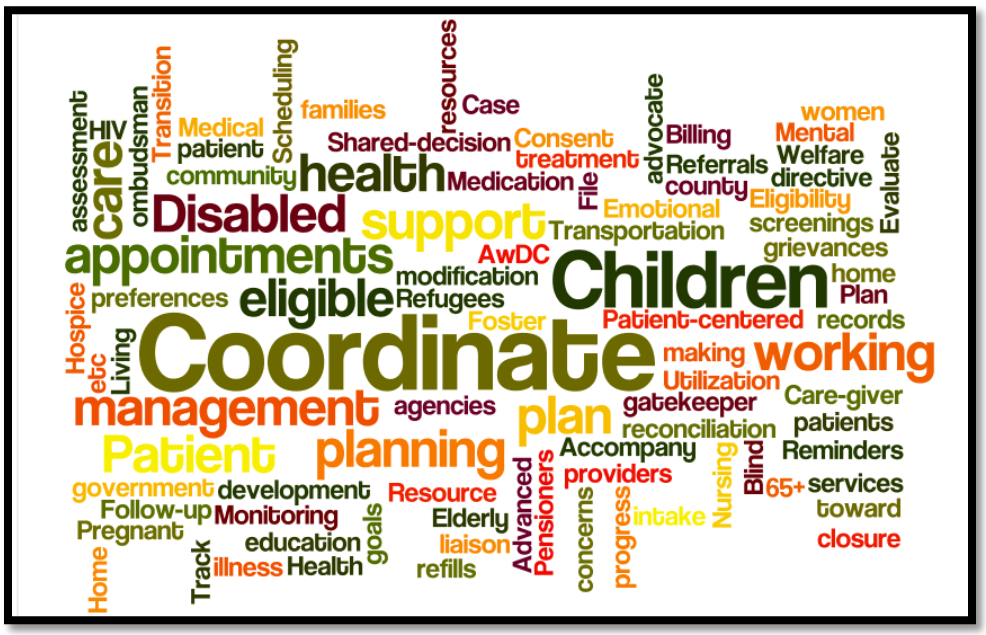
CARE COORDINATION FOR MEDICAID BENEFICIARIES:

PAPER 2:
Colorado Landscape



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Paper 2

Cover Art:
Text in Wordle is from the list of care coordination activities includes in the survey mentioned in this report.
Wordle by Jonathan Feinberg

Contents

Executive Summary

This is the second in a series of concept papers on care coordination. This paper analyzes the current landscape of care coordination within Medicaid programs in Colorado. The last paper in the series offers recommendations based on both the national literature review and data from this report that is specific to Colorado.

This paper summarizes work conducted during the spring and summer of 2012 to better understand care coordination as it exists within the Department. The first task was to create a Care Coordination Work Group. This group developed an open-ended questionnaire, which program managers at the Department used to provide information on how care coordination was conceptualized in their programs. The results from the questionnaire are presented first.

From the open-ended questionnaire evolved a multiple-choice survey that asked similar questions in more depth. The multiple-choice survey then made it possible to tabulate responses and to present these data visually. This is the second part of the paper. Please note that this qualitative information is from the perspective of one person per program. If the same questions were asked of contractors, care coordinators, or clients, some variation of response would be expected. Each phase of this project is meant to lay a foundation for a deeper dive into the next phase.

Questionnaire

In the questionnaire, Medicaid program managers were given the opportunity to share how care coordination and/or case management are defined by their programs, as well as to describe the care coordination components of their programs. Not surprisingly, the most elaborate definition comes from the Affordable Care Collaborative (ACC). The data shows that not only are definitions different, but the term to be defined is also different: definitions were offered for case management, intensive case management, on-going case management, and care coordination. Thus far, there appears to be no clear link between the details of definition and the robustness of services. Much thought should be given before attempting to standardize the definitions to ensure that beneficiary flexibility is not diminished in the formalization process.

The following section further explains the Medicaid programs and how care coordination is incorporated. The ACC asked each of the RCCOs to document a formal system of care coordination; summaries of these descriptions are included. While each plan is unique there are many shared themes. Every RCCO has a system for differentiating levels of care coordination needs; because these tiers are not uniform, further discussion with the RCCOs is advised. All RCCOs mention the use of data to stratify and to manage care for clients, starting with health risk assessments. Two RCCOs have case management software (ThinkHealth and Altruista). The other common themes were the use of evidence-based guidelines and preparation for care transitions. Some RCCOs stated that clients will be assigned to a specific care coordinator who will draw up a care plan. Three RCCOs are focusing their care coordination efforts on patients with chronic conditions and one is focused on a specific geographical area. Care coordinators range in these programs from health coaches to PCPs. In addition to the RCCOs, non-ACC Medicaid programs each have their own systems of care coordination, which are explained later in the paper.

Survey
The results from the survey are organized into four categories: 1) program characteristics, 2) populations served, 3) care coordination activities, and 4) network interactions. Answer choices were provided and a write-in option was included.

Program Characteristics: This table shows the diversity of program characteristics that relate to care coordination requirements and remuneration in Colorado Medicaid programs. Since many clients are served by multiple programs (see Map 1; also look for client survey follow-up in the future), the services they receive can vary substantially, causing confusion and poor transitions. Some standardization is desirable, where possible and where the outcome improves the quality of care coordination. This necessitates further research and on-going discussion within the Department and with stakeholders.

Populations Served: The results from the survey reveal two patterns in the way Medicaid clients are currently served in Colorado. First, we see a complex web that is difficult to follow even when mapped out. Note that these populations are often served by other government agencies as well as by non-profits (see Map 2). It is not difficult to image the overlay of these additional services onto the already confusing map. Second, more programs peripherally serve many population segments than programs that primarily serve specific populations. For example, the ACC and the managed care programs: Rocky Mountain Health Care and Denver Health Managed Care serve nearly all populations. From a primary care gatekeeper perspective, it makes sense that these programs should serve a wide range of clients. Then, there are populations that are the primary focus and populations that are the secondary focus within the same program in Home Health, Hospice and PDN, CCT, PACE and CAHI. The programs that appear to be the most targeted are those for pregnant women and persons with mental illness in the BHOs.

Care Coordination Activities: Medicaid program managers were asked to state whether 30+ care coordination activities were required in their programs and then to mark each activity as generally successful or not fully achieved. There were eight activities that were required by 7 or more of the 13 programs surveyed and there were twelve activities that were required by fewer than 5 of the 13 programs. The success of these programs cannot be compared since each program was evaluated by a different person (the manager of that program) and because not all managers felt comfortable providing answers. The success of a program can vary within a program by contractor or by population segment served. That said, the results show the older programs PACE and EPSDT to be quite successful, the ACC and BHO to be relatively successful, and CAHI to have mixed results. Home Health was paired with Home Health and Private Duty Nursing, and would have been more successful had the program been surveyed in isolation. The managed care organizations, Denver Health and Rocky, required only that care coordinators filed grievances, but were successful in a number of other activities (the respondent was unable to say which activities were less successful). A more scientific method would be required to properly evaluate the programs; however the point of the exercise was simply to demonstrate the variation in the requirements and in the extent to which these requirements were met.

