

POLICY BRIEF

**Care Coordination and  
Medicaid Managed Care:**

*Emerging Issues for States and  
Managed Care Organizations*

*June 2000*

*Margo Rosenbach*

*Cheryl Young*

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**MATHEMATICA**  
Policy Research, Inc.

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## ***Care Coordination and Medicaid Managed Care: Emerging Issues for States and Managed Care Organizations***

As states enroll increasing numbers of individuals with special health care needs into Medicaid managed care, they are devising innovative approaches to ensure that both psychosocial and medical needs are being met. These needs may be multiple and complex, requiring services from many different providers both inside and outside managed care networks. To complicate matters further, managed care organizations (MCOs) may be unfamiliar with the special needs of the Medicaid population, even as they are serving them in increasing numbers.

Comprehensive care coordination enables people with special health care needs, especially those with chronic conditions, to navigate through complex Medicaid managed care systems. A relatively new trend, care coordination can include brokering for social support and medical services, breaking down boundaries between systems of care, assisting families with transportation and telephones—in short, whatever it takes to keep patients at home and healthy. Although care coordination services are growing in significance for vulnerable groups, little is known about states' experiences in designing and implementing them.

Some states—notably, Oregon and Washington—have led the way in mandating that MCOs develop care coordination services to ensure that medical and social needs are identified and met. In addition, the proposed Medicaid managed care rule implementing the Balanced Budget Act (BBA) of 1997 requires states to ensure that each MCO meets requirements related to continuity and coordination of care. Most states, however, are just beginning to explore the feasibility and desirability of implementing care coordination services in their Medicaid managed care programs.

This publication summarizes a study of care coordination in five states, conducted by Mathematica Policy Research, Inc., for the Center for Health Care Strategies. It addresses the following questions: What is care coordination, and how are states structuring care coordination requirements within their Medicaid managed care programs? How have MCOs chosen to implement care coordination services? What are the best practices among states and MCOs? What lessons have states and MCOs learned?

This study focused on care coordination programs in a risk-based managed care context. However, the concepts and models can easily be applied in other contexts, such as traditional fee-for-service or primary care case management, either by contracting separately for care coordination programs or by developing state agency-sponsored initiatives.

### **Findings in Brief**

The study makes the following points:

- Care coordination programs take time to develop but can be put in place even after a state has implemented Medicaid managed care.
- For the Medicaid managed care population, care coordination must be broader than simply expanding case management to include referrals for social services.

***T**here is no standard definition of care coordination.*

*... care coordination programs may coordinate a full range of medical and social support services offered within and outside the managed care plan.*

- Creative problem-solving, through advocacy, is emerging as an important new role for care coordinators.

The study is based on interviews with state officials, MCO officials, and advocates in Colorado, Delaware, New Mexico, Oregon, and Washington. The interviews took place between March and July 1999.

## What Is Care Coordination?

There is no standard definition of care coordination. Interviewees were asked to define the term and to indicate how care coordination differs from case management (see chart on next page). Although the features are presented as a dichotomy, in reality, they exist along a continuum, with some features more or less dominant depending on program structure.

Case management programs typically rely on a medical model focused on a patient's health care context, while care coordination programs tend to use a broader social service model that considers a patient's psychosocial context (such as housing needs, income, and social supports). Case management programs tend to coordinate services internally, focusing only on covered services. In contrast, care coordination programs may coordinate a full range of medical and social support services offered within and outside the managed care plan. As a result, care coordination programs typically arrange covered and noncovered services for patients. For MCOs and their staffs, the coordination of noncovered services may be the most important factor differentiating care coordination from case management.

## Implementation Lessons

The states studied vary in the origin of care coordination, program requirements, payment arrangements, implementation process, and future directions. They also represent a range of implementation models:

- Oregon designed and implemented an Exceptional Needs Care Coordination (ENCC) program for its aged and disabled Medicaid managed care population. Washington subsequently adopted Oregon's ENCC model but substantially changed the program requirements.
- Colorado and Delaware developed care coordination programs for children with special health care needs.
- New Mexico required MCOs to cover case management services for specific populations, such as women and their infants, children up to age three, adults with developmental disabilities, the chronically mentally ill, and traumatically brain-injured adults.

*Care coordination programs take time to develop.*

*MCOs cannot be expected to develop care coordination services . . . at the same time as they are enrolling new members.*

FEATURES OF CASE MANAGEMENT VERSUS CARE COORDINATION IN MEDICAID MANAGED CARE		
	Case Management	Care Coordination
<b>Objective</b>	Contain costs	Facilitate access
<b>Target population</b>	High-cost/high-use patients	High-risk populations
<b>Organizational location</b>	Utilization management	Quality assurance
<b>Functional orientation</b>	Prior authorization	Problem solving
<b>Model</b>	Medical model	Social service model
<b>Context</b>	Health care context	Psychosocial context
<b>Services</b>	Covered services	Covered and noncovered services
<b>Nature of coordination</b>	Promote coordination and communication across disciplines within the organization delivering medical care	Promote coordination of social support and medical services across different organizations and providers

While designing and implementing care coordination programs, the five states learned many lessons, demonstrating the complexity of these programs and the careful planning required. The lessons are summarized on page 7. Two in particular stand out:

- Care coordination programs take time to develop. States need to allow enough time to work with MCOs, providers, and advocates before implementing Medicaid managed care for people with special health care needs. MCOs cannot be expected to develop care coordination services—including devising protocols and hiring and training staff—at the same time as they are enrolling new members. According to Oregon officials, MCOs developed “ownership” of the ENCC program by participating in its planning and development well in advance of implementation. In contrast, Washington officials noted that MCOs struggled to develop the ENCC program within just a couple months after implementation of mandatory managed care.

