Making Connections:
Strengthening Care Coordination in the Medicaid Benefit for Children & Adolescents

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

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Table of Contents

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Introducing Care Coordination Strategies for States

This guide offers strategies to strengthen care coordination in order to increase the effective use of the comprehensive array of preventive, diagnostic, and treatment services covered by Medicaid under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit – also referred to as the Medicaid benefit for children and adolescents – and services covered in separate state CHIP programs. A variety of examples are showcased, along with numerous resources that we hope states will find useful. We acknowledge that care coordination is a dynamic field and many innovations are currently in development or testing. The purpose of this guide is to offer proven strategies that state Medicaid and CHIP agencies can adopt or adapt. The four strategies presented in this guide were selected because they have been implemented by multiple states and have produced outcomes demonstrating the value of improved care coordination.

The Facts: Why Care Coordination is Important

Care coordination provides a bridge across multiple systems that serve children and families, for example, health care providers, schools, Head Start, and community-based organizations. It helps to ensure, directly with the family or indirectly, that a child receives additional screening, diagnosis and/or treatment as recommended by a health care practitioner. This includes arranging for appointments, referral forms, transportation, reminders and follow-up, and feedback reporting, as appropriate. Successful care coordination for children requires effective communication among providers, patients and families across the health system, and also among the multiple systems that serve children.

State Medicaid programs have long pursued greater coordination and integration of care in order to improve quality and contain costs. In the 1990's, pursuit of these goals led many states to transition from fee-for-service delivery systems to Medicaid managed care—today more than 70% of Medicaid beneficiaries receive their care through some form of managed care arrangement. In federal fiscal year 2012, 78% of the 44 million children in Medicaid or CHIP were enrolled in a managed care or primary care case management (PCCM) delivery system. (Data extracted from CMS 2012 Statistical Enrollment Data System (SEDS)).

More recently, states have been working to develop new delivery system models that increase integration of services and coordination. As of April 2014, at least 18 states were seeking to increase integration of services (and thus care coordination) by implementing accountable care models, for Medicaid and/or CHIP enrollees. Thirteen of these states include children among the populations served. Also, as of April 2014, at least 18 states were making payments to patient-centered medical home programs that serve children as well as adults. Additionally, as of July 2014, at least 16 states had approved Affordable Care Act (ACA) section 2703 Health Home State Plan Amendments and an additional 12 states are receiving additional federal funding to support states in planning their health home state plan amendments (SPAs). All of these models of integrated care delivery systems have care coordination as a central tenet of service delivery. Early results of some of these models are showing improvements in certain quality of care measures and an ability to produce cost savings, while metrics on outcomes are still being evaluated.

Delivery systems for children deserve focused attention because of the differences between children and adults. These differences include demography (higher rates of ethnic diversity, higher poverty rates, and greater disparities in care); continuous physical, social-emotional and cognitive development; dependence on adults; and other different needs, conditions, and services.

In light of these trends in a rapidly changing health care system, and with demonstration funds available from the ACA for integrated models that include care coordination, now is an opportune time for states to strengthen care coordination for children through their Medicaid and CHIP programs. This is particularly true for children with special health care needs. New resources are available, such as advances in information technology that support better coordination by improving the flow of information among the systems and providers that serve children. The Department of Health and Human Services (HHS) has established care coordination as a priority and is dedicating resources to this effort, including grant funding, policy guidance, and technical assistance.

Care coordination provides a bridge across multiple systems that serve children and families.

Care Coordination Defined

In research and in practice, the term care coordination (like case management and care management) is used to describe a range of activities that more holistically link individuals and families to services. The treatment of children, especially young children, is almost always conducted in the context of the family. Care coordination, then, is about helping to connect a child to services while assisting the family in providing for the child's care. Care coordination improves the communication flow among all: health care practitioners, patients, systems, and agencies. For families, it can ease the process of receiving services by helping to manage the care of the child, reducing duplication of effort, easing transitions and limiting gaps between service providers. For some families, a care coordinator may assist in securing health coverage, transportation or other support/enabling services.

There is no single, widely accepted, definition of care coordination. However, there are similarities among the definitions. Below are three key concepts that appear in many definitions:

1. *Comprehensive*: All services a child receives, including services delivered by systems other than the health system, are to be coordinated.
2. *Patient-centered*: Care coordination is intended to meet the needs of the child and the family, both developmentally and in addressing chronic conditions.
3. *Access and Follow-up*: Care coordination is intended not only to connect children and their families to services, but also to ensure that services are delivered appropriately and that information flows among care providers and back to the primary care provider.

Care Coordination in Medicaid

There are multiple authorities in Medicaid under which states can claim Federal Financial Participation for care coordination. Federal authorities under which states implement care coordination are outlined in the next section. Although Medicaid regulations do not define "care coordination," and care coordination is not a section 1905(a) service, case management **is** a 1905(a) service in Medicaid that has a meaning very similar to care coordination, and is defined as:

- *Case management services means services furnished to assist individuals eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 CFR §441.18. (42 CFR §440.169(a))*

A more detailed description of federal expectations for case management is included in the description of the targeted case management benefit under which state Medicaid agencies can offer certain services to individuals in defined locations within the state or to those who belong to groups specified by the state. Specifically, federal regulations at 42 CFR §440.169(b) define targeted case management services to include the following four components:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services.
2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment.
3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services.
4. Monitoring and follow up activities.

