



Toward the Development of Care Coordination Standards

*An Analysis of Care Coordination in Programs
For Older Adults and People With Disabilities*

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Executive Summary

Overview

*In 2006, the oldest of the baby boomers, the generation born between 1946 and 1964, turned 60 years old.*¹ Given that this generation is expected to live to an average age of 78, these 79 million older adults will likely find themselves in need of long-term supports and services. And in seeking those services out, they will face a complex and undoubtedly fragmented health, mental health, and long term care (LTC) service delivery system. This loosely jointed system is beleaguered by poor communication and coordination among providers and payers and little, if any, integration between acute health services, long-term health services, mental health services, and social support services.

One way state, county, and local governments are attempting to mend this fragmented service delivery system is through care coordination, also referred to as case or care management. Although seemingly simple, under this umbrella term we find great diversity in the rules, regulations, guidelines, and services provided in care coordination programs across states and even within the same state. These variances often relate to funding source, population served, and geography, among other factors. However, despite the differences, there are core and underlying essential elements of any care coordination program. It was the goal of this analysis to determine those essential elements of quality *care coordination* and present them as recommendations for consideration.

Care coordination in state and federal programs for older adults and people with disabilities has been connected to a variety of positive outcomes for both program beneficiaries and their informal/family caregivers. For example, care coordination has been associated with improved functional status, decreased hospital admissions, and fewer nursing home stays. Care coordination has also been linked to a decrease in unmet needs and reduced stress among family caregivers. Moreover, programs that include care coordination have been shown to decrease state Medicaid costs by increasing the length of time to Medicaid spend-down and reducing nursing home spending.

This analysis includes a history detailing the evolution of care coordination and how it has been interwoven into Medicare/Medicaid funded programs, benefit packages in LTC insurance policies, and other state and local initiatives designed to assist families in arranging for the LTC needs of a loved one. For decades, individual programs serving older adults and people with disabilities have been providing some form of care coordination. A criticism of many of these programs has been that care coordination happens only within one service delivery system; that is, care coordination is provided in the acute health care system among doctors and hospitals, but that coordination does not involve the coordination of social (e.g., friendly visitors), mental health (outpatient clinics), or LTC needs (e.g., home attendant services). Only recently has the importance of integrating care coordination across the range of services and systems been recognized. Some of the most successful models found are summarized in the section titled *Care Coordination and Care Coordination Models Today* and in *State Care Coordination Standards and Guidelines*.

As mentioned earlier, our analysis revealed that the scope and services covered by care coordination, which exists in every state nationwide, vary from program to program. One major differentiating factor was the qualifications of the case manager or care coordinator providing the service; *Appendix B* charts those differences in a sample of state programs, accounting for the minimum education level, licensure/certification, and training/continuing education.

We found much disparity in how care coordination/case management is financed. Some agencies providing case management had to absorb the cost of case management, while other programs were reimbursed directly for each unit of service that was provided. As most programs providing home- and community-based supports and services are Medicaid waiver programs, funding comes from both federal and states sources. Many states, for example, Illinois, have drawn from state general funds in addition to state Medicaid funds to adequately pay for care coordination. Additional research and analysis should be done regarding the fiscal avenues for care coordination reimbursement, as many states, not unlike New York, are paying more attention to both the qualitative and financial benefits of care coordination, subsequently exploring the possibilities for improvement and change in regulations and rules. According to a report by the National Association of State Medicaid Directors, in 2007 at least twenty-one states had created some form of care coordination model, with seven states pursuing plans to create one.²

New York State

In New York, care coordination is provided to older adults through several programs, including (but not limited to) the NY Connects point-of-entry (POE), Expanded In-home Services for the Elderly Program (EISEP), and the Program for All-inclusive Care for the Elderly (PACE). Care coordination services are also provided to individuals with mental retardation/developmental disabilities (MR/DD) and their families through the Care at Home programs and other Medicaid waiver programs through the Assertive Community Treatment program for those with mental health diagnoses and the Community Follow-Up Program for those with HIV/AIDS, to name but a few. To illustrate New York's array of programs we have included an analysis (Table 4) that highlights some core elements. Moreover, some older New Yorkers are able to access care coordination services through their LTC insurance plans while others pay out of pocket for private geriatric case managers, a growing profession in many states.

Despite the number of programs mentioned above, care coordination in New York, like many other states, is relatively limited in availability considering the number of individuals who could benefit from the service. The term "care coordination" also lacks universal definition. Contributing to the complexity, currently, New York does not have statutory framework governing care coordination, nor are there credentialing requirements that set core competencies for individuals providing these services.

Whereas adoption of standards for care coordination will certainly improve the care and services provided to the state's residents, it also has the potential to save the state critical health and LTC dollars. For instance, New York's State Office For the Aging (NY SOFA) estimates that almost 80 percent of callers to NY Connects (NY's POE program) will be private pay, which is not unlike other states. A pioneering state, Wisconsin

successfully established case management as a core service that serves both private pay and public funding beneficiaries. As a result, private pay callers using this service are promptly provided assessment, expert advice, and access to more appropriate services on the up front, rather than “wading” around a fragmented system, spending dollars unnecessarily and in the wrong places. The long-term effect is that their private pay status is maintained longer, delaying and even avoiding the use of public funding for care and services. Establishing standards for care coordination may therefore be a crucial element for the success of this program and others like it.

At this time, when dramatic improvements are being planned for New York’s health and LTC systems, important steps should be taken to ensure that older adults and the people with disabilities receive quality care coordination.

Recommendations

Based on our analysis of both quality and cost measures in care coordination programs across the country, we make the following four recommendations:

1. Develop quality standards for care coordination that incorporate six essential elements:

Assessment Driven

Comprehensive Care Plan

Ongoing Evaluation

Qualified Care Coordinator

Client Centered

Accessible

2. These quality standards should be included in a statutory framework.
3. Strive to develop a qualified workforce to provide care coordination as a foundation to the success of the restructuring movement toward more home- and community-based care services.
4. Ensure that any state and/or federally funded program that has care coordination as a service explicitly provides for the payment of it either independently or as a designated portion of an administrative fee.

To summarize, care coordination has been an important part of programs serving older adults and people with disabilities for several decades and will become even more important as states rebalance their LTC systems. As states move toward home and community-based services in response to federal mandates and budgetary concerns, care coordination will be central to the success of many programs. Programs including care coordination have been demonstrated to improve outcomes for older adults and their

caregivers and have the potential to save states Medicaid dollars. However, ensuring that care coordination efforts are successful depends on setting standards for these services, as several states have already done.

History of Care Coordination in Programs for Older Adults and People With Disabilities

When considering care coordination, we must look back to its origins. In 1965, Congress amended the Social Security Act of 1935 to include Medicare, a federal health insurance program for older adults. The original intent of this program was to cover the costs for acute medical care: doctor's visits and hospital stays. In the development of the Medicare program, coordination of care was not given much attention. Furthermore, the payment structure for physicians and hospitals did not provide much incentive to coordinate care at all.

