

Title V & XIX Interagency Agreements

Issue Brief Number 1

Care Coordination /Case Management (CC/CM) and Interagency Agreements

Prepared by the MCH Library and Johnson Group Consulting

The terms care coordination and case management (CC/CM) have a variety of meanings across professional fields, practice settings, and populations. Some distinguish between these two terms. Thus, depending on the program or source of funding, the terms may vary, even though the functions remain the same. For example, while most Title V programs emphasize “care coordination,” Medicaid generally uses the term “case management.”

What is important is to know: what the service is, who is delivering the service, how the service is financed, and what impact it is intended to have for the population served. (Rosenbaum et al., 2009) Especially now, when budgets are tight and new opportunities for maternal and child health (MCH) are being introduced under health reform, interagency agreements (IAAs) between state Title V programs and Medicaid can be a powerful tool in assuring coordination and mutual support in delivering services such as CC/CM.

Care Coordination and Case Management for MCH Populations

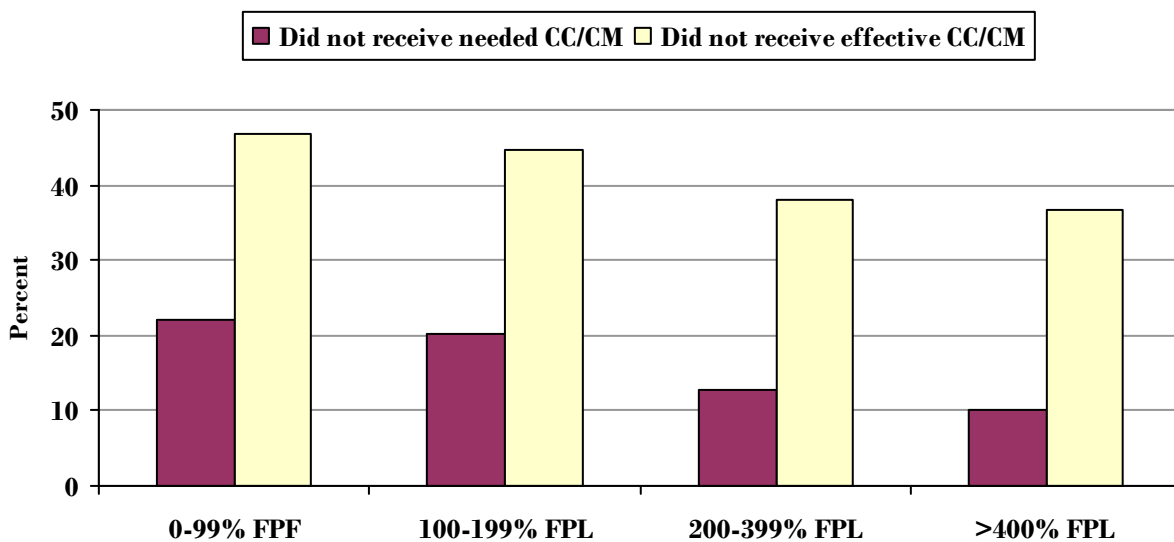
In terms of maternal and child health (MCH), care coordination and case management are terms used interchangeably to describe an array of activities that are designed to: strengthen connections between families and providers, link families to services, improve access to needed services, avoid duplication of effort, and improve health outcomes. An important body of research suggests that case management represents a valuable and effective service, both for families that face other barriers to receiving appropriate, high quality care and for individuals with special health care needs. In both Title V and Medicaid CC/CM is used to serve these two broad groups. (Johnson and Rosenthal, 2009)

The first group who can benefit from CC/CM includes women and children whose health care needs fall within a “normal” or typical range (i.e., do not have special health care needs) but who have access barriers related to factors such as geographical distance, language, or health literacy. Such factors are concentrated among, but not limited to, families with lower incomes. National surveys indicate that low-income families seeking care for their children are more likely than middle/high income families to: have a “big problem” getting necessary care. (Simpson et al., 2005) Disparities in access also persist for African American and Hispanic American children (Flores, 2010; Coker et al., 2010), as well as for those with developmental disabilities and mental health conditions. (Nagaswaran et al., 2010) Poor and uninsured children are also less likely to have a well-functioning medical home. (Stevens et al., 2009) Low-income pregnant women are more likely than their more affluent counterparts to face such access barriers.

The second MCH group in need of CC/CM includes those who have special health care needs and chronic conditions. Children with special health care needs (CSHCN) have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require

health and related services of a type or an amount beyond that required by children generally. (McPhearson et al., 1998) Thus, by definition, CSHCN need and typically use more health care services than other children, leading to higher costs for this group. Research documents the benefit of CC/CM for CSHCN. (Wise et al., 2007; Rosenbaum et al., 2009, Turchi et al., 2010) Positive results include reduced absence from school, decreased caregiver strain, and fewer ambulatory care visits. According to the American Academy of Pediatrics, care coordination for CSHCN is defined as “a process that links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of children and provide them with optimal health care.” (AAP, 1999; Antonelli et al., 2009) National surveys indicate unmet need for case management among CSHCN. (See graph.)