Performance expectations relevant to care coordination are embedded in different sections of Medicaid program standards, such as those governing Primary Care Case Management (PCCM) programs and Health Homes for Medicaid beneficiaries with chronic conditions. According to section 1905(t)(1) of the Social Security Act (the Act), the term "primary care case management services" means care management related services (including locating, coordinating, and monitoring of health care services) provided by a case manager under a primary care case management contract. Similarly, ACA section 2703 created an optional Medicaid state plan benefit for states to establish Health Homes to coordinate care for people with chronic conditions. Health Home services include comprehensive care management, care coordination, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services. Medicaid managed care entities are required by regulation to coordinate health care services for each of their enrollees, and to designate a person or entity to be primarily responsible for this coordination.

The Centers for Medicare & Medicaid Services (CMS) is also fostering improved care coordination through a number of initiatives such as Quality Demonstration Grants authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the State Innovations Model initiative authorized under ACA section 3021. These initiatives are outlined in Appendix A – Federal Support for Care Coordination.

Finally, CMS is fostering care coordination through measurement – an important part of any improvement effort. Measurement is not only needed to assess overall success, but also to identify specific areas for improvement within a broader issue. CMS has adopted several measures that can be used to assess the effectiveness of care coordination. The 2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) includes several measures related to changes in health outcomes that indicate care coordination is having an effect. One (reported) example from North Carolina's Medicaid program attributes a reduction in asthma-related emergency room visits by children to care coordination.

There are efforts occurring, both inside and outside of Medicaid, including in the private sector, that are designed to improve care coordination for children and their families, people with chronic conditions, and others. States, payers, provider associations, and non-profit organizations, among others, have led and contributed to these efforts. Where possible, aligning care coordination efforts can strengthen state Medicaid agencies' abilities to improve care.

Federal Authorities to Reform State Medicaid Delivery Systems

Strengthening care coordination inherently means changing the way services are delivered. Identified here are the major avenues through which states can obtain CMS approval to change the delivery system. This brief summary of federal authorities that enable delivery system reform provides a starting point for understanding what types of changes are possible.

There are multiple authorities in Medicaid under which states can claim Federal Financial Participation for care coordination.

State Plan Amendments

The state plan is the contract between the state and federal government that specifies and describes, among other things, how the state will operate its Medicaid program. Once a SPA is approved, it does not need to be renewed. Nor do states need to demonstrate budget neutrality.

- **Targeted Case Management State Plan Amendment.** Enables states to provide *case management services* as defined in 42 CFR §440.169 to assist Medicaid beneficiaries who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. Under this authority states do not need to comply with federal requirements for comparability of services and statewideness (as defined in section 1902(a)(1) of the Act), enabling them to limit the services to an area within the state and defined subgroups of Medicaid beneficiaries (the targeted population). States **do** need to comply with the freedom of choice requirement. However, if the target group consists of individuals with developmental disabilities or chronic mental illness, the state may limit providers to qualified Medicaid providers of case management capable of ensuring needed services to this specific population.
- **ACA Section 2703 Health Home State Plan Amendment.** Enables states to implement Health Homes for Medicaid beneficiaries with chronic conditions. Health Homes are intended to integrate primary care, behavioral health, and long-term services and supports. Health Home services include: comprehensive care management, *care coordination*, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services.

- **Section 1932(a) of the Act State Plan Amendment.** Enables states to establish voluntary and mandatory managed care programs, including both PCCMs and managed care organizations. Under this authority states do not need to comply with federal requirements for comparability of services, freedom of choice, and statewideness (as defined in section 1902(a)(1) of the Act). This authority does not allow states to require dual eligibles (people eligible for both Medicaid and Medicare), American Indians or children with special health care needs to enroll into managed care. It does allow states to offer voluntary enrollment to these groups.
  - **Primary Care Case Management (PCCM) Contract.** Section 1905(a)(25) of the Act enables states to use existing PCCM contracts to reward quality. It also limits providers eligible to offer services through a contract and allows states the ability to incentivize quality and share savings. Providers are offered a capitation amount for *care coordination* activities.
- **Integrated Care Model State Plan Amendment.** Section 1905(a)(25) authorizes primary case management services, as defined in 1905(t)(1), which enables states to offer *coordinating*, locating and monitoring activities, and create incentive payments for providers who demonstrate improved performance on quality and cost measures under the Medicaid state plan. Under this authority states may not restrict freedom of choice, and must comply with federal statewideness and comparability of services requirements. Care managers could coordinate a full range of services beyond primary care to include integration of primary, acute, and behavioral health care, as well as long-term services and supports.

State Contracting Authority

Under section 1915(a) of the Act, a state enters into a voluntary contract with an entity to provide state plan services. This authority provides a vehicle for *voluntary* enrollment into capitated managed care. States have flexibility in contract design on section 1902(a)(1) requirements of state-wideness, comparability, and freedom of choice. Section 1915(a) of the Act offers a Medicaid managed care authority independently of or concurrently with a section 1915(c) waiver to implement a managed care delivery system.

Waivers

Waivers can be used to change the delivery system and incorporate care coordination into service delivery. Waivers are approved for a specific time period and must be renewed at the end of that time in order to continue the program. Waivers must be budget neutral—meaning that the total cost to the federal government under the waiver may not exceed the amount the federal government would have spent absent the waiver.

