Part Three

High Performing Medical Homes: Care Coordination and Case Management
Part Three / Key Takeaway Messages

- The terms “care coordination” and “case management” are both used, often interchangeably, to describe a range of activities that better link children and families to services and supports, promote access, address needs, and ensure follow up. A basic level of care coordination/case management for all patients is a defined part of the medical home.

- The definition of a medical home includes basic, routine care coordination. When a child has an identified physical, developmental, mental, or other condition, additional care coordination/case management may be needed. Similarly, when the child is in a family experiencing social risks and conditions (e.g. social determinants of health) that threaten the child’s health and development, more intensive care coordination may be essential. A high performing medical home in Medicaid must provide care coordination capable of responding to both bio-medical and social risks and conditions.

- Under EPSDT, children are entitled to case management coverage. Medicaid regulations specify a case management benefit, but do not define “care coordination.” States also can use the targeted case management (TCM) benefit under Medicaid, with flexibility to offer certain services to individuals in defined groups (such as young children), specific geographic areas, and delivered by qualified providers. Federal regulations define the following four categories of activity: 1) assessment, 2) development, 3) referrals and relative activities, and 4) monitoring and follow-up. In addition, states can pay for an array of care coordination activities in primary care settings or in the community apart from the case management benefit.

- Medicaid case management benefit categories can be used to cover this more intensive care coordination. States are financing care coordination under the case management or targeted case management benefit categories. Operationally, financing may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM, payment), or through incentives or bonuses for performance. Whatever the finance mechanisms, as described in Medicaid regulations, reimbursement should include direct time with the child and family and other time involved in gathering information, developing or updating the care plan, following up with families, scheduling appointments for referrals, and checking in with families and monitoring the care plan are covered services.

Defining Care Coordination and Case Management

The terms “care coordination” and “case management” are both used, often interchangeably, to describe a set of activities in child and family health used to promote optimal access to a range of services and supports. Even though the AAP, MCHB, and other child health leaders generally use the term care coordination, Medicaid traditionally finances coordination under the case management benefit. In research and practice, the terms care coordination and case management describe a range of activities that better link children and families to services and supports, promote access, ensure follow up, and address needs. One type of care coordination/case management is for those with health conditions within the “normal range,” which is designed to reduce barriers related to language, health literacy, culture, geographic access, and economic and social environments. For children with special health care needs, care coordination provides additional help navigating the broader health care system and communicating with multiple providers. For some families, a combination of medical and social needs calls for more intensive case management.
Research has shown that care coordination/case management is associated with whether or not a child receives the care they need for physical, mental, and developmental conditions.\(^9\)\(^10\) Studies have shown that when a problem is suspected (or even diagnosed and services prescribed), young children often fall into the gaps in receiving services and coordinating care across different health care providers and systems, including mental health, child development, and early childhood education.\(^11\) Moreover, care coordination/case management often represents a key strategy within managed care for select populations because it can lead to more appropriate service utilization and reduced costs, including better management of existing health conditions and reduced episodes requiring high-cost medical interventions.

A basic level of care coordination/case management for all patients is expected from the child health practitioner and office as part of being a medical home, particularly in referring to and following up with subspecialty services.\(^12\) Pediatric medical home care coordination is a patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and strengthen families.

The AAP Finance Committee recommends that medical homes be financed sufficiently to include basic case management/care coordination, patient/family education, counseling, and related community coordination services. Payment sufficient to cover the cost of this basic care coordination is essential for ensuring the quality of the medical home.\(^13\) Of course, many families already serve the function of coordinating a whole range of care for their children, including medical care (and dental care) but extending to child care and other child activities. For many families, the primary child health practitioner merely needs to check-in with the parents to make sure the child’s basic needs (including safety, supervision, and nurturing) are being met and care is coordinated. Often brief and routine care coordination can be done by telephone. As described in part two, the well-child visit and general office practice perform this general care coordination function for all children within a medical home.

When a child has an identified (i.e., diagnosed) behavioral, cognitive, developmental, or physical condition — often categorized as “special health care needs” — additional care coordination/case management may be needed as the medical home provider likely is making referrals to specialty and related services. Having dedicated staff time or community-based care coordination resources supports more efficient, effective, and completed referrals and helps to ensure that there is a team-based approach to providing services that is integrated and responsive to child and family needs.\(^14\) Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs in order to achieve optimal health outcomes. Key activities include creating care plans, monitoring plan actions, and sharing timely information among all members of the care team, including the patient and their family. However, the child may have family and social risks and conditions (i.e., social determinants of health) that threaten her health and development, even if these have not yet manifested in adverse health conditions, illness, or disability. EPSDT is designed to prevent such conditions from worsening. As shown in Figure 11, in part four of this sourcebook, these risks and conditions may be related to: the physical and material home environment, the physical and mental health status of the parents, the family’s social ties and connections, and the parent-child relationship. Case management/care coordination is particularly important when the risks need to be addressed by providers and programs beyond the medical care system, as they require knowledge and skills that extend beyond what can be expected from (or is a good use of the expertise of) the primary care practitioner.
Case management and care coordination in Medicaid

