E) of this rule. Payment for targeted case management</p>

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
					<p>services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid reimbursable TCM services are:</p> <p>(a) Assessment. Activities...:</p> <p>(i) Activities performed to make arrangements to obtain from therapists and appropriately qualified persons the initial and on-going assessments of an eligible individual's need for any medical, educational, social, and other services.</p> <p>(ii) Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for HCBS waiver services administered by ODMRDD.</p> <p>(iii) Activities related to recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for HCBS waiver services administered by ODMRDD.</p> <p>(b) Care planning - Activities related to ensuring the active participation of the eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the eligible individual. These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).</p>

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
					<p>(c) Referral and linkage -Activities that help link eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services.</p> <p>(d) Monitoring and follow-up:</p> <p>(i) Activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible individual.</p> <p>(ii) Conducting quality assurance reviews on behalf of a specific eligible individual and incorporating the results of quality assurance reviews into amendments of an ISP.</p> <p>(iii) Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and MUIs and integrating prevention plans into amendments of an ISP.</p> <p>(iv) Ensuring that services are provided in accordance with the ISP and ISP services are effectively coordinated through communication with service providers.</p> <p>(v) Activities and contacts that are necessary to ensure that guardians and eligible individuals receive appropriate notification and communication related to unusual incidents and MUIs.</p>

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
					(e) State hearings-Activities performed to assist an eligible individual in preparing for a state hearing related to the reduction, termination or denial of a service on an ISP.
Individual Options	DMR	ICFMR LOC	11,800	County boards of MRDD	Same as above

Waivers are required to provide care/case management sometimes also called service coordination or service and support administration. The state has three options related to the manner in which care management is provided; it may provide case management as a service within the waiver, or as a State plan service (Targeted Case Management) under §1915(g)(1) of the Act and/or as an administrative activity, performed by state or local government employees or contractors. States may use a core service definition proposed by CMS or develop their own definition which would need to be approved by CMS.

ODJFS and Aging have elected to provide care management as an administrative function; ODMRDD has elected to provide care management as a service which is in the state plan.

Social Security Act defines case management services offered under the state plan as- (2)^[128] For purposes of this subsection, the term “case management services” means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Other Definitions of Care Management

Program or Services	Administrative Agency	Pop. Served	Approx. #s Served	“Care Management” Entity	Regulation/definition
Managed Care	JFS			Managed Care Plan	<p>OAC 5101:3-26-03.1</p> <p>8) MCPs must provide case management (CM) services to coordinate and monitor treatment rendered to members with specific diagnoses or who require high-cost or extensive services.</p> <p>(a) MCPs must notify all members of the CM services they may be eligible to receive;</p> <p>(b) The MCP’s CM program must include and document the following, at a minimum:</p> <p>(i) Screening and identification of members who potentially meet the criteria for case management;</p> <p>(ii) Assessment of the member’s health condition to confirm the results of the screening and determine the need for case management;</p> <p>(iii) Notification to the member and their PCP of the member’s enrollment in the MCP’s case management program; and</p> <p>(iv) Development and implementation of a treatment plan for members in case management.</p> <p>(c) MCPs must report case management program-related data to ODJFS, as required</p>