These Medicaid waivers can incorporate care coordination for children served by the waiver:

- **Section 1915(b) of the Act – Freedom of Choice Waiver.** States may request waiver of federal requirements on freedom of choice, comparability of services, and statewideness. This enables states to establish Medicaid managed care or selective contracting programs that could be limited to a geographic area within the state or to subgroups of Medicaid beneficiaries. Under this authority states can require all Medicaid beneficiaries (including dual eligibles, American Indians, or children with special health care needs) to enroll in managed care and/or PCCM programs. These waivers are granted for periods up to five years if they provide for dual eligibles. Most waivers are approved for two years.
- **Section 1915(c) of the Act – Home and Community-Based Waiver.** States may request a waiver to provide long-term care services and supports in community settings to beneficiaries who would otherwise need to receive care in an institution. These services can include *case management and care coordination*. States may not restrict freedom of choice under this waiver but may request waivers of comparability of services and statewideness, enabling them to limit the services to an area within the state and to subgroups of Medicaid beneficiaries. They may also limit participation to a specific number of beneficiaries. Initial waivers are granted for periods of three or five years and renewals for five years. (States may combine this type of waiver with a section 1915(b) waiver to waive freedom of choice.)
- **Section 1115(a) of the Act – Research and Demonstration Waiver.** States may request waivers of most federal requirements to enable them to implement policies that promote the objectives of Medicaid and CHIP programs. States can expand eligibility, provide services not otherwise covered by Medicaid, and implement innovative reforms to their Medicaid programs. They may limit the innovations to an area within the state and subgroups of Medicaid beneficiaries. These waivers are granted initially for five years, with three-year renewal periods.

Strategies to Strengthen Care Coordination

State Medicaid agencies have used a wide variety of strategies to provide care coordination for children and adolescents. While some of these approaches require federal approval of specific authorities described in the prior section, others can be implemented without a state plan or waiver amendment. Some states have developed new delivery system models that better coordinate care, while others have worked to improve care coordination within their existing models. This guide examines approaches that state Medicaid agencies have used to strengthen care coordination and that have demonstrated improved outcomes for children. These are examples of strategies and not intended to suggest they are the exclusive ways in which State Medicaid agencies can provide care coordination for children under the Medicaid and CHIP programs.

Strategy 1 **Build care coordination into provider standards for medical homes.** Care coordination for children can be built into patient-centered medical home programs. Most states with Medicaid medical home programs require or encourage providers to obtain recognition from a national accrediting body, such as the National Committee for Quality Assurance; other states administer their own recognition programs. States have the opportunity to incorporate care coordination into provider standards in both approaches.

Strategy 2 **Support primary care providers with care coordination entities.** Some states have created entities that support primary care by providing care coordination (and other) services. These entities include community health teams and networks, which often have dedicated care coordinators on staff to link families and provider practices to services that support children's health.

Strategy 3 **Build care coordination requirements into contracts with managed care organizations**. States with Medicaid managed care delivery systems can include language to strengthen and promote care coordination in their managed care contracts. States using this strategy must also be able to monitor performance of the system to ensure compliance with the contract.

Strategy 4 **Implement a multi-faceted intervention to improve coordination across systems.** State Medicaid agencies can implement multi-faceted interventions to address specific barriers to coordination between medical and other systems serving children. To implement a multi-faceted intervention, states can develop and promote tools to support providers in communicating and coordinating care, build mechanisms to monitor care coordination, and offer technical assistance to primary care practices. States can also measure the impact of the intervention in order to evaluate its effectiveness.

STRATEGY 1: Build Care Coordination into Provider Standards for Medical Homes

In the past few years, many states have worked to improve Medicaid delivery systems, including implementing patient-centered medical homes (PCMH). The PCMH is an approach to the delivery of primary care that is patient-centered, comprehensive, coordinated, accessible, and committed to quality and safety. The PCMH offers states a lever with which to improve care coordination for children.

According to a study conducted by the National Academy for State Health Policy (NASHP), between 2007 and 2013, 27 states implemented PCMH programs, under which enhanced payment is aligned with national or state-developed qualification standards. Most states require provider practices to obtain PCMH recognition from a national accrediting body, such as the National Committee for Quality Assurance (NCQA), while others administer their own recognition program. These standards are designed to emphasize the patient-centeredness of the PCMH, reinforce incentives for best practices in technology, and focus attention on aspects of primary care that improve quality and reduce cost. The standards are based on advances in evidence and changes in practice capability. Care coordination can be used to accomplish many of these standards and is a part of many recognition programs. For example several of the NCQA standards are directly related to care coordination, specifically Standard 5: Track and Coordinate Care.

Some accreditation or recognition programs incorporate different tiers or levels of accreditation; as a practice achieves additional standards, it can ascend to a higher tier, which can in turn impact the level of reimbursement or medical home payment it receives. For example, in NCQA's 2011 Standard 5: Track and Coordinate Care, the only "must pass element" for level 1 recognition requires referral tracking and follow-up. Practices seeking to be recognized at levels 2 or level 3 PCMH can also earn more points if they track laboratory tests and follow up, or coordinate with facilities/care transitions to receive a higher score. PCMH patient experience is also recognized in this process, as several of the standards are related to enhancing access and continuity of care.

The PCMH should not be confused with another promising strategy that can be used to provide care coordination: the Health Home. As mentioned earlier, the ACA created Health Homes for Medicaid beneficiaries with chronic conditions, which includes care coordination as a core service. Health Home providers in this context integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. A state is eligible for eight fiscal quarters of a 90% enhanced federal match for specific Heath Home services identified in section 2703 of the ACA that are provided to an individual with chronic conditions.