Network Interactions: The survey results demonstrate that Medicaid programs are heavily networked; yet the effectiveness of these networks is not clear. There appears to be significant overlap, unclear communication paths, and confusion in the system. While there is some variation, the general observation is that nearly all entities are extremely important to the network. Given how many entities must be coordinated to manage an individual patient's care or to manage the health of a specific population, the importance of care coordination, and the role of the care coordinator, is without question.

Part I: Open-Ended Questionnaire

Definitions

Accountable Care Collaborative (ACC)

Each of the seven RCCOs is contractually required to provide care coordination for its Members, or to coordinate with a Member's existing care coordinator. According to the RCCO contract, care coordination includes:

Assessment and Follow-Up

- Assess the Member's health and health behavior risks and medical and non-medical needs, including determining if a care plan exists and creating a care plan if one does not exist and is needed. Create a Personal Health Record for each Member to help facilitate communication and ensure continuity of care across providers and settings.
- Follow-up with Member to assess whether the Member has received needed services and if the Member is on track to reach his/her desired health outcomes.

Resources and Referrals

- Help Member schedule and get to appointments.
- Develop a knowledge base of care providers, case management agencies and available services, both within the Contractor's network and the Members' communities.
- Link Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports. Create a library of community resources.
- Know the eligibility criteria and contact points for community-based service available to the Member's in the Contractor's Region, subject to the Department's direction.

Care Integration

- Ensure that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care.

Care Transitions

- Provide care coordination that aims to keep Members out of a medical facility or institutional setting and provide care in the Member's community or home to the greatest extent possible.
- Provide assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, promote continuity of care and prevent unnecessary re-hospitalizations and document and communicate necessary information about the Member to the providers, institutions and individuals involved in the transition.

Advocacy & Troubleshooting

- Document problems and provide solutions to problems encountered by providers or Members in the provision or receipt of care.
- Identifying and addressing barriers to health in the Contractor's region, such as Member transportation issues or medication management challenges.

Client and Family Centered Care

- Ensure that Members, and their families if applicable, are active participants in the Member's care, to the extent that they are able and willing.
- Provide care and care coordination activities that are linguistically appropriate to the Member and are consistent with the Member's cultural beliefs and values.

Behavioral Health Organizations (BHO)

Case Management: Clinic Services, Case Management. Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician. (State Plan Amendment)

According to the Uniform Coding Standards Manual used by BHOs, case management includes:

- **Assessing service needs** – client history, identifying client needs, completing related documents, gathering information from other sources;
- **Service plan development** – specifying goals and actions to address client needs, ensuring client participation, identifying a course of action;
- **Referral** and related activities to obtain needed services – arranging initial appointments for client with service providers/informing client of services available, addresses and telephone numbers of agencies providing services; working with client/service providers to secure access to services, including contacting agencies for appointments/services after initial referral process; and
- **Monitoring and follow-up –** contacting client/others to ensure client is following the agreed upon service plan and monitoring progress and impact of plan.

Care Coordination: The process of identifying, screening and assessing Members' needs, identification of and referral to appropriate services, and coordinating and monitoring an individualized treatment plan. The treatment plan should include patient/family involvement in planning and consent to treatment. Care Coordination helps integrate health, mental health, and support services that help a Member remain in his/her community. Care Coordination is critical for Medicaid members receiving wrap around services under an HCBS waiver. (BHO Contract)

Intensive Case Management: Community-based services averaging more than one (1) hour per week, provided to adult Members with serious mental illness who are at risk of a more intensive twenty-four (24) hour placement and who need extra support to live in the community. ((b)(3) services in the 1915(b) waiver)

The Coding Manual defines these services as: Assessment, Care plan development, Multi-system referrals, Assistance with obtaining wraparound services and supportive living services, and Monitoring/follow-up activities.

*HCPF has drafted a State Plan Amendment (SPA) for targeted case management that will apply only to Medicaid members with a BHO-covered diagnosis. The SPA will permit case management to be delivered wherever it is needed and not be restricted to CMHCs or clinics.

Colorado Alliance for Health and Independence (CAHI)

No definition

Colorado Choice Transitions/Intensive Case Management Services (CCT)

Case management: Assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Case Management: Seek out and inform all Medicaid-eligible individuals under age 21 that EPSDT services are available and of the need for age-appropriate immunizations; Provide or arrange for the provision of screening services for all children; Help Medicaid beneficiaries and their parents or guardians

to effectively use health services and resources and provide support services (such as scheduling and transportation assistance). Assure that health problems are diagnosed and treated early, before they become more complex and costly to treat. (Although "case management" does not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness.)

Hospice Program

Care Coordination: The hospice provider shall designate a member of the interdisciplinary team to provide coordination of care and to ensure continuous assessment of each client's and family's needs and implementation of the interdisciplinary plan of care. The designated member shall oversee coordination of care with other medical providers and agencies providing care to the client. (Benefits Manual)

Home Health

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care and other health care support services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care with the understanding that this information is or will be incorporated into the current or future medical care of the patient. (Benefits Manual)

Single Entry Point Agencies (SEPs), HCBS waivers

Case Management: The assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic reassessment of such client's needs. (10 CCR 2505-10, 8.390.1)

On-going Case Management: The evaluation of the effectiveness and appropriateness of services, on an on-going basis, through contacts with the client, appropriate collaterals and service providers. (10 CCR 2505-10, 8.390.1)

Program of All-Inclusive Care for the Elderly (PACE)

No definitions for care coordination or case management.

Part 460.102 "Interdisciplinary Team"
IDTs are responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24 hour care delivery.

Part 460.104 "Participant Assessment"
Comprehensive assessments must include: physical and cognitive function and ability, medication use, participant and caregiver preferences for care, socialization and availability of family support, current health status and treatment needs, nutritional status, home environment (including home access and egress), participant behavior, psychosocial status, medical and dental status, and participant language.

Part 460.106 "Plan of care"
The IDT must promptly develop a comprehensive plan of care for each participant. The plan of care must specify the care needed to meet the participant's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment. The plan of care must also identify measurable outcomes to be achieved and be developed and reviewed in collaboration with the participant or designated representative. On a semi-annual basis, the IDT must reevaluate the plan of care and defined outcomes and make changes as necessary.

Rocky Mountain Health Plans Medicaid Prepaid Inpatient Health Plan (PIHP), ASO model

Care Coordination: Identifying, screening and assessing Members' needs, identification of and Referral to appropriate services, and coordinating and monitoring an individualized treatment plan that includes involvement of patient and family.

Medicaid Denver Health Medicaid Choice Staff Model HMO Plan

Care Coordination: Identifying, screening and assessing Members' needs, identification of and Referral to appropriate services, and coordinating and monitoring an individualized treatment plan that includes involvement of patient and family.

