CHCS Center for Health Care Strategies, Inc.

Care Management Definition and Framework

A growing number of state Medicaid programs are expanding managed care programs for SSI-eligible adults. These states are challenged with determining how to effectively design, implement, and evaluate managed care programs to meet the complex needs of beneficiaries with disabilities. In response, the Center for Health Care Strategies (CHCS) developed the *Managed Care for People with Disabilities Purchasing Institute* (MCPD-PI) to enhance the capacity of Medicaid managed care programs to serve the SSI-eligible population.

A key component of the MCPD-PI was a care management workgroup. This group, facilitated by CHCS with participation from all MCPD-PI states (California, Indiana, Nevada, New York, Pennsylvania, and Washington), sought to answer the question: "What is care management?" The need for a clear definition was critical – each of the participating states expressed concern that they were purchasing an ill-defined care management product.

The workgroup developed a consensus definition of care management and prepared a tool – the Care Management Framework – that can be used by any state to design care management programs and to enhance consistency in state contracts and requests for proposals. The resulting definition and framework is designed to serve as a guide for state purchasers regarding "must have" care management components as well as a menu of care management tools and strategies from which to assemble an approach.

Care Management Definition

Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.[1]

Care Management Framework

The following framework (see other side) outlines and defines the key components of a comprehensive care management program and provides examples of tools and strategies that can be used by states in designing programs to effectively meet the needs of beneficiaries with complex and special needs.

About CHCS

The Center for Health Care Strategies (CHCS) is a national non-profit organization dedicated to improving the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities. CHCS works directly with states and federal agencies, health plans, and providers to design and implement cost-effective strategies to improve health care quality. For additional tools and more information, visit www.chcs.org.

[1] Adapted from: R. Mechanic. Will Care Management Improve the Value of U.S. Health Care? Background Paper for the 11th Annual Princeton Conference. Available at: http://sihp.brandeis.edu/council/pubs/Princeton%20XI/Rob%20Mechanic%20paper.pdf.

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Care Management Framework

Care Management Components	Definition	Tools / Strategies
Identification **Stratification** **Prioritization**	Identification, stratification, and prioritization should be used to identify consumers at the highest risk who offer the greatest potential for improvements in health outcomes. Programs should incorporate clinical and non-clinical sources of information to identify consumers who will most benefit from care management.	▪ Health risk assessments ▪ Predictive models (algorithm–driven model that uses multiple inputs to predict high-risk opportunities for care management) ▪ Surveys (e.g., Patient Health Questionnaire 9, Short Form 12) ▪ Case finding (e.g., chart reviews, surveys) ▪ Referrals (from member, provider, community)
Intervention	Interventions should be tailored to meet individual consumer need, respecting the role of the consumer to be a decision maker in the care planning process. Interventions should be designed to best serve the consumer, be multi-faceted, improve quality and cost effectiveness, and ensure coordination of care.	▪ Evidence-based practices ▪ Interactive care plan, developed based on consumer-set priorities ▪ Multidisciplinary care teams ▪ "Go to" person ▪ Medical home ▪ Physical/behavioral health integration ▪ Specialized patient engagement (e.g., self-management training)
Evaluation	Evaluation should include systematic measurement, testing, and analysis to ensure that tailored interventions improve quality, efficiency, and effectiveness. Careful and consistent evaluation will build the evidence base in terms of what works for complex and special need populations.	▪ Program evaluations ▪ Rapid-cycle micro experiments (e.g., continuous quality improvement, testing, and program adjustments) ▪ Representative measures of quality (e.g., HEDIS, CAHPS) ▪ Representative measures of cost (e.g., ROI calculations)
Payment/Financing	Payment/financing should be aligned to support improvements in care management by rewarding consumers and providers for participating in interventions/evaluations and establishing accountability for quality and cost.	▪ Pay for performance at multiple levels (e.g., health plan, provider, and consumer level) ▪ Share in program savings (gainsharing) ▪ Case management/medical home payments