

CM Manage Case

Manage Case		
Item	Details	VA "As-Is" Details
Description	<p>The Care Management Manage Case business process uses State-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as:</p> <ul style="list-style-type: none"> ■ Medicaid Waiver program case management ■ Home and Community-Based Services ■ Other agency programs ■ Disease management ■ Catastrophic cases ■ Early Periodic Screening, Diagnosis, and Treatment (EPSDT) <p>These are individuals whose cases and treatment plans have been established in the Establish Case business process.</p> <p>It includes activities to confirm delivery of services and compliance with the plan. Also includes activities such as:</p> <ul style="list-style-type: none"> ■ Service planning and coordination ■ Brokering of services (finding providers, establishing limits or maximums, etc.) ■ Facilitating/Advocating for the member ■ Monitoring and reassessment of services for need and cost effectiveness. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs. 	<p>As part of the description DMAS notes that it, also provides direct oversight for Development Disabilities waiver and Tech waiver members.</p> <p>For Medicaid Waiver Program, DMAS notes that some waivers do not have case management.</p> <p>As a case that may also be established and managed DMAS includes among others: Maternal Infant Child Coordination, Family Planning Waiver, Managed Care, Client Medical Management and, Fraud and abuse.</p>
Trigger Event	<ol style="list-style-type: none"> 1. Scheduled time to review case 2. Receipt of information regarding services delivered/not delivered(including claims information) 3. Receipt of benefit/policy changes that may affect a treatment plan 4. Receipt of information regarding an enrollment change, including disenrollment 5. Receipt of information regarding change in member's conditions or situation 	<ol style="list-style-type: none"> 1. DMAS also includes annual renewals of eligibility as a scheduled trigger event. 2. DMAS also includes among other specific requests: appeals and grievances, fraud and abuse.
Result	<ul style="list-style-type: none"> ■ Case history is updated with revision to the following: <ul style="list-style-type: none"> ○ Changes to the case history ○ Needs assessment changes ○ Treatment Plan changes 	<p>DMAS notes that some needs assessment and treatment plan cases can be escalated to another level of review or to a higher or lower level of</p>

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	<ul style="list-style-type: none"> ○ Associated Providers List ○ Case file data (e.g., contact dates and times) ○ Content of communications to be sent to providers, members 	service. Additionally, results can include improved health and social outcomes.
Business Process Steps	<p>Start: Review case (review of the member's status and needs)</p> <p>Based on review, take follow-up action, as needed, to:</p> <ul style="list-style-type: none"> ■ ID services delivered, issues impeding delivery of service and/or member's progress: ■ Establish appointment with member to review case status ■ Contact provider(s) to review member's progress ■ Review services provided (claims payment information) ■ Close case for non-chronic conditions or change in member's status ■ Revise treatment plan to: <ul style="list-style-type: none"> ○ Add or remove services ○ Change nature of plan (e.g. shifting drug regimen, shifting from drug to behavioral) ○ Reassess needs ■ Revise expected results <p>Prepare communication data sets for the members and providers</p> <p>Verify that updates to appropriate data store have been made or make updates</p> <p>End: Send communications data sets to:</p> <ul style="list-style-type: none"> ■ Manage Member Communications ■ Manage Provider Communications 	<ol style="list-style-type: none"> 1. During intake for tech waiver, DMAS will participate in the assessment process.
Shared Data	<p>Member Information</p> <p>Provider Information</p> <p>Payment History Information</p> <p>Benefits/Reference</p> <p>Case History</p> <p>Assessment protocol</p> <p>Treatment Plan protocol</p> <p>Disease data store</p>	
Predecessor	<ul style="list-style-type: none"> ■ Establish Case ■ Enroll Member; Disenroll Member ■ Manage Payment Information 	
Successor	<ul style="list-style-type: none"> ■ Manage Member Communication 	

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	<ul style="list-style-type: none"> ■ Manage Provider Communication 	
Constraints	States and programs within states use different criteria to manage cases. Diseases included in Disease Management differ from state to state. States define and treat catastrophic cases differently. EPSDT case management is not required, but states may choose to have it to strengthen preventive measures.	Service availability and delivery systems differ and can impact treatment.
Failures	Information required to Manage Case is not available, or is inaccurate	
Performance Measures	Cases are updated within the timeframe specified by State policy Movement towards desired health care outcomes as a result of case management as a performance measure for the future.	DMAS does not have a uniform standard for assessing and measuring performance of all the target member populations impacted by the Manage Case business process. For each target group a different aspect of the program may be assessed and measured; for example, DMAS may monitor timeliness of managed care assignments and timeliness of re-assessment screenings for waiver recipients.