Medicaid Suspension
Module 3: Coordination of Care

Office of Medicaid Eligibility and Policy
Medicaid Eligibility and Community Support
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Washington State Health Care Authority

Topics

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- Coordination of Care Models
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Background

Background

Substitute Senate Bill 6430 directs the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) to raise awareness of best clinical practices to engage individuals with behavioral health disorders and other chronic conditions during periods of incarceration…

To meet the requirements of the bill HCA engaged stakeholders to determine:

- Behavioral health and care coordination best practices
- Identify funding opportunities
- Content of trainings and resources

Background

HCA created their own training and education workgroup with representation from:

- Managed Care Plans
- Behavioral Health Organizations
- Department of Corrections
- Washington Association of Sheriffs and Police Chiefs
- HCA and DSHS subject matter experts
- Association of counties

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What does it mean to Suspend?

Beginning July 2017 incarceration or commitment in a state hospital will not affect eligibility but will determine the scope of coverage.	
Coverage will not end but will be limited to inpatient hospitalizations lasting over 24 hours. This is called a suspended benefit package.	Upon release, full scope coverage is reinstated without the need for action by the individual.

Suspension Overview

The purpose of suspension is to provide continuity of care for recipients of Apple Health during periods of incarceration or commitments in a state hospital by:

- Suspending, not terminating, existing coverage
- Applying for health care coverage in suspended status
- Identifying and communicating behavioral health best practices to promote a smooth transition into the community

Coordination of Care Definition

Care Coordination

An individuals' healthcare needs are coordinated with the assistance of a Care Coordinator.

The Care Coordinator:

- Provides information to the individual and the individual's caregivers,
- Works with the individual to make ensure he/she receives the most appropriate treatment, while ensuring that health care is not duplicated.

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Care Coordinator

A health care professional or group of professionals, licensed in the state of Washington, who are responsible for providing Care Coordination services to individuals.

Care Coordinators may be:

- A Registered Nurse, Social Worker, Mental Health Professional or Chemical Dependency Professional employed by the Contractor or primary care provider or Behavioral Health agency; and/or
- Individuals or groups of licensed professionals, or paraprofessional individuals working under their licenses, located or coordinated by the primary care provider/clinic/Behavioral Health agency.