Health Homes differ from the PCMH in important ways. For example, a PCMH is intended to transform the way a practice delivers primary care to all its patients, while Health Homes are intended to transform the way care is delivered to a subset of high-need patients. A Health Home can exist within a PCMH, in another health care delivery model, or in a freestanding facility.

While the Health Home provision is specific to serving individuals with chronic conditions, states have designed their Health Homes to build on the expertise and experience of their existing PCMH initiatives. Some states have broadly focused their Health Home state plan benefit to advance practice transformation. States have indicated that Health Homes have strengthened the state's overall primary care delivery system, driving transformation toward an integrated service delivery system. State examples of Health Homes are not included in this guide because the model is too new to have produced reported outcomes, but CMS will provide future updates as experience with implementing Health Homes grows.

Patient-centered medical homes transform the way a practice delivers primary care to all of its patients.

Examples of Effective Care Coordination in Medicaid Patient-Centered Medical Homes

In 2007, **Colorado** enacted legislation calling for medical homes for all children enrolled in Medicaid and CHIP programs. The initiative, which has since been replaced by the more comprehensive Colorado Accountable Care Collaborative model, was led by the Colorado Department of Health Care Policy and Financing (the state Medicaid agency), and was implemented in July 2008. Colorado identified care coordination as a vital part of the medical home and aspects of care coordination are included in several of the 11 standards that medical homes for children had to meet. The standards required that the medical home take primary responsibility for care coordination, that there is a system in place for children and families to obtain information about and referrals for community and non-medical services, that the provider and staff communicate in a way that is family-centered, and that the child/family has a personal provider on the team familiar with the child's health history. Payment for care coordination was built into fee-for-service payment rates to providers under a section 1932(a) SPA. The program paid primary care practitioners (PCPs) an enhanced rate for all EPSDT visits. This rate was calculated to be approximately the equivalent of a $3.00 per member per month (PMPM) amount.

The program also included staff that supported providers by providing links to community services, as well as practice coaching for quality improvement initiatives, and assistance with medical home certification. A case study of the Colorado program found reduced costs for several non-ER medical services, and reduced emergency room utilization.

The patient-centered medical home coordinates care across all elements of the broader health care system.

In 2010, **Minnesota** received approval to amend its Medicaid state plan to allow the state to implement its health care homes program. (Minnesota calls its PCMHs *health care homes*, not to be confused with the ACA's Health Homes for Chronic Conditions.) This SPA allows the Medicaid program to make payments to providers who meet the standards to be recognized as health care homes for Medicaid beneficiaries (including children) with one or more major chronic conditions. Payments range from $10.14 PMPM for a patient with one major chronic condition, to $45.00 PMPM for a patient with ten or more chronic conditions. To be recognized as a health care home in Minnesota, medical providers need to meet the standards specified in the state plan. These standards define care coordination to mean, "a team approach that engages the participant, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the participant's well-being by organizing timely access to resources and necessary care that results in continuity of care and builds trust." The standards include several care coordination requirements of particular benefit to children, such as requirements to coordinate with schools, and to "engage participants in planning for transitions among providers and between life stages, such as the transition from childhood to adulthood."

Minnesota's health care homes program places a strong emphasis on evaluation and performance measurement. Early results indicate that the program is having a positive effect. Practices participating in the program received higher patient experience ratings than the state average. This is true particularly for the categories, "Getting Care When Needed," and "How Well Doctors Communicate," two areas directly related to effective care coordination. Several other states have implemented these programs under other authorities and are producing promising early results.

STRATEGY 2: Support Primary Care Providers Through Care Coordination Entities

Some states have created community health teams and networks to augment the care coordination provided by advanced primary care providers (defined as those providers who meet the state's standards for a PCCM provider, medical home, or ACA section 2703 Health Homes for Chronic Conditions). Community Health Teams – also called Community Care Teams, Networks, or Pods in some states – are comprised of multidisciplinary staff, typically from the fields of nursing, behavioral health, pharmacy, and social work. These entities often have dedicated care coordinators on staff. Teams emphasize in-person contact with patients, and link families and provider practices to services such as community resources in order to integrate primary care and support children's health goals.

Examples of Effective Relationships: Care Coordination Entities Supporting Primary Care Providers

Vermont established regional Community Health Teams (CHTs) as part of its Vermont *Blueprint for Health*, which was created as part of a Medicaid section 1115 demonstration waiver to integrate a system of health care for patients, improve the overall health of Vermont's population (including both Medicaid and commercially-insured populations), and improve control over health care costs by promoting health maintenance, prevention and care coordination, and management. Each CHT employs the equivalent of five full time staff members at an annual cost of $350,000. The CHTs are considered a core resource and in order to operate in Vermont, an insurance plan must agree to share in the cost of the CHTs. In fact, all five payers in the state (Medicaid, Medicare, and three commercial plans) share the costs. Primary care practices participating in the Blueprint receive fee-for-service payments and a PMPM payment based on their NCQA certification score. The CHTs provide community-based support services and multi-disciplinary care (supporting the areas of behavioral health, social work, pharmacy, etc.). Analysis of the initial pilot program found that there were significant decreases in hospital admissions and emergency department visits in the regions in which the CHTs operated. At the different pilot sites where the CHTs were installed, inpatient use and per person per month costs decreased by over 20%, and emergency department use declined 31%. Overall use and cost per person dropped significantly as well.