Program Descriptions

Accountable Care Collaborative (ACC)
The ACC passively enrolls Medicaid clients into the program by assigning them to a Primary Care Medical Provider (PCMP) who receives a Per Patient Per Month (PMPM) payment to coordinate care. Clients served by the ACC include families with dependent children, adults without dependent children, women and children (with Baby Care), old age pensioners, and clients receiving Aid to the Needy, Disabled with SSI.

The Regional Care Collaborative Organization (RCCO) contract defines comprehensive care coordination as assessing the client's health needs, developing a care plan, linking members to medical services and other non-medical supports, serving as a liaison between medical and non-medical providers, assisting in transitions, promoting continuity of care, preventing readmissions, connecting the client to the Ombudsman to resolve problems and file grievances, following up with clients, and tracking clients' progress toward desired health outcomes.

Regional Care Collaborative Organizations (RCCO) Formal Systems of Care Coordination
The RCCO contract requires the contractor to document its formal system of care coordination. These reports were submitted to the Department within 60 days of the contract's effective date.

Rocky Mountain Health Plan, RCCO Region 1
Rocky has a tiered system that ranges from preventive and wellness care to varying degrees of disease management requirements to complex outpatient care to, ultimately, care transitions. Rocky intends to use SDAC data as well as other sources of information to determine the tier for each Member. Rocky currently offers evidence-based disease management programs for Members with cardiac disease, diabetes, asthma, and high-risk pregnancy.

Colorado Access, RCCO Regions 2,3,5
New Members are given a health risk assessment (HRA), enrolled into care management, assigned to a care manager, and provided with an individualized care plan. The HRAs are loaded into Altruista (a care management software that uses evidence-based clinical guidelines and algorithms to guide assessment and management of Members). The data is shared with the PCMP and the level of care management is determined. Colorado Access has a Transitions Access Program (TAP), which is a multi-step 30 to 40-day intervention to help patients move from one care setting to another. TAP provides a personal health record, medication self-management, follow-up visits, and patient education. TAP patients at risk of readmission are offered a home visit with a case manager.

***"A care plan** is a professionally established, Member-focused tool which reflects existing Member health conditions and needs, as well as priority short- and long-term Member goals. The care plan serves as a map of the Member's care and is reflective of the Member's capabilities and empowerment. When appropriate, the Care Plan is focused on increasing the Member's self management skills, awareness of warning symptoms of disease progression, and understanding of the course of their chronic health condition."*

Integrated Community Health Partners (ICHP), RCCO Region 4
ICHP uses a "stratification Algorithm" to place members into one of three tiers for care coordination. The initial assessment includes total Member cost, hospitalizations, ER visits, and medications, and will eventually align with the CRGs in the SDAC. All newly-attributed Members are given HRAs and are reassessed annually or as health conditions change. Care coordination activities include scheduling, medication management, coordination of transportation, and other related activities. Additional protocol is established around care transitions. The PCMPs and Community Mental Health Centers (CMHCs) participate in Community Care Coordination and Case Management Teams, which meet regularly.

Colorado Community Health Alliance (CCHA), RCCO Region 6
CCHA employs the fundamentals of quality improvement coaching to help improve physician office workflow processes and to implement care coordination aligned with the medical home model. When a Member is identified for care coordination, using SDAC and other data, the care coordination management software, ThinkHealth, creates a care plan and the Member is assigned to a Health Partner. The program is divided into Complex Care Management, General Care Management, Transitions of Care Program, Maternity Care Management, and Pediatric Care Management. The target population includes patients with inappropriate or high use, readmissions, high cost imaging, high-risk chronic diseases, multiple co-morbidities, substance abuse / mental health problems, non-adherence with treatment regimen, complex medical issues, impaired mental status, or insufficient support system or community resources. CCHA will also evaluate, test, and implement evidence-based programs and clinical models including shared medical appointments, targeted chronic disease initiatives, maternity programs, and prevention programs.

Community Care of Central Colorado, RCCO Region 7
Community Care of Central Colorado uses a provider-based care coordination model. The initial phase is limited to two PCMP groups in Colorado Springs. All providers in these practices have agreed to team-based patient-centered care, to collecting data and assessing patients, to managing care and providing self-care support, and to providing community resources to Members. Care management involves addressing barriers to treatment goals, reconciling medications, e-prescribing, follow-up, and tracking. The program is divided into patient navigation (helping patients address barriers to care), case management (hands-on support to high-risk, high-cost patients), and disease management (support to patients who are able to self-manage chronic conditions). Currently disease management is available to patients with asthma, diabetes, cardiovascular disease, and depression.

The Department requires each RCCO to measure the 3 Key Performance Indicators (KPI):

1. ER visits
2. Hospital readmissions
3. Use of high-cost imaging

In addition to the 3 KPIs, the RCCOs suggested a number of other care coordination measures:

- Number of members with HRA completed within 90 days of enrollment
- Number of members enrolled in care management, by tier
- Number of members who refuse care management
- Number of members who leave care management program, by reason
- Number of goals met within 6 months of enrollment
- Number of follow-up calls/visits within 7 days of hospital discharge
- Number of follow-ups with PCMP, with other providers
- Use of tools for standardized screening, risk factors, medication lists
- Number of written care plans
- Number of self-management plans
- Number of service connections made to other resources

Behavioral Health Organizations (BHO)
Almost all Medicaid members are enrolled automatically in a BHO managed care plan. Any members with a BHO-covered mental health diagnosis may receive care coordination/case management services. Currently, case management in the state plan is defined as medically necessary services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician. Colorado has drafted a State Plan

Amendment (SPA) for targeted case management that will apply only to Medicaid members with a BHO-covered diagnosis. The SPA will permit case management to be delivered wherever it is needed and not be restricted to CMHCs or clinics.

Care coordination is the process of identifying, screening, and assessing Members' needs, identification of and referral to appropriate services, and coordinating and monitoring individualized treatment plans. These treatment plans include strategies to ensure that all Members and/or authorized family members or guardians are involved in treatment planning and consent to the treatments. Care coordination is contracted out and care coordinators are required to coordinate with other HCPF programs and other state agencies, as well as to help integrate medical and behavioral health for Members.

Uniform Service Coding Standards Manual 2012 Colorado Division of Behavioral Health		
CPT/HCPCS Code	**Unit**	**Procedure Code Description**
H0002	Encounter	Behavioral health screening to determine eligibility for admission to treatment program
H0032	Encounter	Mental health service plan developed by non-physician
T1016	15 minutes	Case management as defined as "medically necessary services provided through a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician" and "designed to help clients gain access to needed medical, social, educational, and other services." Includes assessment, development of care plan, referral to services, monitoring, and follow-up.
H0038	15 minutes	Self-help/peer services
H2015	15 minutes Per diem	Comprehensive community support services
H0023	Encounter	Behavioral health outreach service
H0025	Encounter	Behavioral health prevention education service

Children with Life Limiting Illness Waiver (Proposed)
This is a palliative care waiver program for children under 18 with a life limiting illness and can be provided together with curative treatment. Under this waiver, palliative care includes care coordination and pain and symptom management. Care coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client, and central coordination of medical and psychological services. The care coordinator organizes the multifaceted array of services. This approach enables the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. A key function of the care coordinator is to assume the majority of responsibility (otherwise placed on the parents) for condensing, organizing, and making accessible to providers critical information that is related to care and necessary for effective medical management. The activities of the care coordinator enable seamless care.

