Aetna Medicaid Integrated Care Management (ICM)
April 2016

The Aetna Medicaid Integrated Care Management (ICM) identifies and works with members using a biopsychosocial framework. We effectively engage our complex and vulnerable members to improve outcomes and to help them remain in the least restrictive and most integrated environment. This is done consistent with each individual's personal and cultural values, beliefs and preferences.

Basic framework of ICM:

- Members identified and stratified by predictive modeling using claims, chronic conditions and the impactability of each condition
- People with complex illnesses and comorbidities are less responsive to standard care and benefit from an individualized approach
- All assessments include medical, behavioral and social components and evidence based practices
- Psychosocial assessment is imbedded in chronic condition self-management (formerly "disease management"). Co-occurring medical and behavioral health problems are common in our most vulnerable members. Case managers are expected to asses for and address these needs, in addition to coordinating care and assisting providers.
- Standardized available programs include Neonatal Abstinence, Palliative Care and Community Health Workers

Fully Integrated Systems of Care:

- Model developed and launched in several Aetna Medicaid plans
- Framework for coordinated care of people with severe mental illness as well as for those with chronic and disabling physical conditions using a coordinated network of physical and behavioral healthcare providers as well as community-based organizations and Aetna Medicaid Medical Management (medical directors, case managers and utilization managers)
- Aetna Medicaid Integrated Care Management creates and supports an integrated system of care for each chronically ill member
- We have successfully deployed Integrated Health Homes coordinating behavioral and physical health care, member and family health education, and Community resources such as supported employment, peer support services, and trauma-informed care

How it works:
A 25 year old member with type 1 diabetes was hospitalized every 2 weeks with ketoacidosis. Hospital staff referred her for diabetes education. Aetna's case manager, using a whole-person approach, identified that she was well-educated about diabetes but had the following issues:

- Living with her baby at her grandparents
- 2 children in State custody
- Assessments revealed active substance abuse (alcohol) and a likely undiagnosed BH disorder

The case manager facilitated BH referral through her PCP and bipolar disorder was diagnosed and treated; member also accepted substance abuse treatment. Results:

- Diabetes control stabilized with no hospitalizations in the next 6 months
- Case manager assisted with housing
- Member was able to begin reunification with her 2 older children