In addition to studies evaluating the CHTs, studies comparing patients participating in Vermont's Blueprint for Health program with those not participating have shown favorable trends. These include healthcare expenditures, acute episodic care, and effective and preventive care. Vermont notes in its annual program report that for both commercial and Medicaid populations served by the Blueprint there are favorable trends (with trend lines either plateauing or decreasing) for annual healthcare expenditures per capita and for the rate of inpatient discharges.

Some states have community health teams or networks that have dedicated care coordinators who link families and providers to support services.

North Carolina developed Community Care of North Carolina (CCNC), building on the PCCM program established by the state's Medicaid program in 1989. The program is currently operated under a 1932(a) SPA and a 2703 Health Homes for Chronic Conditions SPA to treat Medicaid enrollees with two qualifying conditions, or one qualifying condition and at risk for a second. The program consists of 14 regional networks. Each network includes physicians, nurses, pharmacists, hospitals, health departments, social service agencies, and other community organizations. These groups work together to provide care coordination services for their patients, including children. The primary form of care coordination provided by the networks is population management support to practices, which includes: customized reports, patient assessment, care planning, and medication management. Additionally, CCNC has case managers present in all 100 counties in the state. These case managers also use the CCNC Informatics Center to provide data that can be used to help coordinate care. The Medicaid program makes fee-for-service payments to the providers in the networks for the services they deliver to enrollees. In addition, both the primary care providers and the networks receive PMPM payments to pay for care coordination services. CCNC payment examples:

- The networks receive $13.72 PMPM for the Aged, Blind, and Disabled (ABD) population, and $3.72 for the non-ABD population.
- Primary care providers receive a $5.00 PMPM for the ABD population, and $2.50 PMPM for the non-ABD population.

CCNC has produced outcomes that indicate effective care coordination:

- CCNC saved nearly $1.5 billion in health care costs from 2007 to 2009.
- CCNC made an impact on specific diseases, including asthma, which was the primary reason for hospital and emergency room visits for children. In 1998, NC Medicaid spent $23 million on asthma related care. CCNC implemented an Asthma Disease Management Program, and achieved improvement in all three of its performance measures (continued care visit with assessment of symptoms, assessment of triggers, and action plan) from 2009 to 2010.

STRATEGY 3: Build Care Coordination Requirements into Managed Care Contracts

Managed care is the dominant delivery system in Medicaid – more than 70 percent of beneficiaries receive their care through some form of managed care. As of July 2011, 35 state Medicaid agencies, the District of Columbia, and Puerto Rico contracted with managed care organizations to deliver a comprehensive package of benefits to over 29 million Medicaid beneficiaries (51% of over 57 million Medicaid beneficiaries). An even higher percentage of children enrolled in Medicaid or CHIP – 78% of 44 million children – were enrolled in managed care and PCCM delivery systems, in federal fiscal year 2012 (Data extracted from CMS 2012 Statistical Enrollment Data System (SEDS). While federal managed care regulations at 42 CFR §438.208 require managed care entities to provide care coordination for each enrollee, state contracts with managed care plans can stipulate robust performance expectations to strengthen care coordination, with a strong state performance monitoring system to ensure compliance with the contract. CMS is offering technical assistance to states to help craft contract language, monitor managed care performance, and address any identified deficiencies.

Managed care contracts can define performance expectations to strengthen care coordination and compel performance monitoring.

New Mexico enrolls the majority of its Medicaid beneficiaries (including children) into a comprehensive managed care plan under a section 1115 demonstration waiver. Now named Centennial Care, it was, until recently known as Salud!, a 1915(b) waiver program. New Mexico's managed care contracts identify primary care responsibilities that align with the principles of the patient-centered medical home and specifically note that: "The PCP [primary care provider] shall ensure coordination and continuity of care with providers who participate with the CONTRACTOR network and with providers outside of the CONTRACTOR network according to the CONTRACTOR policy." Examples of external services for which the managed care organizations must contract with appropriate providers, include school-based services, behavioral health services, home and community-based waiver programs, special rehabilitation, Children's Medical Services, the Family, Infant and Toddler Program, Protective Services, Juvenile Justice Divisions, and the Medicaid School-Based Services Program.

An independent study of Salud! (prior to it becoming Centennial Care) found positive results in the four managed care plans operating in New Mexico. For example, all four managed care plans achieved maximum performance measurement scores (New Mexico scores its managed care plans by assigning a numeric value to several different performance criteria, such as in several HEDIS measures, including: annual preventive dental visits for children (ages 2-21), well child visits for children (first 15 months; 3-6 years), children and adolescents' access to PCPs, childhood immunizations, use of appropriate medications for people with asthma (ages 5-9 and 10-17 years), breast cancer screening, and diabetes disease management (HbA1C testing)).

It is intended that the 54 school-based health centers across New Mexico that are part of the managed care network will play a larger role in the coordinated care of their patients, as a result of the care coordination requirements in the newly launched Centennial Care. These centers are credentialed with Medicaid and bill for services provided to Medicaid eligible patients.

STRATEGY 4: Implement a Multi-faceted Intervention to Improve Coordination Across Systems

Coordinating care across systems is even more difficult than coordinating care within a single system. Children with complex needs often receive care not only from the medical system but also from other systems, including: Early Intervention under the Individuals with Disabilities Education Act (IDEA), juvenile justice, Head Start, WIC, and child welfare. Specific barriers to coordination between medical and other systems include:

- Primary care providers' (PCP) lack of familiarity and comfort with non-medical services;
- Cultural barriers across disciplines;
- Lack of feedback to the PCP from referral services after a referral was made; and
- Lack of communication mechanisms between PCPs and non-medical service providers.

