

# ACC PIAC Provider & Community Experience Subcommittee

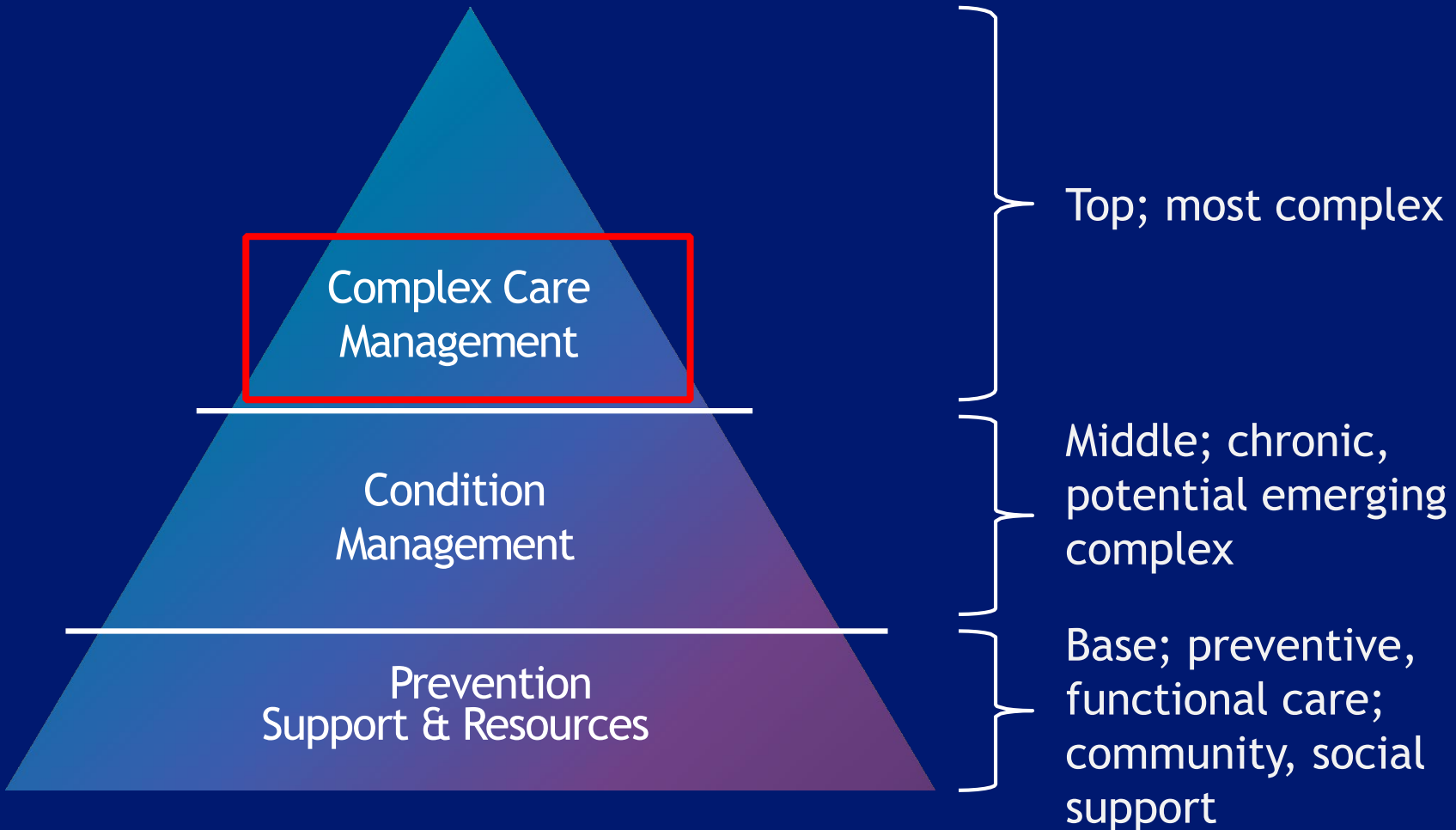
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# Statewide Approach to Addressing Member Health & Cost through Population Management



# Population Management Framework

- Targeted interventions for populations and conditions to improve health and reduce cost
- Management of 10 conditions based on prevalence, comorbidity and cost with specific focus on:
  - Maternity, Diabetes, Hypertension, Chronic Heart Failure, Asthma, COPD, Anxiety, Depression, Chronic Pain, and SUD
- **Complex Care Management:**
  - Higher level of services and extended care coordination efforts with members with complex care needs



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# Complex Care Management

Members who have more complex needs may require more intense levels of care coordination, also referred to as Extended Care Coordination. This is not the only intervention for members with complex care needs, but it is a core RAE function that can support members in achieving their physical health, behavioral health, and social needs.

Extended Care Coordination activities include a robust care plan adhering to best practices which are reflected in the RAE contract Section 11.3. RAEs are required to ensure care plans are regularly and sufficiently monitored and include the following:

- A lead care coordinator,
- Goals and outcomes,
- Be member and/or caregiver driven.
- Aligns with the Population Management Strategic Plan.
- Protects Member privacy.



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# Members with Complex Care Needs Definition

As of July 1, 2021, the Department defined members with complex care needs as those with annual costs of \$25,000 or higher. This definition did not include behavioral health utilization or costs from other systems. This definition was in effect until December 31, 2021.

On January 1, 2022, most RAEs transitioned to either their own definition of members with complex care needs (which was subject to Department approval) or to four or more chronic conditions for adults. Chronic conditions may include: asthma, COPD, hypertension, heart failure/cardiovascular disease, depression, SUD, anxiety, maternity, diabetes, or chronic pain. The Department retained the \$25,000 or higher criteria for pediatrics until a more robust definition is developed.



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# Complex Member Definition

## Purpose

Ensure the Accountable Care Collaborative effectively addresses the needs of high-risk, Complex Members by targeting resources to deliver better care for these members in a way that improves health and has the potential to reduce costs.



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# RAE Proposal Process

Last fall, most RAEs submitted to HCPF a request to use an alternative stratification methodology for defining members with complex care needs in their region that included, the following:

- RAE's overall strategy and how it aligns with the HCPF purpose of effectively addressing the needs of high-risk, members with complex care needs by targeting resources to deliver better care for these members in a way that improves health and has the potential to reduce costs
- Explanation of how members with complex care needs will be identified, including the specific criteria to be utilized.
- Explanation that their newly defined population of members with complex care needs meets the following criteria:
  - average per member per month cost of complex members must be at or above the 75th percentile of annual costs
  - population of members with complex care needs are impactable
  - RAE has the capability to provide a description of and data for priority subgroups -- two at a minimum with at least one adult and one pediatric as outlined below
  - size of the complex population must be at least as large as the complex definition defined by cost only but no more than five (5%) percent of the total RAE population.
  - RAE must be able to flag individual complex members

The Department reviewed the RAE proposal for alignment with the Department's goals and policies around managing Complex Members.



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# RAEs Complex Member Definitions



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