Care Coordination among CSHCN, US, 2005-06



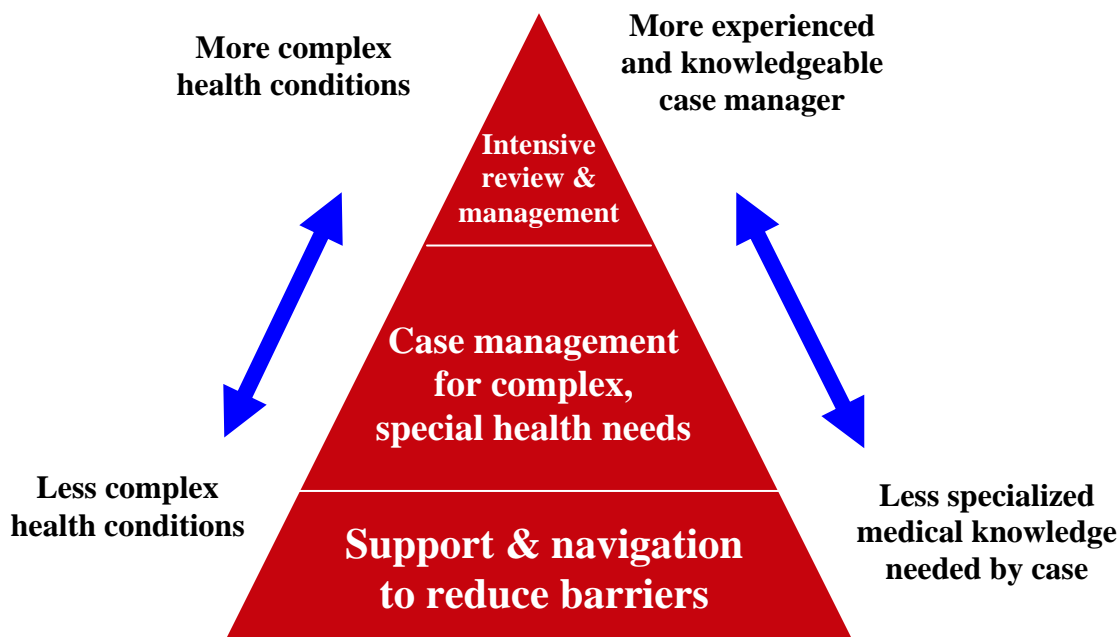
Note for graph: Categories are from questions regarding: CSHCN who did not receive extra help with care coordination when needed in prior 12 months; and CSHCN who needed but did not receive effective care coordination in prior 12 months.

Source: Child and Adolescent Health Measurement Initiative (CAHMI). 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Retrieved July 22, 2010 from www.cshcndata.org

Researchers at the George Washington University have conceptualized three tiers of CC/CM in a pyramid structure. (See Figure 1.) At the base of the pyramid is “basic” CC/CM that helps families overcome access barriers through social support and help with navigating the health system. The second tier is CC/CM for individuals with complex conditions and special health care needs. In the third tier, a case manager is also expected to make determinations as to what care is or *is not* necessary, in addition to their roles in assisting with access. For any family, one case manager may work across all three tiers or three different CC/CM providers might be involved as part of a case management team.

Medicaid Financing for Care Coordination/Case Management

Medicaid plays a particularly crucial role in financing CC/CM for children because of its unique pediatric coverage and payment rules. In federal Medicaid law, case management includes reimbursable activities in three categories: (1) administration activities serving as CC/CM; (2) case management as a distinct class of medical assistance; and (3) CC/CM as a component of a class of covered professional, clinical, or institutional services or as a dimension of managed care. In other words Medicaid might reimburse for CC/CM as: an administrative service, a stand-alone category of medical assistance, or part of a broader case or practice-driven activity (e.g., part of medical home or managed care arrangement). Actual practice within these categories varies widely from state to state, community to community, and practice to practice.



For children's services delivered under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component, CC/CM would similarly be covered under the three categories defined above. In some states, special EPSDT case management programs are operating. (See examples below).

Examples of CC/CM for MCH Populations

- ***EPSDT Informing, Outreach, and Case Management:*** Many State Medicaid agencies have used Title V programs to assist in carrying out their obligations under EPSDT to provide outreach and informing, as well as assistance with scheduling and transportation to children. One approach is to reimburse Title V (health departments) for time spent in assisting families in appropriate use of the EPSDT benefit. Some states use local EPSDT coordinators (e.g., Colorado, Iowa, Michigan, and Minnesota). Public health nurses, social

workers, or others employed by a local health department typically fulfill this role. Title V-Title XIX IAAs in Alabama, Colorado, Iowa, and Minnesota support collaboration related to EPSDT.