Over the years, changes in the rules and regulations governing this program have allowed for demonstration projects, particularly in the area of disease management, which holds care coordination as a key component. In 1984, *Social HMOs* (SHMOs) under Medicare were proposed and put into operation in 1985. These SHMOs added extra services to the existing Medicare model, including care coordination, and aimed to prevent frail beneficiaries from entering nursing homes. Member benefits were managed by case managers who did not need to get physician approval for benefit authorization. Case managers worked with clients (and families) to determine how to use covered benefits up to the program's caps. Case managers monitored all service plans monthly.³ A criticism of the SHMO was that care coordination was not integrated across both social and medical services. Often physicians were not aware of the services their patients were receiving. This likely explains why cost savings expected in this program were not realized.⁴

More recently, financial incentives have been put in place to encourage care coordination under specific reimbursement models. In 2003, Congress enacted the *Medicare Modernization Act* and subsequently opened the door for the creation of the *Medicare Advantage Plans*. These plans provide a capitated rate for all enrollees, thus encouraging plans to provide coordinated care. Despite the aim, the Medicare Commission "doesn't know how effectively Medicare Advantage plans coordinate care."⁵ Currently, about 20 percent of Medicare beneficiaries chose to receive coverage through a Medicare Advantage plan.

A timeline of major events that shape care coordination today

1935	Social Security Act (SSA) signed into law
1965	SSA amended to create Medicare, Medicaid
1965	Older Americans Act (OAA) Administration on Aging, State Units on Aging
1973	OAA amended to create the Area Agencies on Aging
1980	National Long Term Care Demonstration (Channeling)
1981	Medicaid Waivers first authorized under Omnibus Reconciliation Act
1984	Social HMO under Medicare demonstration under the Deficit Reduction Act (in operation in 1985)
1990	Americans with Disabilities Act
1997	Balanced Budget Act
1999	Olmstead Decision
2003	Medicare Modernization Act (Medicare Advantage Plans)

Another early care coordination vehicle was Medicaid. Also established in 1965 under an amendment to the SSA, Medicaid's intent was to provide health insurance to a variety of people (including children) with low incomes. Medicaid now provides the greatest proportion of funding for LTC for older adults. Although not present as a core service at its inception, care coordination has been slowly built into the system through waiver programs¹ (*see descriptions of such waivers below*).

Medicaid 1115 Waiver: This waiver allows for research and demonstration projects and is intended to demonstrate and evaluate policies or system reforms that have not been previously tried on a broad basis.⁶

Medicaid 1915(b) Waiver: These are often referred to as managed care waivers that implement managed care delivery systems or otherwise limit beneficiaries' choice of providers. Most often this involves mandatory enrollment of beneficiaries into managed care programs. Under these waivers, programs do not have to operate statewide and cannot be used to expand eligibility. However, states can use any savings to provide additional services.⁷

Medicaid 1915(c) Waiver: Designed for home and community based LTC, these provide both medical and nonmedical services to those who are eligible for nursing home placement. This waiver program stipulates that per participant costs cannot be greater than per participant costs for nursing home care and states may set limits on the number of participants in the programs, often called "slots."⁸ In New York, the 1915(c) waiver program for older adults is called the Long Term Home Health Care Program (LTHHCP) or the "nursing home without walls." In this program, care is coordinated by case managers and services include home-delivered meals, housing improvements, medical social services, and respite care.

Some states have combined 1915(b) and (c) waiver programs, which independently limit participant freedom of choice (under 1915[b]) and provide home and community based LTC services (under 1915[c]). States can implement concurrent waivers as long as all federal requirements are met for both programs.⁹

In 1980, just prior to the Medicaid Waiver programs being fully initiated and in response to the growing concern over the costs of institutional placement and desire for more home and community based services, a national demonstration sponsored by the Administration on Aging, the Health Care Financing Administration (HCFA) (now the Center for Medicare and Medicaid Services or CMS), and the Assistant Secretary for Planning and Evaluation (ASPE) was initiated. This program, the National Long Term Care Demonstration (a.k.a. Channeling), placed significant emphasis on care coordination (case management) for frail adults in the community. The demonstration tested two forms of care coordination. The *Basic* model superimposed care coordination onto preexisting services, eligibility, and funding streams. The *Financial Control* model utilized a pool of funding from Medicaid, Medicare, and other public sources to increase the types of services available in communities and provide these services, through care coordination,

¹ *It is important to note that mental health services are not covered in these waiver programs.*

to older adults over sixty-five who had activities of daily living (ADL) limitations regardless of financial eligibility.¹⁰

In both models, older adults were assigned to case managers, usually social workers or others with human services experience, who conducted comprehensive assessments, care planning, service arrangement, monitoring, and reassessment.¹¹ Despite these efforts, the program was not able to demonstrate the financial outcomes hoped for, mainly due to research design flaws.

About 7.5 million beneficiaries (14% of Medicaid enrollees) in 2003 were also eligible for Medicare. These “dual eligibles” accounted for about \$105 billion in Medicaid expenditures or 40 percent of total Medicaid spending.¹² In an attempt to control costs, states have placed care coordination deliberately at the center of the Medicaid program for older adults and people with disabilities in order to improve care and reduce expenditures. Specific examples of care coordination programs for dual eligibles are detailed in the section to follow.

Three major events in the 1990s further shaped the landscape of home- and community-based services, the realm of care coordination. First, in 1990 Congress passed the *Americans with Disabilities Act (ADA)*, making it illegal, among other things, to discriminate against individuals with disabilities. Next, the Balanced Budget Act of 1997 permanently established the Program for All-Inclusive Care for the Elderly (PACE) as a provider type. This model will be described in the next section. Finally, as a result of the ADA, in 1999 the Supreme Court ruled in “*Olmstead vs. L.C.*” that states must provide services “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” This decision placed states on notice that they had to develop plans to move people out of institutions and into the community and could not keep people on waiting lists for Home and Community Based Services (HCBS). The upside is that more people with disabilities and older adults now have options for community living that were not in place prior to *Olmstead* and the development of HCBS waivers in Medicaid. The downside of this shift is that people receiving HCBS in some programs experience firsthand the disjointedness of the medical, social service, and mental health delivery systems and would benefit greatly from implementation of care coordination as an integral component of HCBS.

Care Coordination and Care Coordination Models Today

As noted earlier, the coordination of care across service settings by an individual is labeled and defined in many ways. Most commonly, we see care coordination labeled as case management. The Center for Medicare and Medicaid Services (CMS), in a recent Federal Register Publication, clarifies case management and care coordination:

Case management is commonly understood to be an activity that assists individuals in gaining access to necessary care and services appropriate to their needs. Many individuals, because of their age, condition, illness, living arrangement, or other factors, may benefit from receiving direct assistance in gaining access to services. In the context of this regulation, it is the individual's access to care and services that is the subject of this management—not the individual. Because case management has been subject to so many different interpretations over the years, many Medicaid agencies now refer to case management 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.¹³

As we move away from siloing health, mental health, and social services and move toward providing more holistic care—in recognition of its potential to improve quality and increase cost effectiveness—a need arises to solidly define coordinated care across service settings. To this end, we propose the following definition:

Care Coordination can be defined as proactive, responsive, continuous, and consensual coordination of medical care, mental health, and social support services for an informed elder and his/her family. The goals of care coordination are to 1) assist that elder and his/her caregivers in achieving health and wellness for as long as possible in the least restrictive setting possible and 2) to maximize the return on investment of human and financial resources.²

The definition above stems from an analysis of other care coordination definitions and successful care coordination models currently in place and also reflects what we have learned from listening to stakeholders regarding the essential components of care coordination.

In our search for common ground, we have found that care coordination can be categorized into five models/settings: PACE (and PACE-like) programs for individuals who are dual eligible, other managed care models, single point-of-entry models, programs in the Veteran's Administration, and private fee-for-service.

Note: Although this paper focused on Care Coordination programs for older adults in LTC, we wanted to provide a snapshot of the range of services related to and/or associated with care coordination across settings. To this end, you will

² The New York Academy of Medicine is interested in and will accept comments on this definition of Comprehensive Care Coordination.

find a comparison table of essential features of differing approaches to care coordination in Appendix A.