These services are provided by a Hospice or Home Care Agency with staff that has received additional training in palliative care concepts. The care coordinator can also be an Agency Registered Nurse with a minimum of three years clinical pediatric experience; a minimum of one

year clinical End of Life Care experience; or End of Life Nursing Education Consortium (ELNEC) or equivalent training within the last five years. Duties are both administrative and clinical.

Colorado Alliance for Health and Independence (CAHI)
CAHI is a 5-year pilot program for Medicaid clients, age 21 and over, who qualify for Aid to the Needy Disabled/Aid to the Blind (AND/AB-SSI) and are enrolled in any Home and Community Based Services (HCBS) waiver program or any clients, age 60-64, who are Old Age Pensioners (OAP-B) and are enrolled in HCBS. CAHI does not define care coordination, but contractually requires a list of care coordination activities including: scheduling and coordinating appointments and transportation; helping clients find appropriate services, including behavioral health services; coordinating with HCBS, county and state agencies; providing technical assistance to PCPs; and facility discharge planning. CAHI has no defined qualifications for care coordinators.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
EPSDT is available to any Medicaid eligible person age 20 and under or any pregnant woman, no matter the eligibility category or waiver. EPSDT staff are responsible for identifying eligible people and informing them of the benefits of prevention and the health services and assistance available, as well as helping beneficiaries use health services and providing support services (such as scheduling and transportation assistance). A fundamental feature of this program is to provide initial and periodic examinations and evaluations to ensure that health problems are diagnosed and treated early, before they become more complex and costly to treat. Although "case management" does not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently. EPSDT also aims to avoid duplication and unnecessary services through care coordination activities.

Federally Qualified Health Centers (FQHC)
The FQHCs serve all Medicaid clients and work with the ACCs, but are a provider type rather than a Medicaid program. Clients served by FQHCs are frequently also served by Medicaid programs that provide some level of care coordination, but there is no formal authority for care coordination associated with FQHC funding. FQHCs, independent of a client's enrollment in Medicaid programs that include care coordination, are reimbursed by FFS for medical services and not for care coordination.

Home Health and Hospice Program
All Medicaid recipients have access to home health and hospice. Medicaid clients enrolled in Colorado Medicaid managed care organizations (MCOs) do not receive Hospice services from his or her MCO. Clients enrolled in an MCO may receive hospice services through Medicaid fee-for-service as a wrap-around benefit.

Medicaid clients enrolled in a Colorado Medicaid home and community-based services (HCBS) waiver may receive Hospice services. The Hospice program uses an interdisciplinary team to provide care; this team includes – but is not limited to – physicians, nurses, social workers, a pastoral or other counselor, and volunteer coordinator. The Hospice provider designates a member of the interdisciplinary team to provide coordination of care and to ensure continuous assessment of each client's and family's needs and implementation of the interdisciplinary plan of care.

The designated person oversees coordination of care, with other medical providers and agencies providing care to the client. Home health coordination is conducted by a registered nurse.

Care coordination in Hospice can be provided by a registered nurse, licensed clinical social worker, chaplain, physician, advanced practice nurse, and/or Hospice Medical Director.

Long Term Services and Supports: Colorado Choice Transitions / Intensive Case Management Services

This program serves adults eligible for HCBS-EBD, BI, Community Mental Health Supports, DD, or Supported Living Services, and who are currently residing in long-term care facilities. Case management services staff assist clients with access to home and community-based services, Medicaid State Plan services, and non-Medicaid supports and services. Case management services support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals. The case managers work with three other services offered through CCT that provide some coordination:

- Mental Health Centers – to organize community-based mental health services when the client discharges to the community.
- Transition Coordinators – to assist with locating housing, establishing a residence in the community, and arranging other community non-Medicaid services.
- Enhance Nursing Services – to provide short-term services immediately prior to and after discharge that helps to arrange home health and other medical services for medically complex individuals transitioning from long-term care facilities. (CCT Benefit)

Case managers have bachelor's degrees in a human service or health-related field or 2 years of experience in HCBS case management. Case management activities include: intake and screening for Medicaid LTSS; arrangement for LTSS; functional assessment and reassessment; development of care plans; transition planning; coordinating and monitoring the delivery of needed services; support of clients in achieving independent living goals; documentation, reporting, and resolution of client complaints and concerns; and reporting of abuse, neglect, mistreatment, and exploitation to the appropriate authority.

Program of All-Inclusive Care for the Elderly (PACE)
PACE participants must be 55 years of age or older, meet the nursing facility level of care (determined by Single Entry Point agencies), live in an area the PACE organization services, and be able to live in a community setting without jeopardizing his or her health or safety.

Each PACE center must have an "Interdisciplinary Team" (IDT) to comprehensively assess and meet the individual needs of each participant. IDTs are responsible for initial assessments, periodic reassessments, plans of care, and coordination of 24 hour care delivery. IDTs must be composed of at least the following members: PCP, RN, Master's level social worker, physical therapist, occupational therapist, recreational therapist, dietitian, PACE center manager, home care coordinator, personal care attendant, and driver. At the recommendation of IDT members, other professional disciplines (speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

Comprehensive assessments review the following: physical and cognitive function and ability, medication use, participant and caregiver preferences for care, socialization and availability of family support, current health status and treatment needs, nutritional status, home environment

(including home access and egress), participant behavior, psychosocial status, medical and dental status, and participant language. IDTs also develop comprehensive plans of care for participants according to the needs identified in initial comprehensive assessments. The plans of care must identify measurable outcomes to be achieved and be developed and reviewed in collaboration with participants or their designated representatives. Comprehensive assessments and plans of care are revaluated on a uniformly scheduled and on-going basis.

Single Entry Point (SEP)

SEP serves Medicaid clients who need long term care services, including: personal care or homemaker services; nonemergency medical transportation; home access modifications; electronic monitoring; assisted living (Alternative Care Facilities); adult day programs; and respite care. SEP agencies serve clients by county of residence. They provide care planning and case management for clients in waiver programs for the Elderly, Blind and Disabled, Mental Illness, and Person Living with Aids and Spinal Cord Injury, as well as make referrals to other resources. Case Management is defined as the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic reassessment of such client's needs. On-going Case Management is defined as the evaluation of the effectiveness and appropriateness of services on an on-going basis, through contacts with the client, appropriate collaterals, and service providers. Case managers are required to have at least a bachelor's degree in one of the human behavioral science fields.