Under EPSDT, children are entitled to case management coverage. Medicaid regulations specify a case management benefit, but do not define “care coordination.” However, many Medicaid agencies now refer to services covered under the case management benefit categories as “care management,” “service coordination,” “care coordination” or some other term related to planning and coordinating access to health care and other services on behalf of an individual. In Medicaid law, case management is a covered service in Section 1905(a) that has a meaning very similar to care coordination, and is defined as follows.

“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)).

At their option, states also can use the targeted case management (TCM) benefit (also known as medical assistance case management). Under TCM, states have the flexibility to offer certain services to individuals in defined groups, specific geographic areas and/or delivered by qualified providers. States submit a state plan amendment to CMS in order to get approval for specific uses of TCM. For example, some states use TCM as the benefit category to finance select home visiting models for pregnant women and young children; others use TCM to provide specific styles of care coordination for children with special needs, developmental disabilities, or mental health conditions. A targeted case management benefit could be established specifically for very young children in households where the identified need for such case management was to strengthen the safety, stability, and nurturing in the home environment to improve the child’s healthy development.

Federal regulations define case management services to include the following four categories of activity and explicitly exclude direct delivery of medical, educational, social, or other services to which the individual has been referred.

1. Assessment (and periodic reassessment) to determine the need for any medical, educational, social, or other services, which includes taking client history, conducting structured assessment, and collecting other information;

2. Development (and periodic revision) of a care plan based on the information collected through the assessment, with specific goals and actions;

3. Referrals and related activities to help individuals obtain needed services, which include activities that help link the eligible individual with medical, social, educational providers, or other programs and services that are capable of providing needed services (e.g., making referrals to providers for needed services and scheduling appointments for the individual); and

4. Monitoring and follow up activities needed to ensure that the care plan is effectively implemented, which includes contacts with the individual, their family, and other providers as necessary and appropriate. (42 CFR Section440.169(b)).
Other provisions in Medicaid cover “primary care case management services” and coordination of services in a “health home” program for people with chronic conditions. In addition, states have the flexibility to pay for an array of care coordination activities in primary care settings or in the community. These might be structured under existing authority, under waivers, or through managed care or accountable care arrangements. Billing codes exist for care coordination, as well as complex chronic care coordination, medical team conferences, and other approaches.

CMS recommends that state Medicaid agencies: build care coordination into standards for medical homes, support primary care providers by financing community-based care coordination entities (e.g., community health teams), put care coordination requirements into contracts with managed care organizations, and use strategies and tools to support care coordination. Federal regulations require that Medicaid managed care entities provide care coordination for each enrollee (42 CFR §438.208). State contracts can define performance expectations to strengthen care coordination, with a strong state performance monitoring approach to ensure compliance with the contract. CMS also recommends that states adopt quality measures for care coordination.

**Beyond Basic Care Coordination: Key Attributes of Effective Practice**

The definition of a medical home includes basic, routine care coordination, yet some children and their families need more intensive care coordination. Intensive care coordination involves skills and knowledge, particularly about community resources, that are different from the professional skills and training of the primary child health practitioner. In pediatric primary care practices with a high proportion of families who need more intensive care coordination, dedicated time from care coordination staff is essential, whether based inside the practice or in the community. Within a high performing medical home in Medicaid, there should be care coordination capable of responding to both bio-medical and social risks and conditions. Further, the frequency and intensity of that care coordination should reflect the complexity of the child’s condition and the family circumstances surrounding the child.

A growing number of practices provide care coordination that focuses on both bio-medical and social determinants, many specifically integrated into primary practice settings. Even though the specific processes and protocols surrounding care coordination vary, the exemplary practices in the Child and Family Policy Center’s Health Equity and Young Children initiative identified a set of common activities. These are in alignment with Medicaid rules and are intended to:

- Assess, screen, and monitor child and family needs, risks, and strengths;

**Core attributes of effective care coordination**

The Health Equity and Young Children Initiative charted some of the core attributes of effective care coordination, with implications to the recruitment, training, and stature within the medical home key to their effectiveness. Exemplary programs and practices reported the following:

- Immediacy and seamlessness of response,
- Concerted and persistent engagement of families,
- Emphasis on fostering family capacity, strengths, and resiliency,
- Recognition as a partner on the care team,
- Engagement and collaboration with other partners and agencies,
- Continuous learning and improvement, and
- Flexibility, humor, humility, and self-care.
• Help families identify priorities and set goals through a process that includes assessment of needs, engagement, and often a written plan;

• Provide and support completion of external referrals for families as needed (with warm hand off, warm transfer when possible, and generally moving beyond referral to scheduling and follow-up);

• Team with others, particularly within the practice/clinic, to ensure coordination and alignment of responses and to effectively bridge language, culture, and community differences; and

• Engage in ongoing coaching that builds parents’ agency and capacity to serve as the child’s care coordinator and advocate with other services and supports.\(^\text{17}\)

It is clear that more intensive case management involves additional personnel, requires staff with skills in engaging families, and takes more time than the typical 15-20 minutes for child health visits.