Programs for people who are consumers who are “dual eligible”

Mentioned in the previous section, individuals who are dual eligible are those older adults who qualify for both Medicaid and Medicare. In many cases these older adults have complex, chronic medical conditions and are mentally, medically, and/or socially vulnerable. Although they account for a small percentage of most states’ Medicaid rolls, collectively they often utilize a large portion of a state’s Medicaid funding. Several state and federal programs have been established to better address the medical and social care needs of these beneficiaries in hopes of providing them with better health outcomes and states with better cost outcomes. Care coordination has played a critical role in these programs.

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

An early demonstration project for dual eligible individuals was the Program for All-Inclusive Care for the Elderly (PACE). The first PACE sites began operating under Medicare and Medicaid waivers in 1990. The Balanced Budget Act of 1997 established the PACE model as a permanently recognized provider type. As of June 2006, the total number of PACE enrollees was just under 11,000, and as of March 2007, thirty-eight PACE, and eight Pre-PACE programs were in operation in twenty-three states. The largest enrolls more than 2,000 elders, but on average, these plans serve a few hundred people.¹⁴

Today’s PACE programs combine Medicare and Medicaid funding streams that provide capitated funding for fully integrated care, meaning that sites receive lump-sum payments to provide all Medicare and Medicaid services to plan members. The model is based on the close collaboration of interdisciplinary care coordination teams, the use of adult day care centers, and the delivery of HCBS to beneficiaries who are fifty-five years or older and nursing home eligible.

The care coordination provided by the PACE program centers around the interdisciplinary team. The interdisciplinary team is composed of a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietitian, PACE center supervisor, home care liaison, health care aides, and transportation drivers. The team usually meets on a daily basis to ensure that the needs of plan members are met.¹⁵

The nature of the interdisciplinary approach is such that the focus is on team-based care coordination rather than on a single care coordinator. An initial comprehensive assessment is completed within a few days of a participant’s enrollment into the PACE program. The interdisciplinary team coordinates and authorizes all acute and LTC services through the PACE center. Monitoring and reevaluation is performed on an ongoing basis and is facilitated by the close contact of all participants with members of the interdisciplinary care team.

PACE services include all Medicare and Medicaid services and extend at minimum to social services, restorative therapies, personal care and supportive services, mental health services, nutritional counseling, recreational therapy, and meals. The service delivery settings include an adult day health center and home and inpatient facilities.

The monthly capitated payments from both Medicare and Medicaid are adjusted to reflect the risk profile of the target population and regional variations in medical care costs. All payments are pooled and can be used for any program-eligible adult, giving the program the flexibility to deliver services in the most efficient manner. As a result of a fully capitated reimbursement structure, PACE providers assume full financial risk for delivery of comprehensive care. There is also an option for individuals who are not eligible for Medicaid to pay this portion of the monthly fee to gain access to the PACE program.

Wisconsin Partnership Program

The Wisconsin Partnership Program (WPP), also for dual eligibles, began in 1995 with funding from the Robert Wood Johnson Foundation and converted to a Medicare and Medicaid waiver program in 1999. The WPP is very similar to the PACE program but has loosened restrictions on physician choice in that participants are free to choose their own physician.¹⁶ Furthermore, services are primarily home-based as opposed to the day center structure found in the PACE program. To date, the WPP has not served a particularly large group, but enrollment has grown steadily from 900 enrollees in 2000 to 2,500 as of June 2007.¹⁷

As in PACE, capitated Medicaid and Medicare funds are pooled. Interdisciplinary teams coordinate all primary, acute, mental health, and LTC care. The teams include a nurse, nurse practitioner, social worker or independent living coordinator, the client, and the client's primary care physician. Unlike PACE, the WPP serves both older adults and people with disabilities.

The care coordination team develops a written, individualized plan with each member that clearly identifies member preferences, goals, specified treatments and strategies, and the appropriate service provider. The comprehensive service delivery plan emphasizes member choice, communication, prevention, continuity, and quality. The interdisciplinary care coordination team implements, monitors, and coordinates the service plan by providing service directly and/or overseeing and coordinating the delivery of services by contracted providers.

Like PACE, the WPP has been heralded as a success in delivering care coordination to older adults and people with disabilities by emphasizing integration of services across a continuum of needs and settings. The WPP has not yet achieved significant cost savings. A recent analysis showed that WPP monthly costs were higher than those for a comparable population. This may, however, be a reflection of the rate-setting methodology used to set the capitated rates rather than of the program's ability to manage the cost of care. Wisconsin is currently retooling its rate-setting methodology.

Managed Care Models

Although PACE and WPP are technically examples of managed care models, they warrant separate explanation and discussion because of their unique emphasis on integrated care and the interdisciplinary team. Most managed care models do not rely on the collaboration of an interdisciplinary team, and therefore the level of care coordination is somewhat lower.

Georgia SOURCE

The Georgia Service Options Using Resources in a Community Environment (SOURCE) program provides care coordination and HCBS to Medicaid recipients through 1915(b) and 1915(c) waivers. The voluntary program was established in 1997 and Medicaid and Medicare services are provided on a fee-for-service basis. The program is not capitated and reimburses contracted providers for care coordination by means of a monthly fee. That fee is \$150 per month per client, 10 to 20 percent of which is passed on to participating physicians.¹⁸

The SOURCE program is notable for the high level of authority given to care managers and its focus on achieving desired client outcomes. Care managers work directly with primary care physicians to ensure that medical and social services are well coordinated. Care managers also interact with a team that includes a SOURCE project manager and a medical director. Most care managers are social workers or registered nurses, but this is not a program requirement.¹⁹

After an initial assessment, which captures health, psychosocial, and environmental information, a care plan is constructed. The care coordinator then monitors the client by telephone once per month and face-to-face every three months. The care coordinator meets with all HCBS providers each month and with physicians quarterly.

Although still a small program, with about 7,000 clients at eight sites, the program is considered successful; this success is primarily attributed to the flexibility and authority given to care coordinators and the high degree of physician involvement.²⁰

Texas Star+Plus

Texas Star+Plus is another combined 1915(b) and 1915(c) Medicaid waiver program. The program began in 1998 as a demonstration in Harris County, which includes Houston. It is a risk-based, capitated managed care program. The HMO that coordinates and provides care is paid an amount for each beneficiary. The HMO accepts the risk that care costs may exceed the capitated rate. This provides it with the incentive to adequately coordinate care, especially for those beneficiaries at risk for nursing home placement. Enrollment in the program is mandatory for Medicaid beneficiaries.²¹

Care coordination is provided to all beneficiaries who request it and all receiving LTC services. In this program, care coordination is provided by an HMO employee who is responsible for developing a care plan with input from the beneficiary and his or her informal caregivers (if appropriate), working with service providers, and authorizing services.

Single Point-of-Entry Systems

States have increasingly made use of Aging and Disability Resource Centers (ADRCs) to implement Single Point of Entry Systems (POEs) to serve private pay clients as well as those who rely on public funding. A primary goal and purpose of these demonstration grants has been to help state LTC systems evolve in such a way that they seamlessly serve the LTC needs of all people—including those who have not yet spent down their assets to the point at which they are eligible for Medicaid. The Administration on Aging (AoA) has limited data on the extent to which ADRCs have achieved this goal. Anecdotal data suggest that POEs help reduce service duplication and nursing home placement and that private pay clients more actively seek out “options counseling” services from ADRCs.