Coordination of Care Life Cycle

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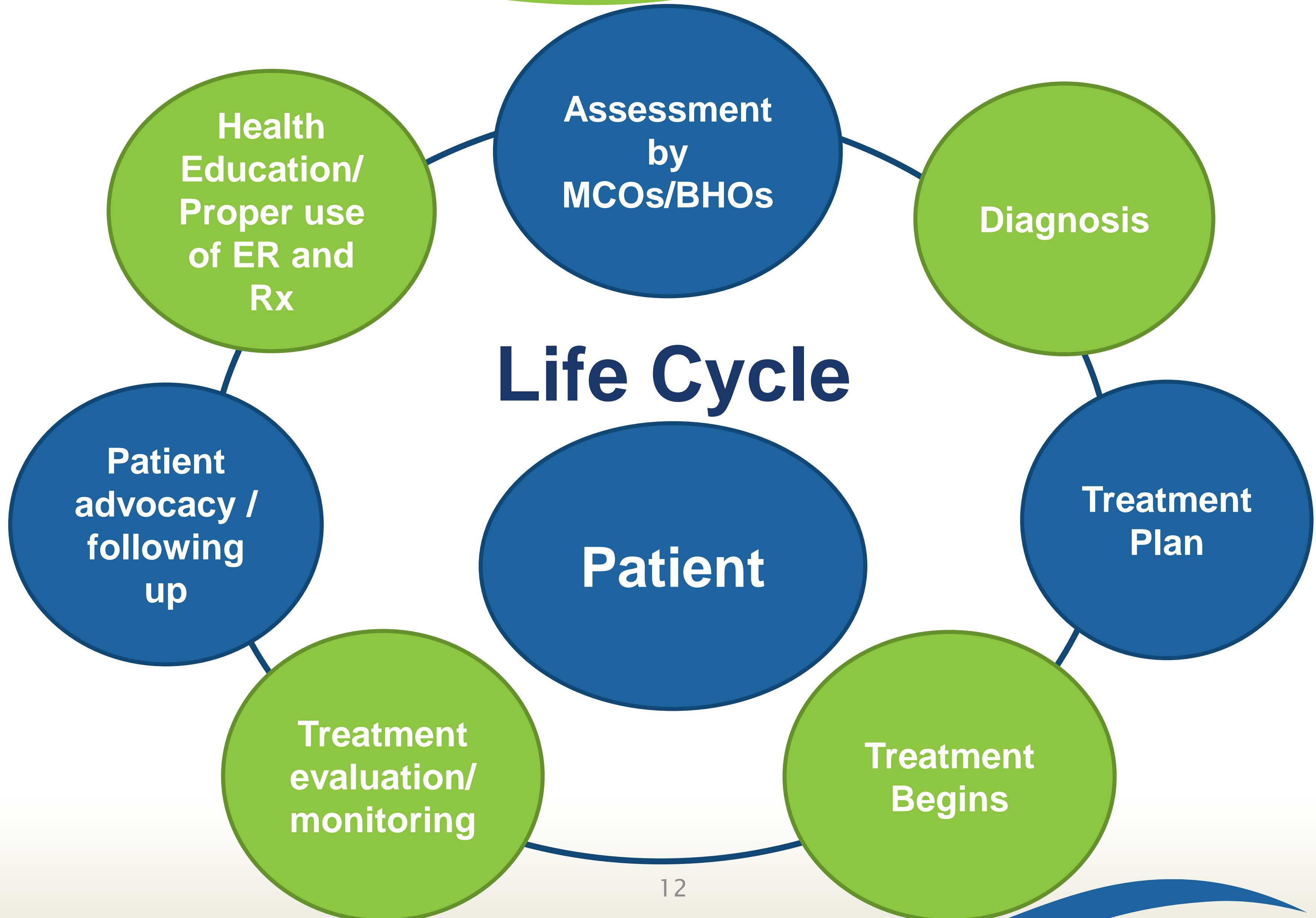

Coordination of Care Models

Coordination of Care Models

The following are some care coordination models for re-entry into the community:

- Patient Centered Medical Home
- Health Homes
- Coleman Model (Care Transitions)
- Peer Bridgers Program
- Community Health Workers
- The Pathway Hub Model
- Targeted Case Management (TCM)

Patient Centered Medical Home

A Patient Centered Medical Home (PCMH) is a care model that involves the coordinated care of individual's overall health care needs and where patients are actively involved in their health care. The following are components of a PCMH care delivery system:

Comprehensive Care

- Medical home practices bring together provider teams to meet the needs of their patients

Patient Centered

- Whole person care that reflects the needs, preferences, and goals of patients and families.

Patient Centered Medical Home

Coordinated Care

- PCMH coordinates with other health care providers in the community. This is especially helpful in a transition situation

Accessible Services

- shorter wait times, enhanced in-person hours, around the clock telephone and online access

Quality and Safety

- uses evidence-based treatments and clinical-decision-supports as an aid to shared decision making with patients and their families

For more information: https://pcmh.ahrq.gov/page/defining-pcmh

Health Homes

The Department of Social and Health Services and the Health Care Authority have collaborated on the Health Home Program with federal partners since 2013. Health homes have received strong support from individuals, local health care providers, and advocates.

The Health Home program helps clients:

- Develop a person-centered health action plan
- Improve self-management of chronic conditions
- Ensure care coordination and care transitions

Health Homes

A health home offers coordinated care to individuals with multiple chronic health conditions including mental health and substance use disorders. The Health Home program provides the following specific services:

- Comprehensive care management
- Coordination of care
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services

For more information: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

Coleman Model (Care Transitions)

The Coleman Model (Care Transitions) facilitates new behaviors, skills, and communication strategies for patients and families.

This model increases self-management skills and provides continuity across the transition assigning a care coordination coach who engages the patient.

Teaches individuals medication management skills and encourages them to be self-aware of their care needs and to ask more questions regarding their care.