State Medicaid agencies can develop and implement multi-faceted interventions to improve care coordination across systems. Through a 3-year learning collaborative, Medicaid-led teams from five states (Arkansas, Illinois, Minnesota, Oklahoma, Oregon) implemented interventions, described below, to strengthen coordination between PCPs and Early Intervention services. All five states measured the frequency of "closing-the-loop" (i.e., how frequently PCPs received feedback about the results of their referrals to the Early Intervention system). Although not all states produced both pre- and post- measures of closing-the-loop, and each state chose different complementary measures (based on the design of their intervention), all states produced outcomes that indicated improved communication and coordination. These included:

- Increased rates of referral to Early Intervention services;
- More frequent (and in two states more timely) feedback to PCPs about the result of their referrals; and,
- In one state, an increase in the percentage of parents who reported that their PCP or the PCP's office staff provided advice or plans for next steps following a developmental screening from 2011 to 2012.

States in this collaborative undertook a series of steps designed to improve communication and coordination between the PCP and Early Intervention services. In each state, Medicaid staff collaborated with other stakeholders to develop an intervention built on policies and resources at the state level and in the community that would produce lasting improvements. Because the barriers to

coordination across systems are multiple, the resulting interventions were multifaceted.

Common elements in these multi-faceted interventions included:

✓ ***Develop and promote tools and resources.*** All five states developed tools and resources to support communication and coordination. These include standardized forms for referrals and care planning, lists of community resources, and training on care coordination practices and policies. Different child-serving programs often have different policies governing who is eligible for their services, how services are delivered, and when they can communicate with other providers. A common referral form can help bridge these differences.

✓ ***Build care coordination into electronic data transmittal systems.*** Primary care providers need ready information to coordinate the care of their patients. Electronic data systems offer state Medicaid agencies and their partners a means to efficiently share this information among providers.

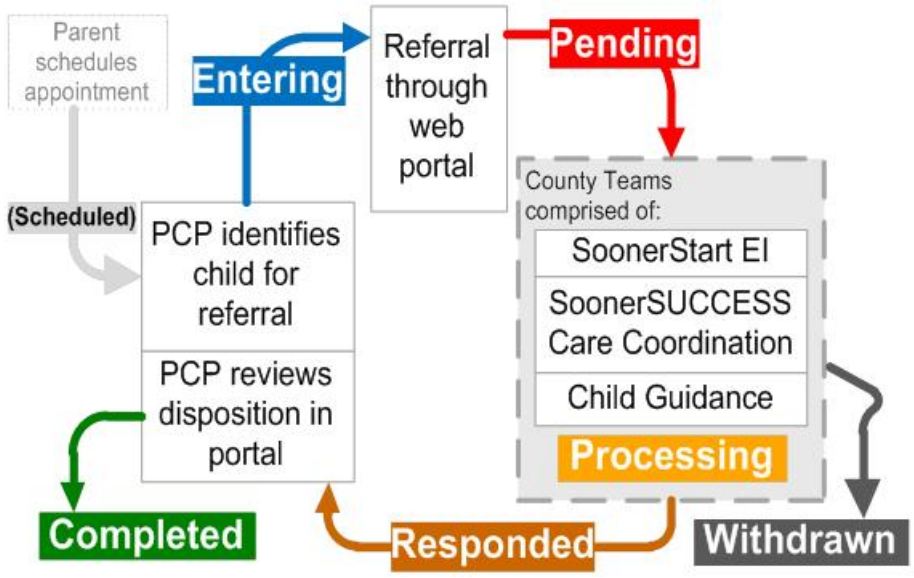
✓ ***Offer technical assistance to providers.*** In order to improve care coordination, providers need to change how they deliver care. State Medicaid agencies can assist providers in determining what to change and how to make those changes. The state Medicaid agencies in the collaborative provided technical assistance to providers through workshops, learning collaboratives, practice coaching, and other methods.

✓ ***Measure care coordination based on the intervention.*** It is particularly difficult to measure coordination *across* child-serving systems. States in the collaborative found no existing validated measure they could adopt to measure their progress. So, states produced graphic logic models (see next page) for their intervention. The model, a formal representation of the communication loop, showed the flow of information from the primary care provider to the Early Intervention provider and then back. States used these models to define a "closing the referral loop" measure.

States can offer providers tools and technical assistance to improve communication, coordination, and monitoring of care.

Implement a Multi-faceted Intervention to Improve Coordination Across Systems: Oklahoma

Oklahoma created a logic model for how the referral process should work and then developed a multi-faceted intervention, which used all four of the common elements to improve care coordination across systems.



✓ ***Develop and promote tools and resources.*** In Oklahoma, the Medicaid agency and SoonerStart (the state Early Intervention program, part of the Oklahoma State Department of Health) worked together to develop a referral form that could be used by both PCPs and Early Intervention providers. By working together they were able to develop a form that:

- Provides Early Intervention providers with the necessary information to assess the child's needs and
- Enables Early Intervention providers to communicate the results of the referral back to the child's primary care provider.

✓ ***Build care coordination into electronic data transmittal systems.*** The University of Oklahoma Health Sciences Center (OUHSC) built the Preventive Services Reminder System in 2002 with funding from the Agency for Healthcare Research and Quality, and the Oklahoma Health Care Authority (Medicaid). This open-source academic system helps primary care providers improve preventive and longitudinal care.

- It provides reminders to ask patients about preventive services and current risk factors.