Since 2003, forty-three states have implemented, or are in the process of implementing, POE systems that provide older adults and the disabled with information about their LTC options. Many of these programs use care coordinators to assess the needs of older adults and assist older adults in navigating the complex systems of medical and social services that exist in most states. Some states are using ADRC models and funds. ADRCs have been established under a demonstration program supported by the AoA and the Centers for Medicare and Medicaid Services (CMS). This program helps local communities establish “one stop shop” centers designed to assist older adults and people with disabilities make informed decisions about LTC and generally act as a “single point of entry” to the LTC system. While the AoA and CMS provide about 25 percent of the funding for these programs, the remaining costs are covered by OAA funds, Medicaid funds, and state and local funds. Currently, there are 100 ADRCs operating in 43 states.²² However, most states are developing their POEs outside this authority by combining funding from OAA sources, CMS sources, and state and local sources.

Colorado POE

Colorado was one of the first states to design a POE system. Discussion about such a system began in Colorado in the 1980s, and a law establishing the system was passed in 1992. The Colorado Division of Aging and Adult Services directs the program, sets statewide rules, and coordinates the work of twenty-five local agencies that serve as the point of entry in local communities.²³

In this program, care coordinators are usually social workers. Care coordinators conduct an assessment of the client needs; this is followed by a review by a licensed health professional (usually an RN) who determines the level of health services needed by the client. The care coordinator then works with the client to create a care plan, arranges for necessary services, and monitors clients at least quarterly to determine if needs have changed. The care coordinator is required to meet with clients at least once every six months. Care is provided through county-level agencies and financed through three Medicaid waiver programs and two state-funded programs.

This program has not been formally evaluated but is considered quite successful in helping older adults avoid nursing home placement. Since its inception, participation in HCBS has more than doubled in the state, while the nursing home population has remained stable. Furthermore, staff reports that the HCBS system has not incurred increased administrative costs and that there has been a reduction in service duplication.

New Jersey Easy Access Single Entry (NJEASE)

The New Jersey Easy Access Single Entry (NJEASE) program began in the mid-1990s. NJEASE is county based but uses a single toll-free number call-routing system that is able to recognize where calls originate and connect them to the correct county agency. In this program, each county is responsible for the creation of its own system, but the state provides technical assistance and training.

Callers are from varying income and functional status levels and may simply receive information or, if the coordinator feels it is appropriate, may receive an assessment over the telephone using a standardized evaluation method called the Comprehensive Assessment Tool (CAT). Based on this assessment, a clients may be eligible and referred to a more comprehensive in-home assessment by a care coordinator, who will then create a care plan and arrange for needed services through Medicaid and other state-financed programs. Unfortunately, because of resource limitations, New Jersey has had some difficulty providing services to all those who need them, and waiting lists have been created. Jersey Assistance for Community Caregiving (JACC), a state-funded cost-sharing program, was created in 2000 to help middle- and upper-income clients receive home care services on a sliding payment scale.²⁴

Despite some problems, several positive outcomes can be attributed to NJEASE. For example, the number of nursing home residents on Medicaid dropped by 10 percent between 1997 and 2002.²⁵

Wisconsin POE

Wisconsin's POE program, which follows an ADRC model, began in 1999 as a part of a major redesign of the state's LTC system. At the same time, Wisconsin created the Division of Disability and Elder Services to manage all HCBS and institutional care for older adults and people with disabilities.²⁶

Clients enter the LTC system by calling or visiting (in person or the Web site) an ADRC. Although the state mandates that each ADRC provide a certain range of services, including information and referral services, the organizational structure and funding of the ADRCs varies by county. In most cases, the ADRC collaborates with AAAs and county social service agencies. In this system, care coordination is provided by an interdisciplinary team (a social worker and a nurse) who assess client needs and provide or arrange for services. Care coordination contractors receive a monthly per-client fee for all of their clients.²⁷ A variety of funding streams, as well as private pay, cover the costs of needed services, and Wisconsin's system is considered very successful in attracting private pay clients.

Department of Veterans Affairs Programs

Geriatric Evaluation and Management (GEM)

The Department of Veterans Affairs (VA) has been a leader in care coordination, providing care coordination services to older and disabled veterans for several decades. The Geriatric Evaluation and Management (GEM) program began in both inpatient and

outpatient VA settings in the 1970s. The GEM program uses an interdisciplinary team approach to coordinate care for patients with complex needs. Team members and team leaders are chosen based on the specific needs of the patient and may include any combination of the following: physician, nurse, social worker, geriatric psychiatrist, rehabilitation therapist, dietician, pharmacist, and other specialists as needed.²⁸

Members of the interdisciplinary team assess the patient's needs and create a coordinated plan of care that includes mental, medical, and social services. Patients are also provided with health education if warranted. The goal of the program is to help patients maintain or improve functional abilities and avoid nursing home placement.

The GEM program has been extensively evaluated and has been demonstrated to have numerous positive results in both cost and patient outcomes. For example, the program has shown improvement in mental health for geriatric outpatients with no additional costs.²⁹ Outpatient GEM has also been shown to slow functional decline.³⁰

VA Care Coordination

The latest advance in care coordination in VA settings is a program called VA Care Coordination. VA Care Coordination began in 2000 as a demonstration project in the Florida Veterans Integrated Service Network (VISN). This program relies heavily on technology, allowing care coordinators to remain in close contact electronically with patients in widespread geographic regions.

This program is also centered on an interdisciplinary team that usually consists of a social worker and a nurse who have direct contact with primary care physicians and specialists. Care coordinators have access to patient medical records and follow patients across episodes of care. Between clinic visits, care coordinators communicate with patients using video, digital photos, and messaging devices. Low-risk patients are monitored by telephone, while high-risk patients have in-home devices for tracking blood pressure, blood glucose levels, and other clinical indicators.³¹

Despite its relatively short existence, the VA Care Coordination program has already shown several substantial outcomes. For example, there has been a 72 percent reduction in emergency room visits and an 81 percent reduction in nursing home placements. The program has been expanded to all VISNs.³²

Advanced Illness Coordinated Care Program

The Advanced Illness Coordinated Care Program (AICC) is a care coordination and support program, delivered by allied health professionals, that was developed to improve the care of people with serious illness. It uses a comprehensive, interdisciplinary approach to caring for those with advanced illness and/or end-of-life care within the patient's continuum of care. The case management approach works with the primary provider (physician) and health care system to integrate a six-visit intervention by a nurse or a social worker into routine care for patients with advancing illness.

The six-visit intervention reduces barriers to palliative care by:

- a. introducing advanced illness and end-of-life discussions among providers and patients,
- b. ensuring support for quality advanced illness care at all levels of the health care organization, and
- c. providing patient-centered care that encourages mutual-participation relationships, informed choice, and patient autonomy.

This model, although adopted early by the VA, can be delivered in a acute care, primary care, or LTC setting. The AICCP was evaluated for its effects on satisfaction and consistency of care with patient's preferences, as well as the cost-effectiveness of the intervention. The study demonstrated that people in the AICCP were willing and able to plan for end-of-life care both more frequently and months earlier than those receiving a usual course of care³³. Moreover, the AICCP improved satisfaction with care, and the program could be delivered in a variety of settings. Although no significant statistical differences were found in terms of cost-effectiveness, a program such as AICCP does not cost more money than usual care, and its benefits improve conditions for patients and caregivers.

Privately Funded Care Coordination

For older adults who are not functionally or financially eligible for care coordination through state- and federally funded programs, locating care coordinators and paying for services is done privately. Some of these older adults pay for services out-of-pocket, while others have obtained LTC insurance. Several states have also instituted LTC Partnership Programs, which are intended to encourage the purchase of LTC insurance.