Part II: Multiple-Choice Survey

Program Characteristics

Figure 1: Program Characteristics

Program	Authority	Payment	Qualification	How many
ACC	Intrinsic	PMPM	None	Most/need
BHO	Intrinsic	Duty Lack	Depends Varies	Most/need
CAHI	State	PMPM	None	100%
CCT	Federal, State	Code	1 year, BA	100%
Denver Health MCO	Informal	Other	None	hard to say
EPSDT	Federal	Duty	None	Other
Home Health, Hospice and Private Duty Nursing	State	Duty	RN/PA MSW/Psychologist Depends	Most
Nurse Home Visitor Program	State	Code	RN/PA	100%
PACE	Federal	PMPM	1 year, MD MSW/Psychologist	100%
Prenatal Plus	State	Code	BA, RN/PA	100%
RMHP	Informal	PMPM	Depends	Other
Special Connections	State; Intrinsic	Duty	Other	Most/need

Additional comments

BHO	Care coordination is a contract requirement to be performed under a capitated full risk contract. These responses are mainly guesses. Fewer than 20% of Medicaid members come into contact with BHOs.
CCT	This service is offered as an HCBS service, which means we do not have contracts with the agencies. The agencies are paid FFS.
Denver Health	Care coordination may be calculated into the capitation rates - not sure
EPSDT	Not sure how many people in this population receive care coordination
Hospice, Home Health, PDN	Authority for care-coordination comes from the Medicaid rules for the program and the licensure requirements from CDPHE. The Hospice rule requires care coordination and defines the expectation of the care coordination. Home Health does not which results in less comprehensive care coordination. HH and PDN will only have RN, but hospice can be managed by the broader group.
Nurse Home Visitor Program	Less than 50%: The only folks eligible to participate are first-time pregnant women or whose child is less than one month old and who are at or below 200% of the federal poverty level. Required care coordination activities: Targeted case management services Other entities: There are likely more than just CDPHE but I'm not aware of others. Successfully achieved/not fully achieved activities: Lisa Waugh used to work for NHVP. She may have some good insight about these questions.
PACE	In PACE care coordination is performed by all members of the Interdisciplinary Team including the PCP and Master's Level Social Worker. Care coordination through Interdisciplinary Teams is one of the strengths of the PACE program. Billing and enrollment problems exist in PACE.
Prenatal Plus	Care coordinator(s) shall, at minimum, hold a bachelor's degree in a relevant human/social services discipline OR be a registered nurse. All members receive some level of care coordination, however, the amount they receive depends on their level of participation in the program. There are different billing packages available to participants. Lower billing packages result in fewer contacts.
RMHC	HCPF Quality section may have better information on this
Special Connections	Licensed/Certified Addiction Counselors

Program Characteristics

Reading the table

Note: The wording of the questions, as well as the answer options and the code that represents each option, is available in the Appendix.

Authority: Figure 1 shows that care coordination in Colorado Medicaid programs is federally mandated and state mandated (see Figure 2), as well as conducted as an intrinsic (carried out by definition rather than law) or informal element of the program. Figure 1 shows how much legal authority and lack thereof varies across programs.

Payment: Similarly, the way care coordination activities are reimbursed varies tremendously. In some cases, practices receive a PMPM for care coordination and in some other cases, care coordination is only reimbursed when it can be assigned a CPT (or other) code. In yet other cases, care coordination is considered part of the duty of staff and is included in salary, but is not reimbursed on a FFS basis. Sometimes in the BHOs, care coordination is not reimbursed, but care coordination activities are carried out regardless.

Qualifications: Qualifications for care coordinators vary just as much as authority and payment. In a number of programs there are no qualification requirements for care coordinators. In some programs care coordinators have one year of experience or a bachelor's degree in a health or human science. In still other programs, care coordinators are expected to be licensed professionals at various levels, including RNs, PAs, MSWs, psychologists, or MDs. In a few programs the qualification required depends on the care coordination activity, or the requirements vary by contractor.

How Many Served: Finally, we asked respondents to describe which members of the population served by their program receive care coordination services on a regular basis (meaning they receive most of the care coordination services available when they are needed). In about half of the programs, all clients of that program receive care coordination. A few other respondents said that most of those clients who need care coordination receive it in their programs, while a few other respondents said it was hard to say or selected "other" as the answer (see additional comments above).

Figure 2: Authority that Requires Care Coordination in Colorado Medicaid Programs

Program	Federal	State	Other
HCPF, Medicaid & CHP+ Program Division, Community Mental Health Services Program (BHOs)	1915(b) waiver. Federal managed care statutes apply (42 CFR 438).	Section 25.5-5-402 C.R.S., 10 CCR 2505-10 8.212.	Uniform Coding Standards Manual
HCPF/Long-Term Services and Supports Strategy Division/Colorado Choice Transitions/Intensive Case Management Services	Section 6071 of the Deficit Reduction Act of 2005. Section 2403 of Patient Protection and Affordable Care Act. Title 42 of the United States Code, Section 1396n.	C.R.S. §§ 25.5-6-402, 25.5-6-602, 25.5-6-702 / 10 CCR 2505-10, Section 8.555.	
Health Care Policy and Financing, EPSDT Outreach and Case Management program	42 CFR Section 441.50 6-44.162 and USC 1902(a)(43) and 1905(a)(4)(B)		Detail specific to Outreach, Case Management and Treatment can be found in Part V State Medicaid Manual, Sections 5010-5360.
Home Health and Hospice Programs		10 CCR 2505-10 section 8.520 – 8.529 10 CCR 2505-10 section 8.540 10 CCR 2505-10 section 8.550	HCPF Program guidelines: Hospice is in effect as of 06-2012 and home health will be in effect 09-2012
HCPF, Long Term Benefits Division, Single Entry Point Agencies (SEPs), HCBS waivers	42 CFR, 1915(c) waiver authority	10 CCR 2505-3, Rules 8.300-8.399 and 8.400-8.499.	
HCPF, Medicaid Rocky Mountain Health Plans Medicaid Prepaid Inpatient Health Plan (PIHP), ASO model	1915(a) Plan; 42 CFR, § 431.54		
HCPF, Medicaid Denver Health Medicaid Choice Staff model HMO Plan		C.R.S 25,5-5-413	

Populations Served by Various Medicaid Programs

	ACC	BHO	CAHI	CCT	DHMC	EPSDT	Home Health, Hospice and Private Duty Nursing	RMHC	Prenatal Plus	PACE	Nurse Home Visitor Program
AwDC	1				1		1				
Blind	1		1	1	1		1	1			
Children with health concerns	1				1	2	2	1			
Disabled and not working	1		1	1	1			1			
Disabled and working	1		1	1	1		1	1		1	
Elderly (65+)	1		2	1	1		2	1		2	
Foster Children	1		1		1	2	2	1			
Health Children	1		1		1	2		1			
Hospice eligible	1		1	1	1	1	2	1		1	
Nursing home eligible	1		2	2	1			1		2	
Pensioners under 65	1				1			1			
Living with HIV	1	1	1		1			1			
Mental illness	1	2	1	1	1	1		1			
Pregnant women	1		1		1	2	1	1	2		2
Refugees	1	1			1	1		1			
Welfare families	2				1	2		1			