- It offers an immunization registry, visit and patient-specific recommendations at the point-of-care, and routine data collection for practice-based research. Many Medicaid providers use this system.
- Oklahoma Medicaid also partnered with the University to add web-based referral and tracking to the Reminder System. They funded assistants to train provider practices in implementing the web portal. The portal facilitated communication between primary care and Early Intervention providers, while enabling the Medicaid and Early Intervention agencies to measure performance.

✓ ***Offer technical assistance to providers.*** Oklahoma Medicaid partnered with the OUHSC to provide Practice Enhancement Assistants (PEAs or practice facilitators) to support the intervention. The PEAs helped participating practices conduct Plan-Do-Study-Act cycles, which are four-step, rapid cycles designed to test and analyze the impact of improvements on a small scale. The PEAs also provide critical technical assistance to practices on the use of the common referral form, and on both implementation and use of the web portal.

✓ ***Measure care coordination based on the intervention.*** Oklahoma measured the referral loop through the web portal that primary care providers and the Early Intervention program used to communicate about an individual child. The web portal tracks when a primary care provider makes a referral, when the Early Intervention program acts on the referral and enters feedback into the portal, and when primary care providers access the feedback. The web portal is able to track the rate at which the referral loop is completed and the time it takes to do so. Using this information, Oklahoma documented reductions in the time needed to complete the feedback loop. Oklahoma's results showed a significant reduction in the time it took to close the feedback loop, dropping from an average of 85 days to 51 days. Oklahoma also increased the percentage of the time that the feedback loop was completed from 43% of the time in 80 days or less to 73%, and from 79% of the time in 160 days or less to 98%.

Conclusion: The Future of Care Coordination

States have demonstrated that they can strengthen care coordination for children and adolescents covered by Medicaid. The four strategies presented in this guide were selected for inclusion because they are already being used by some states and are producing outcomes that indicate improved care coordination and health outcomes.

In addition, four opportunities to foster care coordination for children are emerging in Medicaid. These innovations have only had time to produce preliminary results indicating improved care coordination and health outcomes. However, many experts and policymakers believe they will achieve the expected results. These emerging pathways include:

- Building on ACA section 2703 Health Homes for Chronic Conditions to coordinate care for Medicaid beneficiaries with chronic conditions.
- Paying for care coordination by using the procedure codes, created in 2008, that allow reimbursement for medical team conferences; and other codes, created in 2013, to reimburse for services such as complex chronic care coordination services and transitional care management services.
- Testing new integrated care delivery systems designed to improve care coordination, such as Accountable Care Organizations, Coordinated Care Organizations, and Coordinated Care Entities.
- Adopting quality measures for care coordination as developed through the Centers for Excellence and CHIPRA quality grants.

We encourage states to not only invest in the four proven strategies presented throughout this guide, but to keep an eye on the new and exciting innovations in the field of care coordination, such as the four emerging opportunities listed above. We hope that the ideas in this guide will support state efforts to strengthen care coordination at this opportune time for improvement.

What You Need to Know About EPSDT

EARLY: Assessing and identifying problems early

Children covered by Medicaid are more likely to be born with low birth weights, have poor health, have developmental delays or learning disorders, or have medical conditions (e.g., asthma) requiring ongoing use of prescription drugs. Medicaid helps these children and adolescents receive quality health care.

EPSDT is a key part of Medicaid for children and adolescents. EPSDT emphasizes preventive and comprehensive care. Prevention can help ensure the early identification, diagnosis, and treatment of conditions before they become more complex and costly to treat. It is important that children and adolescents enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

PERIODIC: Checking children's health at age-appropriate intervals

As they grow, infants, children and adolescents should see their health care providers regularly. Each state develops its own "periodicity schedule" showing the check-ups recommended at each age. These are often based on the American Academy of Pediatrics' Bright Futures guidelines*:* Recommendations for Preventive Pediatric Health Care. Bright Futures helps doctors and families understand the types of care that infants, children and adolescents should get and when they should get it. The goal of Bright Futures is to help health care providers offer prevention-based, family-focused, and developmentally-oriented care for all children and adolescents. Children and adolescents are also entitled to receive additional check-ups when a condition or problem is suspected.

SCREENING: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems

All infants, children and adolescents should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. A well-child check-up includes:

- A comprehensive health and developmental history, including both physical and mental health development assessments;
- Physical exam;
- Age-appropriate immunizations;
- Vision and hearing tests;
- Dental exam;
- Laboratory tests, including blood lead level assessments at certain ages; and
- Health education, including anticipatory guidance.

DIAGNOSTIC: Performing diagnostic tests to follow up when a health risk is identified

When a well-child check-up or other visit to a health care professional shows that a child or adolescent might have a health problem, follow up diagnostic testing and evaluations must be provided under EPSDT. Diagnosis of mental health, substance use, vision, hearing and dental problems is included. Also included are any necessary referrals so that the child or adolescent receives all needed treatment.

TREATMENT: Correct, reduce or control health problems found

EPSDT covers health care, treatment and other measures necessary to correct or ameliorate the child or adolescent's physical or mental conditions found by a screening or a diagnostic procedure. In general, States must ensure the provision of, and pay for, any treatment that is considered "medically necessary" for the child or adolescent. This includes treatment for any vision and hearing problems, including eyeglasses and hearing aids. For children's oral health, coverage includes regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health. Some orthodontia is also covered.