Because of the nature of private, out-of-pocket arrangements for care coordination services, determining the number of individuals currently utilizing private care coordinators is difficult. It is clear, however, that demand for this service is increasing as the population ages, nursing home usage goes down, and home-/community-based services flourish. For additional information on private pay coordination, see *Financing Care Coordination*.

New Models of Care Delivery

In the face of escalating health care costs and more individuals (of all ages) living with chronic illnesses and disabilities, several states and the federal government are considering new models of health care delivery. For example, New York is considering legislation related to the concept of the "medical home" and currently has medical home demonstration projects for children with special health care needs. The medical home is a model of health care delivery that is predicated on an ongoing relationship between patients and their personal physicians. Patient care is coordinated by the physician and his/her medical practice team; however, mental health has not traditionally been coordinated in the medical home model. The team is then responsible for following patients across settings and arranging care from other professionals. Care coordination is, therefore, a logical, integral part of this proposed new model of health care delivery. In addition, Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) mandated

a demonstration project to be conducted in up to eight states to provide targeted, accessible, continuous, and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need. Implementation of this project is expected to take place in fall 2008.

Care Coordination Outcomes

Care coordination has resulted in positive outcomes for both clients and their informal caregivers. Care coordination has been associated with improved functional status among older adults, fewer hospital admissions, and fewer nursing home stays. Care coordination has been shown to decrease stress among informal caregivers and reduce unmet needs of community-dwelling older adults.

Decreased hospital utilization and nursing home admissions among recipients of care coordination have also meant lower Medicaid expenditures for states, in some cases. However, it is important to note that not all programs that include care coordination have been designed to reduce state health care expenditures. In some cases, the goal has been to serve greater numbers of older adults and people with disabilities in the community than was done previously in institutional settings. This is especially true in an era marked by the Olmstead decision and other federal legislation requiring that individuals receive care in the least restrictive setting possible. Table 1 (below) details the goals of programs described in this report and the results that have been achieved by these programs.

Client and Caregiver Outcomes

As Table 1 shows, many of the programs for older adults that include care coordination have resulted in positive outcomes for the clients served, such as improved functional ability, reduced hospital admissions, and fewer nursing home placements. For example, hospital days for those participating in the WPP program decreased from 5 days per year per thousand clients to 2.1 days.³⁴ Reduced hospital utilization has also been reported in the PACE³⁵, SOURCE³⁶, VA Care Coordination,³⁷ and GEM³⁸ programs. Similarly, reduced nursing home days were realized in PACE,³⁹ the Social HMO,⁴⁰ SOURCE,⁴¹ VA Care Coordination,⁴² and GEM.⁴³

In addition, the rate of unmet needs among community-dwelling older adults were reduced in the Channeling demonstration.⁴⁴ Reduced unmet needs have also been achieved in state POEs.⁴⁵

Although most programs have not explicitly attempted to improve the quality of life of informal caregivers, this has been an outcome of several programs. For example, the Social HMO was shown to reduce stress among family caregivers.⁴⁶ Similarly, the Financial Control Channeling demonstration reduced reliance on clients' extended networks of informal caregivers, such as friends and neighbors.⁴⁷

Table 1: Program Goals and Results Achieved

Program	Program Goals	Outcomes
Channeling	<p>Research the effect of case management on LTC expenditures.</p> <p>Determine whether the Basic Case Management Model or the Financial Control Model were better able to reduce costs.</p>	<p>Basic Model found to be better at controlling costs.</p> <p>Unmet needs of community-dwelling, frail older adults were reduced.</p>

Social HMO	Use a care management model including HCBS to help frail older adults remain independent and avoid unnecessary nursing home placement.	Fewer nursing home days Reduced stress among family caregivers Later Medicaid “spend downs”
PACE	Provide integrated acute, mental, and LTC services to frail older adults in the community. Eliminate cost shifting between Medicare and Medicaid. Reduce Medicaid/Medicare spending for costly beneficiaries by reducing hospital stays and avoiding unnecessary nursing home placements.	Fewer inpatient hospital days, fewer nursing home days Better able to predict costs due to capitation
WPP	Improve upon the PACE model and outcomes by increasing consumer choice, especially of primary physician	Reduced hospital use and fewer nursing home days
SOURCE	Utilize care management to reduce state Medicaid costs. Improve consumer health outcomes.	Lower overall Medicaid costs per enrollee Shorter hospital stays and fewer patients discharged to nursing homes
Star+Plus	Utilize care coordination to reduce state Medicaid costs.	Saved the state \$66 million in Year 1 and \$56 million in Year 2
CO POE	Improve consumer access to LTC information and services. Address the fragmentation found in the previous system	Consumers have easier access to information Reduction in duplicated services
NJEASE	Redesign and rebalance HCBS and the delivery of LTC information to consumers. Address consumer frustration with the previous system.	Reliance on nursing homes has been reduced, while public resources dedicated to HCBS more than doubled. Number of people on Medicaid in nursing homes dropped 10 percent between fiscal year 1997 and fiscal year 2002.
GEM	Improve the health outcomes and care of veterans across the continuum of care available in the VA system.	Increased functional ability Reduced hospital stays and nursing home admissions
VA Care Coordination	Utilize care coordination and telehealth technology to allow veterans to “age in place”	Fewer ER visits, hospital stays, and nursing home placements

Cost and Expenditure Outcomes

Whereas early care coordination programs, such as Channeling, attempt to reduce state and federal health care expenditures, most current programs have the dual aims of reducing spending and serving more clients. In many cases, therefore, per-participant costs may decrease while overall health care expenditures may increase. Since Maine moved to promoting a more HCBS-based LTC system, total spending has increased by 17 percent, but the state is serving the needs of 30 percent more people.⁴⁸ Any analysis of

expenditure outcomes must, therefore, address *intended* outcomes. In the current climate, expenditures must also be balanced with new mandates that clients be cared for in the least restrictive environment and that LTC consumers be made aware of all their service options.

Despite these caveats, several of the programs detailed above have resulted in reductions in total spending. The most outstanding example is that of the Texas Star+Plus program. The Star+Plus program was shown to save the state approximately \$66 million in its first year and \$56 million in its second year.⁴⁹

Other outcomes that would suggest health care expenditure savings include delayed Medicaid spend-downs among Social HMO clients,⁵⁰ lower Medicaid costs per SOURCE client,⁵¹ and reduced duplicative services in the Colorado POE.⁵² The programs that reduced hospital and nursing home utilization could also be expected to result in reduced spending for states. For example, the NJEASE program has resulted in a 10 percent reduction in Medicaid-supported nursing home residents in the state.⁵³

State Care Coordination Standards and Guidelines

In order to avoid ambiguity and help ensure quality, most states have created standards, guidelines, and state laws to define care coordination and identify who may provide these services (see Appendix A for state policies regarding the qualifications of care coordinators/case managers). In most cases, care coordination/management standards have been written into Medicaid waiver policies, but in some cases they have been codified through legislation or have been created as part of state implementation of LTC Partnership Programs. Table 2 below depicts the type of services mandated by several states' care coordination or case management standards.

Table 2: State Care Coordination Standards

State	Intake Screening	Comprehensive Assessment	Care Plan	Arrange Services	Ongoing Reassessment	Certification/Qualifications	Client-Centered	Accessible to All
Alaska ⁵⁴	√	√	√	√	√			
California ^{55*}		√	√	√	√			√
Iowa ⁵⁶			√	√	√	√		
Maine ⁵⁷	√	√	√	√				
Minnesota ⁵⁸	√	√	√			√		√
Vermont ⁵⁹		√	√	√	√	√	√	
Virginia ⁶⁰	√	√	√	√	√	√		
Washington ^{61†}		√	√	√	√		√	
Wisconsin ⁶²		√	√	√	√	√	√	

* Standards are codified in LTC Partnership Program legislation.