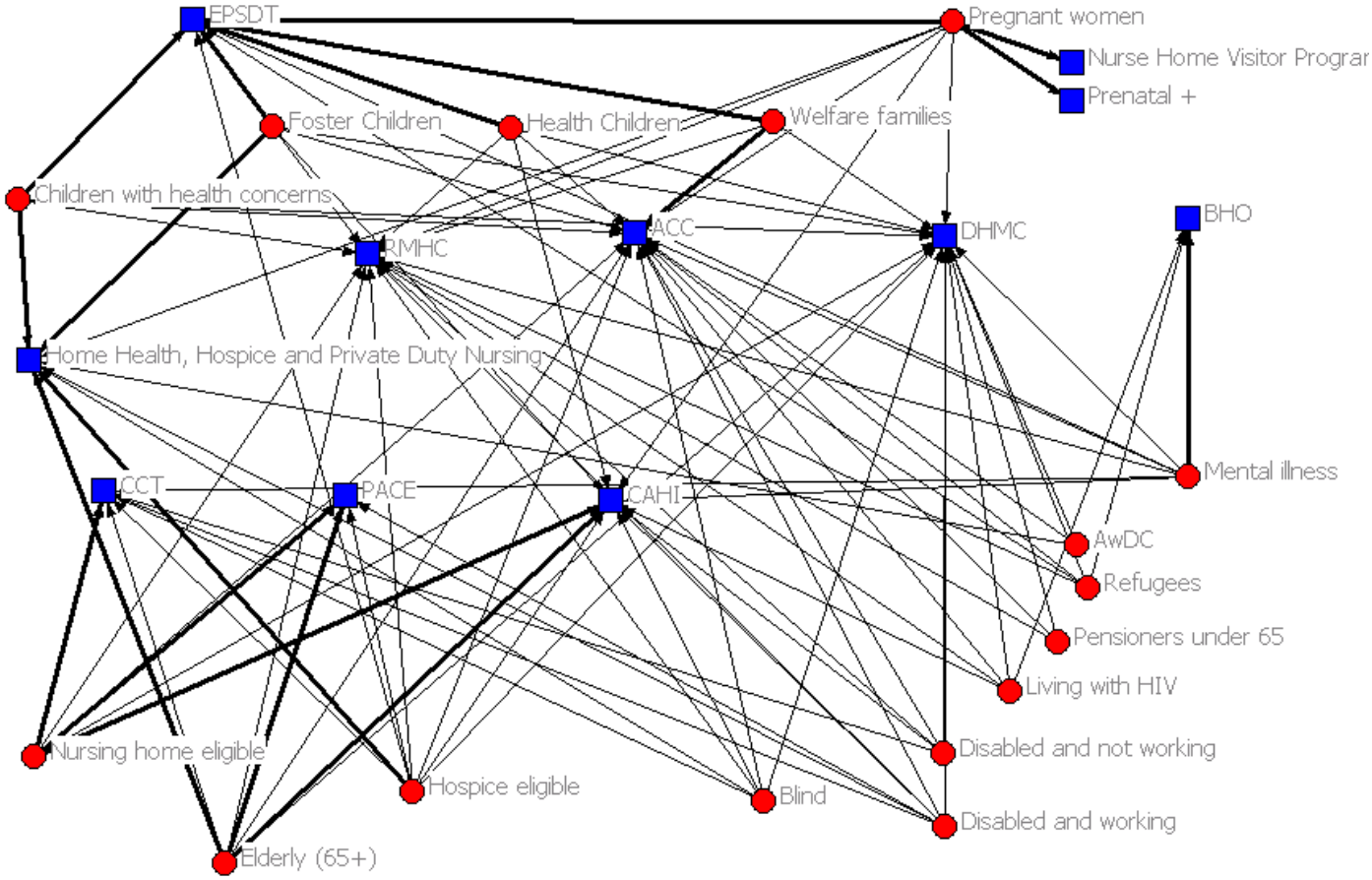
1 - Less than half of the population that receives care coordination in this program

2 - More than half of the population that receives care coordination in this program

Additional Comments

CAHI	Exclusively waiver adults
Denver Health	All clients who see a PCP receive some level of care coordination.
Hospice, Home Health, PDN	Hospice only treats clients with terminal diagnoses. HH and PDN have a much broader client base.
Nurse Home Visitor Program	First-time pregnant women only or women whose first child is less than one month old and who are at or below 200% of the federal poverty level. <50%: The answer would be all of those listed. Clients must be pregnant and determined to be at risk of having a negative maternal and/or infant health outcomes.
Special Connections	Only women while pregnant and up to one year postpartum

Map 1: Populations Served by Medicaid Programs



Borgatti, S.P., Everett, M.G. and Freeman, L.C. 2002. Ucinet for Windows: Software for Social Network Analysis. Harvard, MA: Analytic Technologies.

Reading the map: When 50% or more of the clients served by a HCPF program (represented by blue squares) fall into a population category (represented by red circles), the connecting line is heavy. When the program serves a certain population, but that population makes up less than 50% of the program's clientele, the connecting line is light. The top of the map shows pregnant women, children, and families. The map shows the importance of EPSDT to these populations. The bottom left corner shows the frail population and the programs (Home Health, Hospice and PDN, CCT, PACE and CAHI) that are essential to these populations (nursing home eligible, elderly, or hospice eligible, as well as children with health concerns). The bottom right corner represents special populations that fit into neither the maternal/child nor frail categories. The light lines moving toward the bottom right show that these special populations are not a focal point for most HCPF programs, though they are served by HCPF. The map shows the ACC and managed care programs at the center, serving everyone; it also suggests that the BHOs may not be fully integrated.

