

# Care Management Part 1

---

April 27, 2006



---

1

## Purpose

- What this webcast is – information MCO managers and administrators need to develop care management capacity and systems
- What this webcast is not – a training for interdisciplinary team members



---

2

## Next Webcast

- Tuesday, May 23
- Care Management, Part 2
  - Being interdisciplinary
  - Being person-centered
  - Being cost-effective



## What We Will Cover

- The care planning process
  - Where decisions about services and supports for members are made
  - Where decisions on how to allocate MCO resources are made
- Tools/techniques to help care management teams balance quality, choice and cost
- MCO business and administrative systems and structure to support care management



## Themes

- ❑ Differences between managed care and waiver care management
- ❑ Learnings from implementation of Family Care and Partnership
- ❑ Importance of organizational commitment to the mission and values of person-centered long-term care



---

5

## Some Basics

- ❑ Primary and acute health care
  - FC teams coordinate health care
  - Partnership provides all health care
- ❑ Interdisciplinary care management teams
  - Both programs -- member (and reps), RN, social worker, others as appropriate
  - Partnership – primary care physician, NP
- ❑ Teams authorize services, including the Medicaid card services in the benefit package



---

6

## Terms

- Members = Consumers= Participants
- Interdisciplinary teams (IDTs)
- MCO
- Learnings from Family Care and Partnership

<http://dhfs.wisconsin.gov/WIpartnership/Rep-App.htm>



---

7

## The Balancing Act

- IDTs need to balance:
  - Quality of services and care
    - Care management quality
    - Oversight of provider quality
  - Choice
  - Cost



---

8

## Some Tools and Techniques for Achieving Balance

- Focusing on Outcomes
- Risk Management
- Resource Allocation Decision Method
- Service Authorization Guidelines
- Understanding "Choice"
- Self-Directed Supports



---

9

## Outcomes

- Outcomes – real life results for members
- Outcome-based planning skills need to be developed
  - It takes more time and is not easy
  - Requires problem solving and negotiation skills
- Leads to identification of cost-effective services and supports



---

10

## Outcomes (Cont.)

Bad outcomes for members  
= bad \$ outcomes for MCO

Good outcomes for members  
= good \$ outcomes for MCO

11

## Managing Risk

- If members' overall health and well being deteriorates, the cost of their care will increase
- The IDT works to:
  - Improve or maintain best possible health, including mental health, quality of life
  - Balance benefits and costs in the short and long term
  - Prevent high-cost NH and hospital stays



12

## Managing Risk (Cont.)

- Prevention and wellness is an integral part of the program
  - Program-wide
  - Member-specific
  
- Clinical guidelines help IDTs
  - Depression, mental health/aoda
  - Diabetes, CHF, falls, dementia



---

13

## Resource Allocation Decision Method (RAD)

- A thought and decision-making process for
  - Individualizing care plans around outcomes
  - Being as cost-effective as possible
  
- No longer have to
  - Ask "is this an allowable waiver service?"
  - Follow the MA mandate



---

14

## How RAD Came to Be

- ❑ Concerns that if MCO did not have a way to manage care, and say no when appropriate, we will never be cost effective
  
- ❑ Concerns that in managed care money would rule, and participants would not get what they need



---

15

## The RAD

- ❑ Strives to find the path to:
  - The right service
  - In the right amount
  - At the right time



---

16

## RAD Assumptions

- ❑ It follows the comprehensive assessment and identification of outcomes
- ❑ Cost efficiency is built into every decision, not just major ones
- ❑ People are entitled to an effective care plan, not to specific services in the benefit package



17

## RAD Assumptions (Cont.)

- ❑ Decisions aren't based on what is in others' care plans
- ❑ Cost efficiency is presented to consumers in way that is effective in getting their buy-in to try alternatives
- ❑ RAD Homework

<http://dhfs.wisconsin.gov/LTCare/ProgramOps/RAD.HTM>



18

## Service Authorization Guidelines

- ❑ Teams need guidance - a list of questions and considerations to follow
- ❑ Consumers find them helpful as a reference handout when asking for items or services
- ❑ Examples:
  - Paying family caregivers
  - Lift chairs and other DME
  - Residential care