Medicaid also can pay for services delivered under evidence-based programs that emphasize care coordination, particularly those designed to be embedded in or to support pediatric primary care. Some address household material concerns (e.g., medical-legal partnerships), while others focus more on social support and health care navigation (sometimes including care coordinators with some “lived experience” such as community health workers and family advocates). Some provide direct hand-offs in the office at the time of a well-child visit, and others provide telephone care coordination for practices generally. Some larger health practices, including federally qualified health centers, have a social worker, child development specialist, and/or community health worker on staff that can be connected with the family during a well-child visit to follow-up with care coordination. Some communities have organized systems of referral and care coordination.\(^\text{18}\) Consider the following examples.

• The Help Me Grow program helps states and communities leverage existing resources, identify vulnerable children, link families to community-based services, and empower families to support their children’s healthy development. This approach has been shown to be highly effective in connecting families with concerns about their children’s development and behavior to appropriate, community-based programs and services. Help Me Grow generally involves practitioners referring families to care coordinators who in turn provide their care coordination through a call center. Families are then matched with services and supports, including scheduling appointments. Help Me Grow also provides child health providers with cost-effective alternatives to unnecessary and expensive medical specialty referrals, thereby preserving the capacity of specialists for those children who need it most. Currently operating in 28 states, Help Me Grow uses a mix of public and private funding.

• An intervention called Parent-focused Redesign for Encounters, Newborns to Toddlers (PARENT) provided a non-physician “coach” to provide more guidance, screening, and support to low-income families. Compared with the control group, families were significantly more likely to receive preventive services, developmental screening, guidance, health information, and psychosocial assessments.
for family risks. Parents found the care more helpful and were more likely to have their developmental and behavioral concerns addressed.  

- Child First is an evidence-based model providing intensive, home-based services for high-risk families, using direct psycho-therapeutic intervention and care coordination. It is designed to serve families with multiple challenges and trauma (e.g., maternal depression, domestic violence, child maltreatment, substance use). The Child First care coordinators work with the mental health clinician and facilitate access to family-driven, comprehensive, well-coordinated, individualized services and supports throughout the community. The care coordinator coaches, guides, and supports parents in actualizing the plan. They also foster cross-system relationships with other local agencies and providers. Research shows significant improvements in families having service needs met.

Table 5. Financing Case Management and Care Coordination

<table>
<thead>
<tr>
<th>Core function for high-performing pediatric medical home</th>
<th>Medicaid mechanism</th>
<th>Reimbursement and fiscal sustainability</th>
<th>Quality and value measures for incentives and accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Visit and Prevention Practices</td>
<td>[See Part Two]</td>
<td>[See Part Two]</td>
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<td>Case Management/Care Coordination</td>
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<td>- May occur at low, moderate, and more intensive levels, with tiered payments based on intensity.</td>
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<td>- At low level, role of the pediatric medical home to provide care coordination, follow up, and referrals.</td>
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<td>- At more intensive level, engagement and whole-child/family approach to identify needs and opportunities (through motivational interviewing, appreciative inquiry, and other tools that also promote family self-sufficiency and efficacy)</td>
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<td>- Referral and connection of families to services and supports to address medical conditions and risks, as well as social determinants of health (scheduling and follow-up)</td>
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<td>Case management (most often) or targeted case management benefit.</td>
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<td>Payment on fee-for-service, capitated (e.g., per member per month), or incentive/bonus payments for performance.</td>
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<tr>
<td>Payment structured to finance staff time within practice (e.g. community health worker, CSHCN care manager) or community-based programs providing more intensive care coordination.</td>
<td>Reimbursement that covers the cost related to the staff performing the case management, including the time involved with the child and family and the time identifying and securing referrals and doing the follow-up. For example:</td>
<td>Quality and value measures for incentives and accountability</td>
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<td>For case management provided as a unit of service, this might be $50 to $75 per child contact or visit (including assessment, development of plan, referrals, and follow up).</td>
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<td>For case management provided under a capitated system, this might be $10 to $20 per month based per qualifying child.</td>
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<td>For community-based programs, this might be a unit of service payment of $25 to $50 per hour of contact or a bundled service for six months involvement of $100 to $200.</td>
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<td>Care plans for children and families with higher needs and risks identified, including assessment of more specific needs and specification of actions for families beyond initial screen and referral</td>
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<td>Follow-up report to practice and securing of additional pediatric referrals to other needed Medicaid-covered services</td>
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<td>Documentation of successful referrals</td>
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<td>Measures for and objective measurement of family experience and family engagement (e.g., CAHPS, Promoting Healthy</td>
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</table>
Approaches to Financing for Care Coordination