Care Coordination Activity by Program: Required, Successful & Not Fully Achieved

	ACC	BHO	CAHI	CCT (not yet launched)	DHMC	EPSDT	Home Health, Hospice & PDN	PACE	RMHC	Special Connections	Prenatal Plus	Nurse Home Visitor Program
Patient assessment, screenings, intake		✓👍	✓👍↗	✓	👍	✓👍	✓👍	✓👍	👍	✓	✓	✓
Plan of care, treatment plan	✓↗	✓👍	✓👍↗	✓	👍		✓👍	✓👍	👍	✓	✓	
Evaluate care plan		✓👍	✓↗	✓	👍		✓	✓👍	👍	✓		✓
Track progress toward goals	👍	✓👍	✓👍	✓			✓👍	👍	👍	✓		
Case closure				✓			👍					
Patient-centered planning	✓👍	✓👍	✓👍↗	✓	👍		✓↗	✓👍				
Care-giver preferences			✓👍		👍		✓↗	✓👍	👍			
Consent		✓👍	✓	✓			✓👍	✓👍	👍			
Advanced directive		✓	👍		👍		✓👍	✓👍	👍			
Shared-decision making	✓👍	✓	✓👍	✓			✓↗	✓👍	👍			
Referrals		✓	✓👍	✓	👍	✓👍				✓	✓	✓
Resource development	✓👍	✓👍	✓👍↗	✓		✓👍						
Coordinate with other providers	✓👍	✓👍	✓👍↗	✓	👍	✓👍	✓👍↗	✓👍	👍	✓	✓	
Coordinate with support services	✓👍	✓👍	✓👍↗	✓	👍	✓👍		✓👍	👍	✓	✓	
Coordinate with county and government agencies	✓👍	✓👍	✓👍↗	✓	👍	✓👍		✓👍	👍		✓	
Coordinate with community resources	✓👍	✓👍	✓👍↗	✓	👍	✓👍	✓↗	✓👍	👍	✓	✓	
Billing		✓👍		✓	👍	✓👍		↗	👍			
Eligibility				✓		✓👍		✓👍	👍			
Scheduling		✓👍	✓↗	✓	👍	✓👍		✓👍	👍			
Transportation			✓👍↗		👍	✓👍		✓👍	👍			
Home modification			✓	✓				✓👍				

(cont.)	ACC	BHO	CAHI	CCT (not yet launched)	DHMC	EPSDT	Home Health, Hospice & PDN	PACE	RMHC	Special Connections	Prenatal Plus	Nurse Home Visitor Program
Reminders of appointments, refills, etc.		✓	✓		👍	✓👍		✓👍				
Accompany to appointments												
Emotional support		✓	✓👍	✓			✓	✓👍				
Transition planning	✓↗	✓	✓👍↗	✓	👍		↗	✓👍				
Follow-up with patients		✓	✓↗	✓	👍	✓👍	✓👍	✓👍	👍			✓
Patient education	↗	✓👍	✓↗		👍	✓👍	✓👍	✓👍	👍			
Monitoring patient health	👍	✓👍	✓👍↗	✓	👍		✓👍	✓👍	👍			
Medication reconciliation		✓		✓	👍		✓↗	✓👍	👍			
Medical records management		✓👍		✓	👍			✓👍	👍			
Utilization management, gatekeeper		✓👍	✓👍		👍			✓👍				
File grievances, advocate, liaison to ombudsman		✓👍	✓		✓👍	✓👍	👍↗	✓👍	✓👍			

✓ Required 👍 Successful ↗ Not fully achieved

Additional Comments

BHO	Not fully achieved could be any or all of these.
Denver Health	I have checked the services I know to be provided but am not sure how successful Denver Health is in achieving them.
EPSDT	No services are not fully achieved
Hospice, Home Health, PDN	Hospice is very successful in grief and emotional support. Hospice does all of this well. Home health and PDN does not.
Nurse Home Visitor Program	Assessment of the pregnant woman and her child's needs for health, mental health, social services, education, housing, childcare, and related services. Targeted case management services are required. Successfully achieved/not fully achieved activities.
Prenatal Plus	Nutrition counseling (by a dietician); psychosocial counseling and support (by a mental health professional); general client education and health promotion; and targeted case management (by care coordinator). The program has been shown to improve infant health outcomes (increased birth rate, for example). Not sure what activities are really going well for clients and providers at this juncture.
RMHC	Not aware of any issues, or lack of achievement
Special Connections	Unable to measure if successful or fully achieved

Reading the table

The survey asked respondents to list which care coordination activities were required, were successful, and were not yet fully achieved. The list of activities is a compilation of all activities included from previous answers on the questionnaire and from activities mentioned in articles included in the literature review (Paper 1 of this series). The draft survey was presented to members of the Care Coordination Work Group before they were asked to complete the survey. Some respondents felt more comfortable rating their programs than others. In the table above, a check-mark symbolizes that a certain activity is required, a "thumbs-up" symbolizes that the program is generally successful in delivering that activity, and the arrow symbolizes room for improvement or "not yet achieved."

The activities that are required by the most programs (7-9) are patient assessment, screening and intake, plan of care (or treatment plan), evaluation of care plan, coordination with other providers, support services, county and government agencies, and community resources, and follow-up with patients. The only activity that was required by none of the programs included in this survey was accompanying patients to appointments. Activities that were required only by a few programs (1-4) are: case closure, caregiver preferences, advanced directive, billing, eligibility, transportation, home modification, reminders of appointments and refills, medication reconciliation, medical records management, utilization management and gatekeeper function. While some of these activities are specific to certain programs (for example, home modification is not required of all programs), other elements that are frequently not required might have general applicability and might be considered as part of a standardization process.

In some cases activities that are not required are still performed, often successfully (for example, tracking progress). Some functions may not be included in care coordination because they are achieved elsewhere (for example, billing and eligibility). Before any additional tasks are added to program requirements, it should be clear that these are essential functions of care coordination and that their addition is neither redundant nor unnecessarily burdensome; making these determinations will require broad stakeholder engagement.