19

## Learning from Family Care and Partnership

- ❑ IDTs need structure and guidance to make service authorization decisions
  - The RAD
  - Policy and procedure manuals
  - Service authorization guidelines
  - Team meetings
- ❑ It is important to maintain the ability of IDTs to make decisions
  - Supervisory support and mentoring
  - Not top-down decision making
  - Workgroups to develop P/P & guidelines



20

## Understanding What “Choice” Means

- ❑ LTC Reform Proposal said the redesigned system would provide “More Choices for More People”
- ❑ State staff and local MCOs have grappled with operationalizing “choice” concept
- ❑ “Choice in Family Care” document is helpful to IDTs

<http://dhfs.wisconsin.gov/LTCare/Partners/PDFs/choice.pdf>



21

## What “Choice” Means

- ❑ Living arrangement
  - Having access to non-institutional care
  - Does not mean living wherever you want, without regard to cost
- ❑ Direct care
  - Being able to say who you want to come into your home
  - As long as they accept the MCO rate
- ❑ Providers
  - Choice of network providers for the same service
  - Does not mean access to a provider who only provides a more expensive service model than the one you need



22

## Learning from Family Care and Partnership

- Unrealistic stakeholder expectations about choice:
  - That care plans would all remain the same
  - That MCO members would get whatever they wanted
- New MCOs should communicate that:
  - Care plans may change
  - Providers are not guaranteed the same business
  - Managed care is providing services as efficiently and effectively as possible



---

23

## Self-Directed Supports

- An additional choice for members who want more control over how and by whom services are provided
- More than being a full partner – it means being the boss
  - Direct employer/employee relationship
- Includes more responsibility for the member



---

24

## Self-Directed Supports (Cont.)

- ❑ A continuum of approaches... not an "all or none" approach
- ❑ Tool for cost-effectiveness



## ORGANIZATIONAL STRUCTURES THAT SUPPORT CARE MANAGEMENT



## Organizational Structure

- ❑ Care management and the provision of services and supports are the core functions of the MCO
- ❑ Administrative and business systems should be organized to support them rather than present barriers to them



---

27

## Organizational Structure

- ❑ Organizational Values and Mission
- ❑ Business Systems and Information Management
- ❑ Adequate Staff
- ❑ Training
- ❑ Utilization Review
- ❑ Provider Network
- ❑ Eligibility



---

28

## Organizational Values and Mission

- ❑ Person-centered focus should be imbedded within the culture of the MCO
- ❑ Organizational values and culture is a function of leadership
- ❑ Culture and values provide the context for decision making at all levels of the organization
- ❑ All layers of the organization should be fully aware of the mission and values of the MCO



---

29

## Example of a Mission Statement

- ❑ **Our Mission**  
Community Health Partnership, Inc. (CHP) through creative teamwork, facilitates quality choices that empower people to live as independently as possible
- ❑ **Our Vision**  
Leading the revolution for excellence in managed care, serving people with complex needs, one unique life at a time
- ❑ **Our Core Values**  
Caring, Honesty, Creativity, Respect, Competence, Teamwork



---

30

## Learning from Family Care and Partnership

- ❑ Change in organizational culture
- ❑ Increased emphasis on team work
- ❑ Outcome-based care planning was a change in role and philosophy for care managers
  - Services are a means to an end (outcomes), not ends in themselves



31

## Business Systems and Information Management

- ❑ Managed care is about delivering the right services at the right time
- ❑ IDTs need to know:
  - How to find information about services they need to authorize
  - What providers the MCO has contracts with and what their specialties are
  - MCO service and clinical guidelines
  - State of the art care practices



32

## Business Systems and Information Management (Cont.)

- Automated systems add to efficiency and cost effectiveness
  - case notes
  - assessments
  - care plans
  - service authorizations



---

33

## Business Systems and Information Management (Cont.)

- Supports for IDTs create efficiencies
  - Specialty staff who know how to research best solutions and prices for services
  - Clerical staff support file maintenance
  - Contract management staff to facilitate relationships with providers
  - Coordination of benefits