- ***Case management for CSHCN:*** Virtually every State has CC/CM for CSHCN supported by Title V dollars. In most states, CC/CM for CSHCN is funded by Medicaid. While sometimes strictly administrative in nature, CC/CM for CSHCN is more often covered as stand alone medical assistance case management. This area is ripe with opportunities for shared responsibilities and interagency collaboration. Title V-Title XIX IAAs in Connecticut, Florida, North Dakota, Oklahoma and Washington State reflect different approaches to collaboration.
- ***Maternity and Infant Care Coordination/Case Management:*** Since the mid-1980s states have been using the option to extend Medicaid targeted (medical assistance) case management benefits to pregnant women and mothers of newborns in order to increase appropriate use of prenatal care and improve infant health. North Carolina was among the first States to develop such a benefit and that approach was found to be effective and cost effective. Some states use this approach to finance home visiting programs. Title V-Title XIX IAAs in Kentucky, North Carolina, Missouri, and Wisconsin reflect different approaches to shared responsibility for prenatal case management.

Examples from State IAA Provisions about CC/CM

The MCH Library and Johnson Group Consulting, with support from the Maternal and Child Health Bureau, has developed a free technical assistance program to help states draft or rework effective Title V and Medicaid IAAs. Many states currently have used IAAs to address CC/CM coordination between entities (see examples below). For further information on how to use IAAs to strengthen CC/CM services and further forge meaningful partnerships between agencies, please see <http://www.mchlibrary.info/IAA>.

- **Alabama:** IAA calls for the Title V agency to maintain a care coordination system that ensures Medicaid-eligible children receive appropriate services and that Medicaid will reimburse the Title V agency for these services. In turn, the Title V agency agrees to reimburse Medicaid the state share of costs associated with providing CC/CM services.
- **California:** IAA calls for the provision of CC/CM to assure the provision of high quality health care by organizations and providers who meet professional practice standards.
- **Connecticut:** IAA calls for the CYSHCN Regional Medical Home Support Centers to assist Pediatric Primary Care Providers with CC/CM of CYSHCN who have high severity needs.
- **Florida:** IAA calls for Medicaid to form a staff and statewide advisory group with the Title V agency to oversee the implementation of CC/CM.
- **Illinois:** The Title V agency is to obtain the necessary appropriation for outreach and CC/CM activities; provide payment to agencies performing CC/CM activities; submit to

Medicaid a draft of the next fiscal year Family Case Management Contract Attachment. Medicaid is to maintain a hotline to address CC/CM client concerns.

- **Iowa:** First IAA defines the responsibilities of the parties in assessment, planning, and CC/CM activities related to the recipients of EPSDT. Third IAA calls for the Title V agency to develop and maintain local capacity for MCH services and to provide Medicaid information and CC/CM to EPSDT clients. (Note: Iowa has 3 separate IAAs).
- **Kentucky:** IAA deals primarily with CC/CM services and lists as its objective to provide Medicaid reimbursement for targeted CC/CM services for Medicaid eligible recipients including children in custody of the state and, adults who may require protective services from the state, and for rehabilitative services.
- **Mississippi:** IAA lists as its objective to provide CC/CM and extended services through approved case management agencies over the state to those pregnant/postpartum women and infant Medicaid beneficiaries.
- **Missouri:** Specific IAA (*Prenatal Case Management and/or Service Coordination for Pregnant Women*) deals primarily with CC/CM services and lists as its objective “to provide the most efficient, effective, and cost effective administration of Title XIX case management services.”

(For more examples of how state IAAs treat CC/CM, see

http://www.mchlibrary.info/IAA/resources/T5T19_Examples_Case_Management.pdf)

Emerging Opportunities under Health Reform

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23. Between now and 2014, many different provisions of the health reform legislation will improve access to affordable health coverage for millions for Americans, women and children among them. Four provisions of ACA that are particularly related to CC/CM are highlighted here.

The ACA adds incentives to develop health homes for people with chronic conditions in Medicaid. A new Medicaid option will permit enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. For example, such an option might assist in providing patient-centered medical/health homes for women or children with chronic conditions. (Effective January 1, 2011)

The health reform legislation establishes care coordination network program. The Community-based Collaborative Care Network Program was created to help providers coordinate and integrate services for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)

Grants to states to promote Community Health Teams that support the patient-centered medical home are provided through ACA. Community-based interdisciplinary teams will provide support services to primary care providers. The team’s roles would include: collaboration with providers;

coordination of disease prevention and management; case management; and support for transitional health care needs from adolescence to adulthood.

The ACA created an Innovation Center within the Centers of Medicare and Medicaid Services (CMS) with broad authority to test, evaluate, and adopt delivery/ payment models that foster patient-centered care, improve quality, and contain costs. Models may include: patient-centered medical homes that address women’s unique health needs; physician payment models to transition from fee-for-service to salary-based payment; state all-payer payment systems; and/or chronic care management and care coordination models.

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