Network Interactions

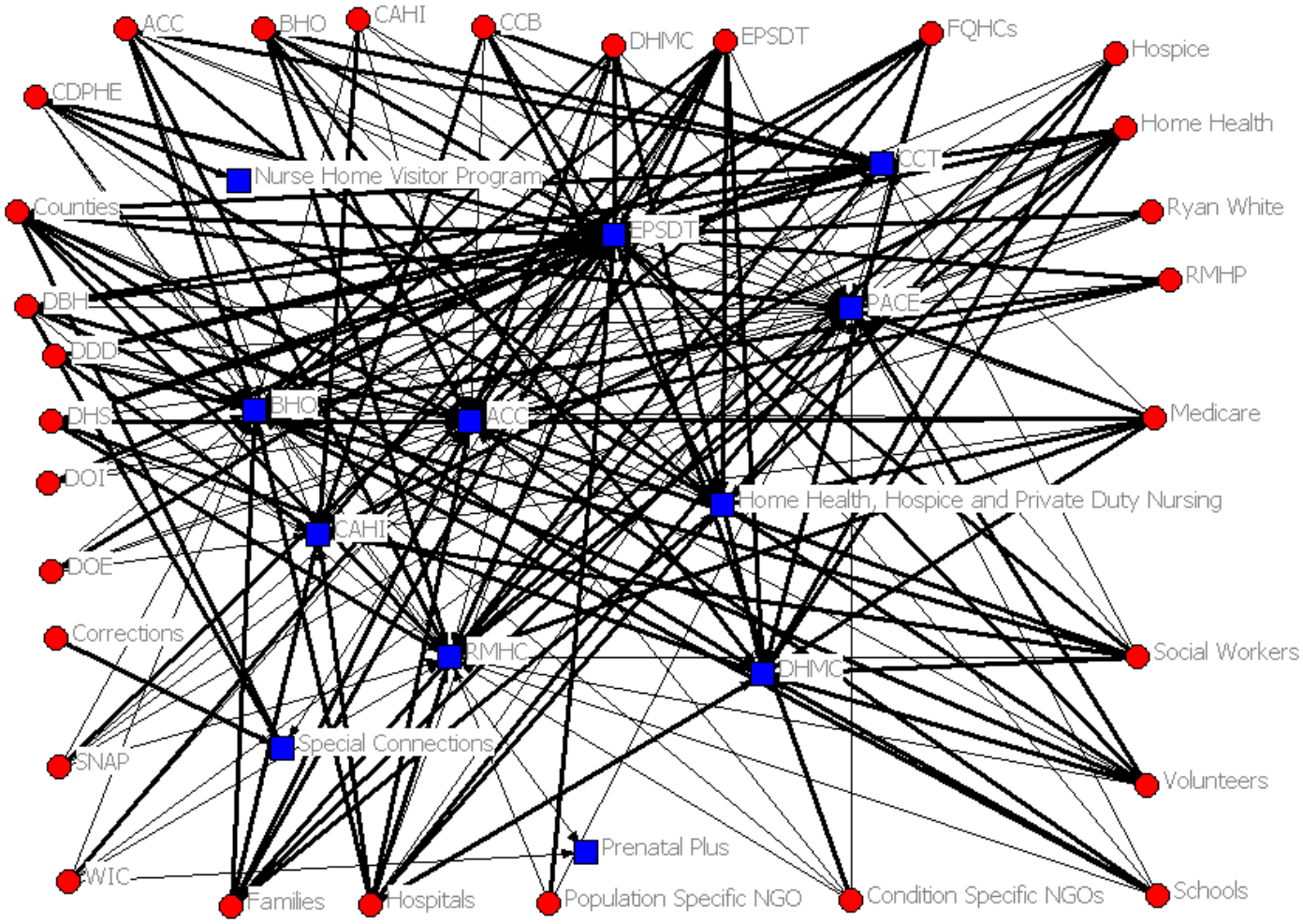
	ACC	BHO	CAHI	CCT	DHMC	EPSDT	Home Health, Hospice & PDN	Nurse Home Visitor	PACE	Prenatal Plus	RMHC	Special Connections
ACC		2	1	2		1	2		1		2	
BHO	2			2	2	2	1		1		2	
CAHI	1	1	2			1			1			
CCB	1		2	2		2	2		1			
DHMC	2	2	1		2	2			1		1	
EPSDT	2	2	2		2	2	2		1		2	1
Home Health	1	1	2	2	2	2	2		1		2	
Hospice	1	1			2		2		1		2	
Medicare	2	1	1	1	2	1	2		2		2	
RMHP	2	2	1			2			1			
Ryan White	1	1	1			2			1			
CDPHE	1	1				2	2	2	1	1	1	
DHS	2		1	2	2	2			1		2	
DDD	1	2	2	2		2	1		1			
DBH	2	2		2		2			1		1	2
DOE	1	1	1			2			1			
DOI	1	1				2			1			
SNAP	1	1		1		2			1		1	
Counties	2	2		2	2	2	1		2		2	2
WIC	1	1				2			1	1	1	
Schools	2	2			2	1			1		1	
Hospitals	2	2	2	1	2	1	2		2		2	
FQHCs	2	2			2	2			1		2	
Social Workers	2	2	2	1	2	2			1		1	
Families	2	2	2	2	?	2	2		2		?	
Condition Specific NGOs	1	1				2			1		1	
Population Specific NGO						2			1		1	
Volunteers	1	2			2	2	2		2		1	
Corrections												2

1 - Rare or occasional interaction 2 - Regular or formal interaction

Additional Comments

Denver Health	Not sure about rare or occasional interactions
Hospice, Home Health, PDN	Hospice has frequent contact w/volunteers - HH and PDN does not. Agencies that see children also interact with the utilization manager vendor and the fiscal agent.
Nurse Home Visitor Program	There are likely more than just CDPHE but I'm not aware of others.
PACE	PACE rarely works with the BHOs, RCCOs, or other Medicaid programs. Pace works regularly with the SEPs.
RMHC	Not sure about client's family
Special Connections	Unsure, providers

Map 2: Network Interactions Map



Borgatti, S.P., Everett, M.G. and Freeman, L.C. 2002. Ucinet for Windows: Software for Social Network Analysis. Harvard, MA: Analytic Technologies.

Reading the map: Medicaid programs surveyed are denoted by blue squares in the center of the figure above. The survey provided the options, which are denoted by red circles. Program managers were asked to check which organizations their programs interacted with rarely or occasionally (denoted in the table above with a 1 and in the map with a light line) and which organizations their programs interacted with regularly or formally (denoted in the table above with a 2 and in the map with a heavy line). HCPF programs are on the top and swing down to the right, non-HCPF government programs are to the left, and community entities are along the bottom and swing up to the right; Medicare is also on the right.

Appendix

Questions and Answer Codes for "Program Characteristics"

	Under what authority is care coordination carried out?
Federal	Care coordination is required in this program by FEDERAL statute or rule
State	Care coordination is required in this program by STATE statute or rule
Intrinsic	Care coordination is an intrinsic part of the program and is carried out by definition rather than law
Informal	Care coordination is an informal element of the program and is relatively successful
Informal but	Care coordination is an informal element of the program and is NOT especially successful
Other	None of the above / I don't know/Other

	Are care coordination activities reimbursed in this program?
PMPM	Care coordination is paid for on a PMPM basis
Duty	Care coordination is reimbursed by paying staff who are expected to perform these activities
Code	Care coordination is reimbursed by CPT or other similar code
Code but	Care coordination is reimbursed by CPT or other similar code AND because the codes do not match the activity a significant amount of care coordination is nor reimbursed
Lack	Care coordination is not reimbursed but care coordination activities are completed anyway
Limited	Care coordination is limited by the lack of compensation for these activities
Other	None of the above / I don't know/Other

	What personnel qualifications are required by your program to perform care coordination?
None	None
HS/GED	High school diploma or GED
1 year	1 year of relevant experience
> 1 year	More than 1 year of relevant experience
BA	Bachelor's degree in a health or human science field
CAN/LPN	Certified Nurse Aid or Licensed Practical Nurse
RN/PA	Registered Nurse or Physician's Assistant
MSW/Psych	Masters of Social Work or Psychologist
MA	Physician
Depends	It depends on which care coordination duty they are performing
Varies	It varies by contractor
Other	None of the above / I don't know/Other

	Describe which members of the population served by your program receive care coordination services on a regular basis (meaning they receive most of the care coordination services available when they are needed).
100%	100% of members, care coordination is an integral part of the program
Most	Most members receive available care coordination services regardless of need
Most/need	Most members who need care coordination services receive these services
Half	About half of members in this program receive care coordination services
<Half	Less than half of members in this program receive care coordination services
Hard to say	Members receive care coordination services, but it is difficult to say who receives what and when
Other	None of the above / I don't know/Other