** Standards are codified in LTC Partnership Program legislation and found in Medicaid Waiver manual.

One state that has codified care coordination standards as part of its LTC Partnership Programs is California. In fact, California's legislation stipulates that the following passage be included verbatim in any LTC Partnership certified policy:

Care Management includes, but is not limited to the following:

- a) the performance of comprehensive, individualized, face-to-face assessment conducted in the client's place of residence;
- b) The development of a Plan of Care;
- c) the performance of a comprehensive, individualized reassessment at least every six months;
- d) when desired by the individual and determined necessary by the Care Management Provider Agency, coordination of appropriate services and ongoing monitoring of the delivery of such services; and
- e) the development of a discharge plan when the Care Management Provider Agency services, or the Policy benefits, are about to be terminated and if further care is needed. If the insured is immediately eligible for MediCal

[California's Medicaid program], the Care Management Provider Agency shall prepare a transition plan.

Care Management/Care Coordination takes an all-inclusive look at a person's total needs and resources and links the person to a full range of appropriate services using all available funding sources.⁶³

California's care coordination standards include several elements *of care coordination* common to the standards of other states, such as comprehensive assessment, care plan development, service arrangement, and ongoing reassessment or evaluation.

Certification and Licensing Requirements

One element not found in California's standards that is found in the standards of several other states (see Appendix B) are certification or licensing requirements for care coordinators. For example, Vermont has a well-developed training and certification program for its care coordinators (although they use the term "case manager"). Before being able to work as a case manager in Vermont, individuals must take part in a training course and pass the state certification examination with a grade of 80 percent or higher. The state instituted this training and certification program in order to assure consumers, and the general public, that case managers are well qualified to make important decisions about the ability of older adults and people with disabilities to safely remain in their homes and communities.⁶⁴ Several other states have also taken steps to ensure that care coordinators are well-qualified. For example, Iowa requires that case managers have a bachelor's degree in a human services field or be a registered nurse.

Appendix B provides information on the required qualifications for case managers and care coordinators in select states. This information was gathered from state government Web sites and, in some cases, by contacting state officials. Not all states responded to these inquiries. In most cases, these qualifications relate to those employed by state Medicaid programs. Qualifications for case management and care coordination positions vary widely. In most cases, preferred qualifications are that case managers or care coordinators be social workers or nurses, but in many instances these professional qualifications can be substituted with previous case management experience. We have also included a sampling of Care Coordinator competencies and responsibilities found in job descriptions of case managers in these same programs (Appendix D).

Client Assessment and Reassessment

Many states have adopted standards and guidelines related client assessment and reassessment. In most cases, state standards require that client assessment evaluate all of the client's social and medical support needs, as well as client informal support systems and client financial eligibility for state and federally funded programs; mental health is not always assessed. Most states also require that clients receive ongoing monitoring to ensure that provided services are adequately meeting client needs and that reassessment be performed regularly. Most state standards require reassessment more frequently than the federal requirement of annual reassessments for waiver program eligibility.

Care Plans

All state standards and guidelines analyzed herein require that a care plan be developed and adhered to through the arrangement and/or provision of medical and social support services. Some state standards require that care plans be client-centered and state that the choices and preferences of clients come first. For example, Wisconsin strongly emphasizes this principle in their state standards. Other states, Virginia for example, stipulate that family members and other informal caregivers be included in care plan development when appropriate.⁶⁵

Financing Care Coordination

Simply stated, there is no uniform way states have funded care coordination. An analysis of nine programs associated with Medicaid waivers (1915[c] and 1115) revealed differences in how states have funded care coordination services. However, two funding streams for care coordination programming and two primary ways of reimbursing agencies for care coordination surfaced.

When examining the way in which states fund care coordination programs, we found that some states have pooled additional funding (e.g., general revenue funds) with money traditionally allocated to Medicaid administrative funds. These states include California, Illinois, Iowa, South Carolina, and Vermont. Other states, like Ohio, Pennsylvania, Utah, and New Jersey, rely solely on Medicaid-designated monies to finance care coordination.

Reimbursement to agencies for the provision of care coordination services also differed from state to state. Some states provided “fee for service” reimbursement, while others (intentionally or unintentionally) provide agencies with a blanket blended rate for administrative costs (which includes care coordination). This means that agencies cannot bill the state for care coordination/case management directly (as is done with a “unit” of physical therapy), but it does not necessarily mean that the state doesn’t account for care coordination costs.

Table 3: Financing Care Coordination in Nine States

	Medicaid + Other General Funds					Medicaid Funding Only			
	CA	IL	IA	SC	VT	OH	PA	UT	NJ
Fee for Service		✓		✓	✓			✓	
Blended Rate	✓		✓			✓	✓		✓

Costs of Care Coordination

The final concern that must be addressed is the cost of care coordination itself within these programs. Although it is difficult to discern the costs of care coordination in capitated programs because all funds for all clients are pooled, several studies have been able to report these costs. For example, in an examination of care management in LTC demonstrations and state programs, Leutz estimated that care coordination costs range from \$100 to \$150 per client per month.⁶⁶

Similar costs have been cited in the SOURCE program, in which a case management fee of \$150 per client per month is paid to the contracting organization.⁶⁷ Likewise, Maine pays \$120 per client per month to its care coordination contractor.⁶⁸

A recent study by researchers at the University of California determined the cost of care coordination (or case management) as a percentage of total Medicaid waiver expenditures across states. The cost of these services ranged from less than one percent of waiver costs in Louisiana to 16 percent of waiver costs in Mississippi, with a national average of 4.6

percent. Care coordination/case management services were shown to comprise 5.9 percent of all waiver expenditures in New York.⁶⁹ The difficulty with this analysis, however, is that it is unclear what is being compared across states. As has been detailed above, care coordination varies widely by state, by program, and by population served.

A select sampling of states' finance care coordination/case management in waiver programs can be found in Appendix E.

Cost of Private Care Coordination

The cost of private care coordination services varies widely, but one estimate puts the cost of initial assessments at \$175 per hour and the cost of developing a care plan at \$168 per hour.⁷⁰ Another estimate states that the cost of private care coordination ranges from \$50 to \$150 per hour.⁷¹

Long Term Care Insurance

Care coordination is also available to many purchasers of LTC insurance, and availability of these services seems to be increasing as this industry develops. However, because of extreme variability in LTC insurance policies by state, company, and policy type, it is difficult to determine specific information about care coordination in these policies, such as when care coordination is available or what this service involves. In fact, the US Department of Health and Human Services Web site simply states that “many policies provide a care coordinator, usually a nurse or social worker from the community. The care coordinator can meet with you to discuss your personal situation. The care coordinator helps you arrange for and monitors your needs on an ongoing basis, if you want that kind of help.”⁷²

Currently, LTC insurance pays for less than 3 percent of all LTC provided in the US. In order to encourage consumers to purchase this insurance, many states have instituted LTC Partnership Programs. These programs vary by state, but in general they allow consumers who purchase approved LTC insurance to protect some or all of their assets if they need to apply for Medicaid after their insurance benefits are exhausted.⁷³ Several states have passed legislation that sets standards for the care coordination available through Partnership Program–approved policies.

In New York, the NY State Insurance Department (NYSID) has encouraged insurance companies to offer policies covering LTC services and has established minimum standards for four classifications of insurance policies covering such services. The four classifications are:

- Long Term Care Insurance
This type of policy has the broadest coverage and the NYSID requires that it cover twenty-four consecutive months.

