Instructional Sheet for Care Management Referral Form - ACO

BMC HealthNet Plan offers care management services to members with chronic and complex medical/ behavioral health conditions and identified socioeconomic barriers to assist members and their providers to manage their condition and follow the prescribed treatment plan. We partner with Beacon Health Strategies to offer integrated care management to those members with a dual diagnosis.

In an effort to better support our providers and members, BMC HealthNet Plan has instituted a Care Management Referral Form that providers may complete and fax directly to us when your office has determined that a member may benefit from the care management services we offer.

Care Management Services Offered

Population Management is an intermediate-level care management program with a focus on helping members develop self-management skills, arranging services and providing health education for members with specific medical, behavioral and social needs. In addition, Population Management interventions may include smoking cessation, diet and nutritional counseling, wellness and prevention, and others for the following targeted medical populations:

- Asthma
- Diabetes
- Depression/Behavioral Health/Substance Use Disorder
- Special Needs

Complex Care Management targets the most complex, highest risk members, including those with special health care needs for which a multidisciplinary approach is utilized, focusing on helping members develop self-management skills, arranging needed services and providing education to meet the varied health needs of this population.

Indications that a patient may benefit from a referral to Complex Care Management for **any medical condition** include but are not limited to:

- 2 or more hospitalizations in the past 6 months, or a hospitalization lasting > 7 days
- Multiple or repeated Emergency Department use
- 2 or more chronic conditions
- Diagnosis or suspected diagnosis of mental health disorder
- Active substance abuse (e.g. alcohol, opiates, cocaine, etc.)
- 5 or more medications or challenges with medication non-compliance
- 5 or more different outpatient providers/specialists
- Frequent missed or canceled appointments
- An illness or event that has caused a change or decline in ability to self- manage
- Barriers or difficulties in accessing services (e.g. language barrier, low health literacy, transportation, etc.)
- Lack of social supports
- Homelessness, poor or inadequate living environment

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Potential Indications for Behavioral Health Community Partner (BH Community Partner)*

- **One Diagnosis of :** SUD, Bi-Polar, Schizophrenia, Mood Disorder, Psychosis, Trauma, Suicidal/Homicidal, Depression, Adjustment Reaction, Anxiety, Psychosomatic /Conduct Disorder or PTSD, **and;**
- **One utilization of:** ESP interaction, Detox, Methadone, 3 + Inpatient Admits or 5+ ED visits in past 12 months, 3 medical co-morbidities, high LTSS utilization, current DMH enrollment

Potential Indications for Long Term Services and Supports Community Partner (LTSS Community Partner)*

- Individual currently enrolled in, or who may benefit from functional assistance of ADLs/IADLs through Long Term Services and Supports, or who need assistance identifying social service needs
- Individual with LTSS needs who experiences frequent ED visits, inpatient admissions, or SNF stays, and may need assistance coordinating functional needs and medical complexities, or transitioning from one level of service to another
- Individuals with brain injury, cognitive impairments, physical disabilities, or intellectual/development disabilities, older adults (up to age 64), and children or youth (ages 3-21) who may benefit from integrated, comprehensive care coordination for their complex LTSS needs

Note: some populations are excluded from participation in the CP Program, as their current Masshealth program already includes care management supports. Excluded populations include:

- DMH Program for Assertive Community Treatment (PACT)
- One Care
- Senior Care Options (SCO)
- Program for All-inclusive Care for the Elderly (PACE)
- Members not enrolled in an ACO/MCO (with exception of ACCS)
- BH CP Identified members (for those with LTSS needs – you can only be assigned to one CP type)

**** Please note that members with the above indications may be better served through other care management and community based services.***

How to Complete the Care Management Referral Form

Member Information

1. Include the member's most up to date demographic information.

Referring Provider Information

1. Include the referring provider's demographic information and NPI #.
2. Include any agency related involvement, if applicable.

Clinical Information

1. Indicate member's diagnosis.
2. Include any relevant clinical information.
3. Indicate reason for referral into the care management program.

Care Management Program

1. Please select the care management program that you are requesting for the member.

Once completed, please fax the Care Management Referral Form to 617-951-3426. If you have any questions about this form, please contact us at 888-566-0008.

BOSTON MEDICAL CENTER
HEALTHNet PLAN

Care Management Referral Form - ACO

FAX TO: 617-951-3426

Member Information

Member Name:_____DOB:_____BMCHP ID #: _____

Gender: _____ Home Phone: _____ Mobile Phone: _____

Address:_____

_____

Guardian: _____

Referring Provider Information

Referring Provider Name:_____NPI #:_____ ☐ PCP ☐ Specialist

Referring Provider/Group Name:_____/_____NPI #: _____

Individual's name and group name if affiliated with multiple groups

Referring Provider Phone #: _____ Fax #: _____

Agency Involvement:_____

_____

_____

Clinical Information – *Please provide the below information to support the referral*

Diagnosis:
Pertinent Clinical Information:
Reason for Referral to Care Management: *(i.e. Are there goals or outcomes that the member is trying to attain?)*:

Care Management Program - ACO

☐ Asthma	☐ Substance Use Disorder
☐ Behavioral/Psychiatric Health	☐ Social Care Management
☐ Special Health Care Needs	☐ BH Community Partner
☐ Diabetes	☐ LTSS Community Partner