Medicaid case management benefit categories can be used to cover this more intensive care coordination. States are financing care coordination under the case management or targeted case management benefit categories, with the former often related to EPSDT requirements. As reported by the National Academy for State Health Policy, states have used a variety of administrative mechanisms to finance case management/care coordination for young children in Medicaid. For example, some states:

- provide a monthly case management fee
- offer payment incentives to practices that demonstrate higher performance in medical home
- emphasize case management in managed care contracts
- use the health home option for persons with chronic conditions
- engage health departments in case management/care coordination
- cover perinatal case management for pregnant women and infants
- develop specific protocols for referrals from primary care to early intervention

The cost of staff time for more intensive care coordination can be substantial and needs to be reimbursed above basic primary care services. Operationally, financing may be through direct reimbursement on a fee-for-services basis, on a capitated basis (e.g., per member, per month-PMPM), or through incentives or bonuses for performance. In any case, the financing may be on a unit-of-service basis (generally related to the time directly spent with the child and family) or as a bundled payment (generally over a longer period). Under either approach, as described in Medicaid regulations, the costs of both direct time with the child and family and indirect time — gathering information, developing or updating the care plan, following up with families, scheduling appointments for referrals, and checking in with families and monitoring the care plan — are covered.

PMPM payments can provide a predictable revenue stream for practices so they can hire and support staff to provide care coordination, while reimbursement by unit of service or as a bundled service may appear less predictable to a practice in recovering the cost of adding care coordination staffing. At the same time, PMPM payments might be set at a rate that limits the number of staff below the level of need, affecting the number of children and families that can be served.

Reimbursement rates should reflect what is needed to provide basic, moderate, and more intensive care coordination/case management. Tiered reimbursement levels with clear definitions can aid providers and managed care organizations in providing the right level of service, making efficient and effective use of available resources. Some states, like New Mexico, are using three levels of tiered case management in Medicaid managed care.

Table 5 is completed for the care coordination-case management role as it was for the well-child visit and office practice role in part two.
Identifying Child and Family Need for Care Coordination and Complexity of Needed Response

Some states use algorithms or criteria for medical complexity, developmental status, and/or psychosocial risk to determine the need for care coordination for their Medicaid populations, particularly related to identifying those with high medical costs. Use of the CSHCN screening tool is one validated, objective approach to assessing chronic conditions (physical, mental, functional). Even though algorithms and criteria for medical complexity have sometimes been used to identify children, states are only beginning to develop child-specific algorithms or criteria that extend beyond medical diagnoses.

Discussed further in this sourcebook (particularly in part four), pediatric primary care practices can screen for health-related, non-medical conditions that pose risks for healthy development, and tools are being developed that provide for screening of social determinants of health. Such efforts can provide a basis for developing new algorithms and estimating both the number and proportion of young children who should receive more intensive coordination, given the range of services that may need to be accessed and coordinated.

Measuring the Impact of Care Coordination

As with well-child visits, states need to apply metrics and measures to ensure children and families who qualify for case management/care coordination are receiving it and that care coordination is producing effective referrals, meeting case plan goals, and increasing family agency in securing and using services. Over time, such metrics and measures also can help determine the degree to which care coordination is reaching its intended population and support continuous improvement in making effective referrals, as well as identifying areas of unmet need or duplicative or misaligned services. An important barrier to measuring the effectiveness of care coordination is discontinuous enrollment in Medicaid for children. If children frequently move on and off Medicaid — as they do in many states — measuring continuity of care coordination is particularly challenging.

In addition, some tools are available for measuring care coordination and family satisfaction. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) patient surveys assess patient experience and help improve the quality of care. The CAHPS 5.0H Child Survey is part of the CMS core set of child health measures and includes supplemental questions related to family-centered care, coordination of care for children, and other aspects of family satisfaction with care. The Care Coordination Tool developed at Boston Children’s Hospital is another resource. In addition the Promoting Healthy Development Survey (PHDS) is endorsed by the National Quality Forum as a valid measure for system, plan, practice and provider-level assessment. The PHDS collects information on referrals and follow up as one domain. It has been used by Medicaid agencies, health plans, pediatric practices, and the National Survey of Early Childhood Health (NSECH).

Part seven of this sourcebook discusses broader issues of measurement, including review of the CMS core set of child health measures and CAHPS.
References