- Nursing Home and Home Care Insurance
This policy allows the purchaser to utilize nursing home or home care but is more limited in the full range of LTC services; it is generally sold at a lower cost than LTC insurance.

- **Nursing Home Insurance Only**
This type of insurances is for purchasers who either have no intention of receiving LTC services in their own homes, or the purchaser simply does not want to pay for additional coverage. Nursing home only insurance must provide at least twelve consecutive months of coverage of custodial care services of at least \$50 a day while confined in a nursing home.

- **Home Care Insurance Only**
Like the nursing home only policy, this policy only covers home care and must provide at least twelve consecutive months of coverage of custodial care services of at least \$25 per day in a private home.

All policies sold in New York are indemnity policies, meaning they pay a specific dollar amount for each day spent in a nursing facility or each home health or home care visit. The policy also must be guaranteed renewable—the policy holder has the right to renew the policy at any time given she/he has paid the premiums on a timely basis.

New York started offering Long Term Care Partnership in 1993 as a way to encourage more people to offer LTC policies. This program allows purchasers of partnership-approved LTC policies to qualify for Medicaid while still retaining some or all of their assets (depending on policy purchased) once the benefits of the LTC policy are exhausted. Medicaid rules will still apply to income, so contributions toward the cost of care may be required.

Each of New York’s Long Term Care Partnership policies offers a minimum of two face-to-face care management consultations per calendar year (in addition to information and referral services offered by insurers) by independent professionals experienced in the field of LTC. The stated purpose of the care management is to provide an independent source of review of a policy- or certificate-holder’s individual situation and advice on the optimal use of insurance benefits and other available LTC services.

Care Coordination in New York State

Like most other states, care coordination takes many forms in New York based on the population served and the program within which care coordination takes place. In fact, the term for these services varies along these lines also, with the term “service coordination” used in programs for mentally retarded/developmentally disabled (MR/DD) clients, “care coordination” in mental health programs, “case management” in programs for clients with HIV/AIDS, and the terms “case management,” “care management,” and “care coordination” all used in programs for older adults and people with disabilities.

Table 4: Role of the Care Coordinator in New York Programs

Services	Ongoing Assessment	Care or Service Planning	Arrange Medical Services	Arrange Support Services	Provide Services (Client)	Provide Services (Family)	Set Client Goals
Programs							
Older Adults/Disabled							
LTHHCP	√	√	√	√	√		
EISEP	√	√	√	√			
NY Connects	√	√	√	√			
PACE	√	√			√		
Managed LTC	√	√	√	√	√		
MR/DD							
HCBS Waivers	√	√	√	√			
HCBS for TBI		√		√			√
Care at Home		√		√		√	√
Mental Health							
ACT	√	√			√		√
HCBS for Children	√	√	√	√		√	
HIV/AIDS							
Community Follow-up	√	√	√	√	√		

As can be seen in Table 4 above, despite the variation in the terms used for these services, several common care coordination elements are found across programs and populations. For example, care or service coordination always involves the development of a care or service plan. In most cases, this plan is developed based on a comprehensive assessment of client social and medical needs. Some integrate the assessment of mental health needs. Furthermore, the care or service coordinator usually arranges for needed services and assesses or evaluates clients on an ongoing basis. In some situations, the care/service plan is developed based on the personal goals or desires of the client. However, although most services found in the care coordination standards and guidelines of other states are also found in programs in New York, there is currently no statutory framework that guides the provision of these services. Finally, New York is one of the few states that do not require care coordinators to meet certain minimum qualifications.

We have also included a table of select New York Medicaid Waiver programs in *Appendix C*. This chart delineates the range of services, rates, qualification for care coordinators, and other areas for each of these programs.

Insights From Current Providers

As part of our evaluation of care coordination programs, we sought input from a group of care coordination professionals from cities throughout the state, including New York City, Albany, Buffalo, Long Island, Oneonta, Rochester, and Syracuse. This roundtable discussion was held at the New York Academy of Medicine on December 13, 2007.

Participants were providers of care coordination services (or case management) to older adults and/or people with disabilities, including those with mental health diagnoses. Half of the participants were social workers and half held other degrees, including nursing and management degrees. One provider was a former recipient of care coordination services. Several important themes emerged from the discussion, such as the need for training and certification of care coordinators, and a need to educate the public about care coordination and their possible future LTC needs.

Continuity of Care

There was a general consensus among care coordinators about the lack of continuity in the health and LTC systems in New York. Participants felt that the care older adults and people with disabilities are receiving in the community is often not coordinated with care they receive in the acute care settings and that there is no seamless way to transition care coordination across programs. They also stated that current programs are narrowly focused on physical functioning and neglect to address clients' psychological or social needs. Participants felt that a lack of these services, including mental health and a lack of choices for LTC in general, is leading to many clients' being placed in LTC facilities before they truly need that level of care.

Participants felt that a care coordination program that could cross program "boundaries" would help keep clients in their homes. They felt that too often, mainly because of financial constraints and a lack of knowledge, clients and their family members waited until emergencies occurred before seeking help. They felt these costly emergency room visits and nursing home placements could often be avoided through care coordination services provided by a well-trained and certified professional. However, participants also believed that a financing system needed to be developed to properly fund a care coordination program. Many felt that policy makers do not understand the time and effort involved in quality care coordination, and it was stated that in most Medicaid-funded programs, care coordination is simply considered an administrative task and is not separately reimbursed.

Care Coordination Training and Certification

Discussion participants felt very strongly that those providing care coordination services should be trained and certified. However, they did not believe that care coordinators should be required to hold a professional license, such as an RN or LMSW. Many participants reported having recent experience with, or knowledge of, unscrupulous businesses or individuals with no training or experience claiming to provide care coordination or care management services. They stated that a certification program would prevent this type of occurrence and that any certification program should have a built-in code of ethics for care coordination professionals. Several individuals spoke of national

organizations to which they belonged that certify care managers, such as the Geriatric Care Managers Society. It was mentioned that some of these groups already have codes of ethics, and certification by one of them may be a viable option for certification as opposed to a new state-created system.

Lack of Knowledge Among Consumers

Another concern of the discussion participants was the general lack of knowledge about LTC, especially among older adults. They stated that many older adults are very reluctant to pay privately for care coordination and other in-home services because they had assumed that these services would be covered by Medicare. The majority of participants agreed with this idea and stated that most clients are surprised to find that Medicare usually only covers acute and primary care services and not LTC.

It was suggested that some form of consumer education is needed. This would ideally inform people about what to expect from Medicare and allow them to plan for their likely future need for LTC and the benefits of having their care coordinated by a qualified professional.

Essential Elements of Care Coordination

Discussion participants agreed with the essential elements of care coordination that we developed through analysis of current care coordination programs and the guidelines and standards for care coordination created by other states: that it be *assessment driven*, include a *comprehensive care plan*, have *ongoing evaluation*, utilize a *qualified care coordinator*, be *client-centered*, and be *accessible*. Participants felt that these six elements included all that was necessary for quality care coordination and did not believe any elements were missing. They also felt that all of these elements are important and necessary for quality care coordination; participants did not recommend removing any elements. Discussion of the six essential elements of care coordination, therefore, involved better defining, clarifying, and improving our existing descriptions for each element.

Discussion participants agreed that care coordination must be assessment driven and that the assessment must include information regarding the client's medical, mental health and social needs. Participants felt strongly that assessments should measure the client's psychological and cognitive functioning. They also stated that assessments should take into account the client's strengths as well as needs. Other suggestions regarding the content of assessments were that they evaluate the client's home environment, spiritual and cultural beliefs, advanced directives and other planning, work history, legal history, drug use, and financial situation and ascertain the client's personal hopes, wishes, and desires for his or her future care and lifestyle. It was recommended that assessments be conducted at a location of the client's choosing and that the assessment include family members or significant others, if the client so desires.