Resources

State and Federal Government

- CMS Medicaid Benefit for Children and Adolescents
- Center for Medicare & Medicaid Innovation
- CMS Managed Care Page
- CMS CHIPRA Quality Demonstration Grants Summary
- Agency for Healthcare Research and Quality (AHRQ) – National Evaluation of the CHIPRA Quality Demonstration Grant Program
- AHRQ Care Coordination Page
- AHRQ Community Care Coordination at a Glance
- Office of the National Coordinator Care Coordination Page
- Section 2703 Health Homes
- Information on Waivers & Demonstration Projects
- Community Care of North Carolina Toolkit
- New Mexico Managed Care Contract
- Vermont Blueprint for Health

Select Care Coordination Publications

- Building Electronic Information-Sharing Systems to Support Care Coordination in Illinois
- Care Coordination in a Statewide System of Care: Financing Models & Payment Strategies
- Designing Evaluation Studies of Care Coordination Outcomes for Children & Youth with Special Health Care Needs
- Financing Care Coordination for Children & Youth with Special Health Care Needs
- Improving Care Coordination & Service Linkages to Support Healthy Child Development: Early Lessons and Recommendations from a Five-State Consortium
- Improving Care Coordination, Case Management & Linkages to Service for Young Children: Opportunities for States

- Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework
- Measuring and Improving Care Coordination: Lessons from ABCD III
- Policies for Care Coordination Across Systems: Lessons from ABCD III
- Oklahoma's Web Portal: Fostering Care Coordination Between Primary Care & Community Service Providers

Data Sources and Information

- AHRQ Care Coordination Measures Atlas
- CAHPS Clinician & Group Surveys
- CHIPRA Initial Core Set of Children's Health Care Quality Measures
- Medicaid Managed Care Enrollment Report (2011)
- Healthcare Effectiveness & Data Information Set (HEDIS) & Performance Measurement
- National Quality Forum Care Coordination Practices and Measures

Organizations

- American Academy of Pediatrics
- Catalyst Center
- The Commonwealth Fund
- The National Academy for State Health Policy (NASHP)
- National Committee for Quality Assurance
- National Quality Forum
- NORC at the University of Chicago
- Patient-Centered Primary Care Collaborative

Tools and Resources

- Assuring Better Child Health & Development (ABCD) Resource Center
- Bright Futures Guidelines
- Enhancing Developmentally Oriented Primary Care
- George Washington University, Health Information & The Law
- Health Services for Children with Special Needs (District of Columbia Specialized Managed Care Plan)

- Medical Home & Patient-Centered Care Map
- Request Managed Care Technical Assistance
- State 'Accountable Care' Activity Map
- State Refor(u)m

Appendix A – Federal Support for Care Coordination

State Medicaid programs have long pursued greater integration and coordination of care to improve health care quality and contain costs. In recent years, the Department of Health and Human Services has established care coordination as a priority and is contributing resources to the field:

Policy Guidance:

- In July 2012, CMS offered states guidance on Policy Considerations for Integrated Care Models that identified several federal authorities under which they could implement care coordination. CMS also offered information about its efforts to work with states to support development of Integrated Care Models.
- In May 2013, CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a joint informational bulletin on Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions that describes
- SAMHSA's Children's Mental Health Initiative, and CMS' Psychiatric Residential Treatment Facility Demonstration Program that promote a coordinated, community-based approach to care for children and adolescents with serious mental health challenges and their families, including intensive care coordination.

CMS Funding:

- The Center for Medicare and Medicaid Innovation's (CMMI) State Innovation Models Initiative has provided almost $300 million in funding to 25 states that are developing or implementing multi-payer initiatives that transform the delivery of health care. Nineteen states received grants to develop a plan, and six received grants to test their models. The six "implementation" states have included care coordination as a key component of their innovation models, and it is likely to be a key component of the plans developed by the other nineteen states.
- Section 401(d) of the Children's Health Insurance Program Reauthorization Act (CHIPRA) authorized the CHIPRA Quality Demonstration Grants. CMS has awarded 10 grants to state-led demonstrations supporting efforts (covering 18 states) to test promising ideas for improving the quality of children's health care provided under Medicaid and CHIP.
- CMMI has established subgroups (such as children in foster care, and high cost pediatric populations), and prioritized the linking of clinical care to community-based interventions for the second round of the Health Care

Innovations Awards. Applicants for these awards can be considered ready partners for state Medicaid programs.

Finally, CMS is itself changing the way it pays for services in the Medicare program to promote integration and coordination of care. Although the Medicare program does not generally serve children, (there are exceptions, such as end-stage renal disease) these changes will support state efforts to improve care coordination for children.

- Fostering Accountable Care Organizations (ACOs). The Federal Government defines ACOs as, "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients." CMS is supporting several initiatives aimed at fostering the creation of ACOs in many parts of the country. Although these ACOs are designed for Medicare beneficiaries, most also serve other populations, including children.
- The Comprehensive Primary Care Initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Four states (Arkansas, Colorado, New Jersey, and Oregon) are implementing this initiative statewide; regional initiatives in New York, Ohio, Kentucky, and Oklahoma are also participating. Medicare is working with commercial and state health insurance plans to offer bonus payments to primary care doctors who better coordinate care.

Other HHS Initiatives:

- The Health Resources and Services Administration (HRSA) gave Early Childhood Comprehensive Systems grants to 49 states, the District of Columbia, and several territories, to help communities build and integrate early childhood service systems that better meet the needs of children and families.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) has created the grant program Project LAUNCH, which seeks to promote the wellness of young children, birth to age eight, and focuses on improving the systems that serve them.