*Care coordination can be implemented even after a state has implemented Medicaid managed care . . .*

*. . . some MCOs . . . leveraged outside resources to support their care coordination programs.*

- Care coordination can be implemented even after a state has implemented Medicaid managed care, as exhibited in Delaware. The state Medicaid agency introduced care coordination for children with special health care needs about four months after they were enrolled in managed care, in response to concerns of advocates and family members about discontinuities in care. In addition, the state’s child mental health carve-out program established a care coordination program for children receiving specialty mental health services.

### **MCO Approaches**

MCOs vary widely in their approaches to designing care coordination models within their organizations. We identified three generic models:

- A centralized team model, generally comprised of nurses and social workers, in which all care coordination staff are located at the MCO central office
- A regionalized model, in which staff may be assigned to serve specific geographic areas
- A provider-based model, in which staff are assigned to support specific provider groups

These models have been simplified here to highlight their key features. In practice, MCOs retain significant flexibility in designing hybrid models and defining staff responsibilities. For example, we observed a centralized team model in which the teams were assigned to specific provider groups, as well as a regionalized model with a centrally based care coordinator for beneficiaries who resided outside the designated service regions of the local staff.

Underscoring this flexibility, some MCOs—particularly smaller plans—leveraged outside resources to support their care coordination programs. For example, one regionalized program established linkages with local health departments to identify and manage high-cost obstetric cases, allowing the MCO and provider group staff to enhance their care management resources.

## STATE IMPLEMENTATION CHECKLIST

**Partner with Other State Agencies**

- ✓ During design phase, develop collaborative relationship with other state agencies (mental health, substance abuse, aging and long-term care, mental retardation/developmental disabilities, education, and public health)
- ✓ Address confidentiality issues up front with other state agencies

**Identify Community Linkages and Resources**

- ✓ Develop resource directories at state and local level to facilitate referrals for non-medical services
- ✓ Conduct statewide, regional, or local training with MCO care coordinators
- ✓ Specify relationship between MCO care coordination programs and other case management programs

**Establish a Role for Consumers**

- ✓ Involve consumers in work group meetings and on planning committees
- ✓ Involve consumers in training sessions to educate care coordinators about special needs of people with disabilities and how managed care can serve this population

**Conduct Routine Meetings with MCO Staff**

- ✓ Conduct weekly meetings with care coordinators to help them develop creative approaches to difficult problems and adopt a problem-solving mentality
- ✓ Convene monthly meetings after the initial implementation period to provide a forum for sharing difficult cases and brainstorming solutions

**Specify Expectations for Health Plans**

- ✓ Be explicit about goals and objectives for MCOs
- ✓ Avoid overly prescriptive and unrealistic requirements, especially during early implementation

**Assist MCOs in Identifying the Target Population**

- ✓ Provide information on new enrollees to MCOs to assist them in identifying members with immediate needs (such as supplies and medications)
- ✓ Consult with MCOs on the type of information that they would find most useful
- ✓ Develop tools for obtaining such information (such as through enrollment broker screenings or claims history analyses)

**Develop an Adequate Rate Structure**

- ✓ Estimate the approximate costs of care coordination services based on rough assumptions of level of effort by care coordinators
- ✓ Discuss these estimates with MCOs to achieve buy-in and ownership
- ✓ Be realistic about the level of cost savings during the short run, especially if there is anecdotal evidence that the SSI population has a high level of unmet needs under Medicaid fee-for-service



*Most programs recognize that expanding medical case management to include referrals for social services may not be enough for individuals with special health care needs.*

*Care coordination programs cannot resolve—and may in fact bring to light—deficiencies in Medicaid managed care program design.*

## Looking Ahead

Care coordination services are currently provided on a continuum that ranges from broadened medical case management to enhanced advocacy. Most programs recognize that expanding medical case management to include referrals for social services may not be enough for individuals with special health care needs. Shifting the paradigm to ensure creative problem-solving through advocacy appears to be the emerging role for care coordinators in the context of Medicaid managed care. Achieving this shift will require collaboration among all stakeholders—the state, MCOs, providers, advocates, and of course, patients and their families. Frequent meetings, especially between the state and MCOs, can resolve policy questions, facilitate shared decision-making and problem-solving, and foster patient advocacy.

Anecdotal evidence suggests that the care coordination concept is well received within Medicaid managed care programs. More objective information, such as consumer and provider surveys, would be desirable, as would empirical information on the utilization and cost impacts of care coordination programs.

Six areas pose additional challenges to states and MCOs:

- Bridging the confidentiality barriers experienced by MCOs
- Addressing boundary issues between MCOs and other agencies
- Increasing knowledge about the availability of care coordination services
- Developing standardized tools for assessment and care planning
- Setting appropriate rates to cover the cost of care coordination services
- Evaluating the effectiveness of care coordination services

Although care coordination programs are evolving, it is quite clear that they cannot resolve—and may in fact bring to light—deficiencies in Medicaid managed care program design. For example, care coordinators cannot remedy long-standing boundary issues or confidentiality concerns between systems of care, such as mental health/substance abuse treatment, long-term care, and school-based care. Nor can health plans support an advocacy orientation when capitation rates are underfunded to begin with.

With the increasing enrollment of people with disabilities in Medicaid managed care, states and MCOs need to devise innovative approaches—such as care coordination services—to ensure that members' special health care needs are met. Fortunately, there are many good examples to build on.

### **About the Authors**

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### **How to Get the Full Report**

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