Source: The Care Transitions Program

Coleman Model (Care Transitions)

The purpose of the Coleman Model (Care Transitions) is to:

- Assists patients and families with communication skills, and teach new behaviors to manage their recovery
- Increase self-management skills and provide continuity of care across transitions
- Teach individuals medication management skills and encourages them to be self-aware of their care needs and to ask more questions regarding their care.

Source: The Care Transitions Program

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Peer Bridgers Program

- Uses Certified Peer Support Specialist
- Bridgers are fully integrated within the clinical interdisciplinary teams
- Services are customized according to the individuals needs
- Currently being used in King County for psychiatric related releases

For more information: King County Peer Bridger Program

Community Health Workers

CHWs are dedicated individuals who have a trusting relationship with patients. They serve as liaisons between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. They are able to:

- Advocate for needs and perspectives of community members served
- Provide cultural link between organizations and communities.
- Help individuals get access to health and social services they need through case study, referral, and follow-up.
- Help community members increase health knowledge and be self-sufficient.

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Community Health Workers

Community Health Workers (CHWs) are frontline public health workers who apply their unique understanding of the experience, language, and culture of a particular population.

CHWs work in a variety of health and social service roles to connect individuals to community resources, do outreach work, and provide peer counseling, health education, case management, or other similar tasks.

For more information:
https://www.cdc.gov/stltpublichealth/chw/index.html

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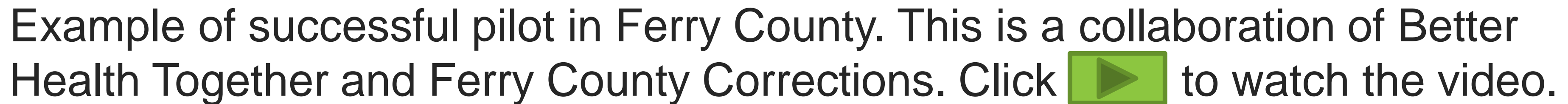
The Pathways Hub Model

Example of successful pilot in Ferry County. This is a collaboration of Better Health Together and Ferry County Corrections. Click  to watch the video.

Targeted Case Management

Targeted Case Management (TCM) refers to case management for specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas.

Providers are recognizing that a one-size-fits-all case management solution is outdated. Case managers are starting to think in terms of solutions that are specific to the needs of the individual they are serving.

For more information: https://info.nicic.gov/hrps/node/25

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Model Structure & Implementation

- Define the Care Coordination model and define core principles to be shared across the health system
- Provide coordination of medical and non-medical services
- Focus on improving transitions between care settings
- Tailor case management to those most at need

For more information: Cope Health Care Solutions

Looking Forward

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Where to Start?

How can Jails get started with limited resources?

- Consider a pilot or project to engage at risk inmates
- Start small – Prioritize your most needy population
- Connect with the Managed Care Organizations (MCOs) in your local area
- Engage providers and other community agencies who may have the same interest in care coordination
- Contact the HCA Medicaid Suspension team if you need assistance

Recommendations

The following are several recommendations that jails can do as part of the care coordination process:

- Gather health information at booking
  - Completion of an observation form is encouraged for handoff at booking
  - Mental health screening at intake
- In facility treatment for substance use disorders
- Jail pre-release planning for seriously mentally ill
- Use of long acting injectable psychotropics
- Medicaid screening and enrollment at booking

Recommendations

The following are several recommendations that MCOs can do as part of the care coordination process:

- Training for individuals on how to use primary care/behavior health services in place of emergency services and RX compliance.
- Use of Assisted Outpatient Treatment (AOT) and Medication Assisted Treatment (MAT)
- Recommend entering into BAA (Business Associate Agreement) for information sharing purposes
- Be responsive to jail's requests or inquires for Coordination of care

Resources

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Additional Resource Information

- **HCA Training & Education Resources**
http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/stakeholder-training-and-education
- **Volunteer Assister**
https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/community-based-training
- **Medicaid Suspension Webpage**
https://www.hca.wa.gov/about-hca/apple-health-medicaid/medicaid-suspension
- **Healthier Washington**
https://www.hca.wa.gov/about-hca/healthier-washington

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Contact Us

Do you have questions or would you like to get involved?

Visit the Medicaid Suspension **Webpage**

HCA Medicaid Suspension
Medicaidsuspension@hca.wa.gov