---

34

## Learning from Family Care and Partnership

- ❑ New MCOs need someone to manage claims processing, coordination of benefits, and service authorizations when the MCO starts
- ❑ Most Partnership MCOs and one FC MCO have contracted with third party administrators to perform claims processing



35

## Adequate Staff

- ❑ MCOs don't know who they will be serving until a person enrolls
- ❑ Must have trained IDTs in place to serve people as they enroll
- ❑ Must have processes in place to put needed services in place on day of enrollment
- ❑ Must cover evening and weekend so needed services can be authorized whenever needed



36

## Adequate Staff (Cont.)

- ❑ MCOs must quickly respond to the need for additional care management staff
- ❑ FC Counties had to keep hiring staff to keep up with enrollment
- ❑ MCOs should have independent hiring authority
- ❑ This may require education of county board and managers



37

## Training

- ❑ Recruiting is an ongoing process
- ❑ Training needs to occur on an ongoing basis
- ❑ Having a well organized and comprehensive orientation and training plan for new staff is critical
- ❑ Systems to keep staff informed also need to be in place



38

## Training (Cont.)

- ❑ Over time best practices and policies evolve
- ❑ Care managers have needed training and support to deal with unexpected situations
  - *AODA and/or Mental Health Example*

<http://dhfs.wisconsin.gov/WIpartnership/pdf-wpp/2004%20Findings.pdf>



---

39

## Utilization Review

- ❑ Managed care relies on accurate, up to date information to analyze and base decisions on
- ❑ IDTs cannot control quality and cost unless they have good information about:
  - What services they are authorizing
  - How effective specific services have been
  - The bottom line of the MCO



---

40

## Utilization Review (Cont.)

- ❑ Decisions about an individual care plan do not depend on how the MCO is doing financially
- ❑ IDTs need to be aware of trends in over or under utilization of any particular service
- ❑ IDTs need to understanding why that is occurring, and change practices if warranted



---

41

## Provider Network

- ❑ IDTs must have timely access to the services their members' need
- ❑ IDTs have vital role in monitoring quality of service providers
- ❑ There must be effective communication between IDTs and the provider network development function



---

42

## Provider Network (Cont.)

Network developers:

- ❑ Must be responsive to information from IDTs about what kinds of services members need
- ❑ Put cost-effective contracts in place
- ❑ Continually revisit contracts and renegotiate terms to increase performance



---

43

## Eligibility

- ❑ Care management teams have responsibilities for:
  - functional screens and
  - maintenance of eligibility and enrollment



---

44

## Functional Screen

- ❑ Information on the functional screen affects eligibility, rates, and quality
- ❑ IDTs need to make sure that screens are accurate and up-to-date
- ❑ MCO is responsible for implementing an effective local quality management system for functional screen accuracy and timeliness



## Eligibility and Enrollment

- ❑ Eligibility and enrollment are different things, eligible does not mean enrolled
- ❑ Financial and non-financial eligibility must be kept up-to-date - enrollment ends with the end of eligibility
- ❑ Enrollment follows eligibility but can be no earlier than the current date
- ❑ There is no capitation payment made for people not enrolled in the program



## Organizational Structure

- ❑ Care management and the provision of services and supports are the core functions of the MCO
- ❑ Administrative and business systems should be organized to support them rather than present barriers to them



---

47

## Webcasts

- ❑ Care Management, Part 2  
Tuesday, May 23
- ❑ Quality Management  
June
- ❑ Suggestions for future briefing topics welcome, please contact Elizabeth Childers at: [ChildEA@dhfs.state.wi.us](mailto:ChildEA@dhfs.state.wi.us)



---

48

## Listserv

- ❑ A listserv for planning grantees and other members of the public interested in managed long-term care expansion has been deployed
- ❑ Sign up for the listserv at this website:  
<http://dhfs.wisconsin.gov/lc/lcare/rfi/Listserv.htm>



## Future Questions

- ❑ If questions arise as you are viewing the recording of this presentation, please submit them to Elizabeth Childers at:  
[ChildEA@dhfs.state.wi.us](mailto:ChildEA@dhfs.state.wi.us)

