ACC Phase III: Care Coordination Overview

Performance Measurement and Member Engagement

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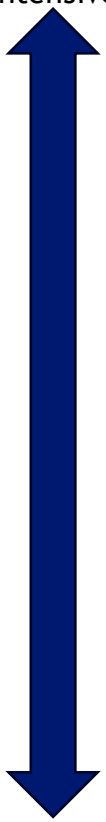
Care Coordination

- RAEs must create a program that supports the full continuum of care coordination for physical and behavioral health care, including:
  - Implementing a 3-tier model that allows for person-centered care and consistency across RAEs
  - Creating a care coordination policy guide for children and adults
  - Partnering with community-based organizations and other agencies serving members
  - Establishing requirements, specifically for members with complex needs and members going through transitions of care
- ⑩ RAEs will work with providers to support care coordination at the point-of-care where possible

Continuum of Care Coordination Program Activities

Least intensive



Most intensive

- General outreach and health promotion
- Support a network of community-based organizations
- Address health-related social needs
- Utilization of the social health information exchange and related systems
- Connect members with appropriate entities for enrollment in other state benefits (SNAP, WIC, etc.)
- Efforts to screen members for both short and long-term health needs
- Targeted outreach to promote preventive care
- Proactive outreach to members with diagnosed conditions
- Coordination of Transitions of Care from clinical settings
- Medication reconciliation for members in the Complex Health Management tier
- Complex case management and effective collaboration with multi-provider care teams

Care Coordination Tiers

Tier	Activities at a Minimum Must Include	Minimum Populations that Must Be in This Tier (RAEs have discretion to add more but not to remove)		
		Adults	Children	Both

Tier 3: Complex Health Management	• Comprehensive needs assessment
	• Comprehensive care plan
	• Minimum monthly coordination with member and treatment team
	• Long-term monitoring/support
		• Chronic Over-Utilization Program
		• Individuals involved in Complex Solutions Meetings
		• Deemed ITP in previous year
			• CANS Assessment indicating high needs
			• Individuals involved in Creative Solutions Meetings
			• Child welfare and foster care emancipation
				• 2+ uncontrolled physical and/or behavioral health conditions
				• Multi-system involvement (e.g., child welfare, juvenile justice)
				• Denied Private Duty Nursing
				• Utilization (in previous 6 months):
				  • 2+ Hospital Readmissions
				  • 30+ Days Inpatient
				  • 3+ Crisis Contacts
				  • 3+ ED Visits

Tier 2: Condition Management	• Assessment based on population/need • Condition-based care plan (may pull from a provider as appropriate) • Minimum quarterly meeting with member and treatment team • Condition management • Long-term monitoring/support	• Value-based payment identified conditions not already listed under "Both" category	• CANS Assessment indicating moderate needs • Obesity • Pervasive Developmental Disorder	• Diabetes • Asthma • Pregnancy (peri- & post-natal) • Substance Use Disorder • Depression/Anxiety
Tier 1: Prevention	• Brief needs screen • Short-term monitoring/support • Prevention outreach and education	• Adult preventative screenings	• Well child visits • Child immunizations	• Dental visits

Care Coordination Collaboration

- RAEs must partner with the following types of organizations for care coordination:
  - Community-Based Organizations (CBOs)
  - Case Management Agencies (CMAs)
  - Dual Special Needs Plans (D-SNPs)
  - Behavioral Health Administrative Service Organizations (BHASOs)
  - Foster Care
  - Emancipated Foster Care
  - Criminal/Juvenile Justice
- RAEs are encouraged to subcontract with Comprehensive Safety Net Providers to meet the care coordination needs of members with complex behavioral health needs

Transitions of Care

- Phase III includes additional focus on transitions of care (e.g. inpatient hospital review program, emergency department, mental health facilities, crisis systems, Creative Solutions/Complex Solutions).
- RAEs must help develop and meet additional requirements focused on transitions of care.
- RAEs must meet the following performance standards:
  - 30 day follow up for physical health inpatient stay.
  - 7 day follow up for behavioral health inpatient discharge.

Q&A

Thank you!

Appendix

Stakeholder Engagement Timeline