Discussion participants agreed that the logical outcome of the assessment process is a care plan that covers all of the client's known medical, mental, and social needs. They felt that creation of the care plan is best done within an interdisciplinary care team and

should include at least a nurse and social worker. Ideally, the team would include other providers, such as the physician, therapists, or direct-care workers, based on the specific needs of each client.

Participants agreed with the assertion that care coordination must be an ongoing process. They felt that “boundaries” between programs and the fact that care coordination is not a recognized, reimbursable service meant that clients who currently received care coordination in New York could not be followed across settings, leading to less-than-optimal care. All agreed that creating a system that allowed care coordinators to have long-term, ongoing relationships with clients would go a long way toward improving the health of older adults and the disabled and allow clients to avoid hospitalizations and premature institutionalization. Participants also felt that an ongoing relationship between care coordinator and client was important for building trust.

Discussion participants also felt strongly that creating requirements regarding how often clients should be monitored and reevaluated was inappropriate. They stated that the timing of these activities should be based on the needs of clients and changes to client functional status.

As stated above, discussion participants strongly supported the need for training and certification of care coordinators. They did not believe it was necessary to require care coordinators to hold any professional license but believed that care coordinators should be able to demonstrate competence in a set of core competencies, such as motivational interviewing and knowledge of available services and supports. Participants also felt that ongoing training and recertification should be required. Participants also expressed that any certification program should hold care coordinators to a code of ethics.

Participants stated that training for care coordinators would better enable them to act in a client-centered way. They believed that care coordination should always be client-centered, meaning that one has to ensure that it is the client’s choices that are met rather than the choices of the care coordinator as long as the client is deemed competent. Some participants stated that they preferred the term “person-centered” to “client-centered.”

Finally, care coordinators in attendance felt strongly that care coordination be available to all who need it. In most cases, older adults and people with disabilities receive care coordination simply based on the types of programs for which they are eligible. The vast majority of the time, older adults and people with disabilities receive care coordination only if it is available in a Medicaid waiver program for which they are qualified. Participants believed strongly that other individuals who are not currently eligible for Medicaid would also benefit from care coordination services and would perhaps be able to avoid utilizing Medicaid for their LTC needs if care coordination services were widely available.

Related to this was the assertion among participants that most people are not well informed about their possible future LTC needs, what Medicare does and does not cover, or the ways that care coordination might allow them to avoid costly hospitalizations or

nursing home stays. Participants stated that a campaign to educate older adults, especially about these issues combined with a care coordination program, might be a way to save the state health care dollars.

Insights From Membership Organizations, Providers, Consumer Advocates, and Other Stakeholders

Following the initial roundtable discussion with care coordination professionals, the New York Academy of Medicine convened three additional stakeholder groups throughout the state with the goal of building consensus on the key elements of a successful care coordination blueprint. The three additional roundtables included:

- July 22, 2008, in Albany, NY
- August 1, 2008, in New York City, NY
- September 24, 2008, in Rochester, NY

Each stakeholder was invited to provide feedback on a draft version of this report; subsequently, a handful of stakeholders willingly offered feedback, which was incorporated accordingly. At each roundtable, participants (including provider agencies, membership organizations, government, LTC coalitions, consumer advocates, and advocacy organizations) were asked to share the benefits, challenges, and wishes for care coordination; also, they were asked to define the qualifications of an ideal care coordinator. As in many multi-stakeholder gatherings, opinions and perspectives in these areas were divergent at points and convergent at others.

Care Coordination at Its Best

Every stakeholder asked to participate in the roundtable discussions has had some connection to care coordination/case management services and has seen the positive outcomes of it. Drawing on this, we asked stakeholders to share what they observed to be the critical factors to the success of care coordination interventions. Two factors stood above all others: family participation/involvement in the care coordination and unbarriered access to different services across the LTC continuum/setting. Also ranking high among stakeholders is care coordination that is person-centered, exists in a community that has adequate resources, had a planning component, includes early intervention; and is culturally relevant to the consumer/community.

Individuals had seen success in models that utilized senior centers, were medically oriented and began at hospital discharge after a major event, worked to maintain small caseloads for care coordinators, utilized a peer model, used predictability models to determine the need for care coordination, and were independent entities from services being coordinated.

Barriers/Challenges to Care Coordination

Not surprising, participants had little difficulty in identifying barriers faced in coordinating care. Barriers include:

Systemic

- No legal authority to cross social-health silos
- Regulatory complications that arise when combining medical and social services
- Ever-changing delivery system

- HIPAA regulations³
- Discrimination and prejudice
- Defining the client—the consumer or the consumer and family caregiver?
- Lack of knowledge about Alzheimer’s disease and related services
- Lack of services in many rural and suburban areas
- Longevity of adults is increasing—placing burden on system
- Funding for care coordination is inadequate

Care Coordinator and Care Coordination Team

- Difficulty in recruiting care coordinators who are knowledgeable about systems
- Problems with interdisciplinary teams working effectively
- Turnover of care coordinating staff
- Care coordinators are not skilled in the area of behavioral health, making coordination difficult
- Difficulty in having all disciplines represented at case conferences

Education/Training

- Lack of basic knowledge of “normal” aging
- Training of paraprofessionals differs across spectrum and often not adequate
- Lack of knowledge about Alzheimer’s disease and dementia

Agency/Organization

- Turf issues between potentially competing providers
- Unrealistic expectations of consumers and clients
- Inattention to case load and case mixes often lead to burnout if not managed
- Technology available but not being provided
- Access to emergency, after-hours services not often in place

The Quality Care Coordinator

Lively and varied discussion about the ideal care coordinator was a highlight at each roundtable. Much like in the initial roundtable with care coordinators, stakeholders expressed varying opinions on the education, training, experience, personal characteristics, and credentials the care coordinator should possess. In addition to the areas detailed below, a chart synthesizing the stakeholders’ perspectives on care coordinator qualifications can be found in Appendix F.

Training

Most stakeholders agreed that some form of ongoing training for care coordinators that reflects state trends is necessary, as many states’ waiver programs require training and/or orientation. An area to consider however, is that continuing education units (CEUs) are often an extra expense to individuals and providers, and in-service training is often more cost-effective. The downside, however, is that standardization and the level of quality of in-service training are not regulated, as they are in continuing education. Although there was a near-consensus among our roundtable participants that training is important,

³ Note: There was much discussion about HIPAA. Many stakeholders felt it was a barrier, while other expressed concern that HIPAA is being misinterpreted—and that misinterpretation is the barrier.

opinions about the frequency, amount, and content of the training varied. A majority of stakeholders agreed that there needs to be an emphasis on the aging process and cultural competence in any training program. Stakeholders identified the following areas in which care coordinators should have competency:

- Gerontology
- Normal aging vs. aging with complications
- Biology and physiology of aging
- Mental health and aging
- Delirium and the different presentation of cognitive disorders
- Ethics and ethical decision making
- Consumer self-determination and independence
- Understanding and managing risk in a person-centered way with elders
- Maintaining and promoting dignity
- Issues related to end of life
- Family dynamics and understanding kinship care
- Human sexuality
- Awareness and knowledge about working with the lesbian, gay, bisexual, and transgender (LGBT) community
- Policy and practice connections
- Medicare and Medicaid
- Respect
- Talking to someone about difficult topics (e.g., incontinence)
- Understanding signs of abuse
- Community supports
- Bereavement, grief, and resilience

Experience

Most, if not all, stakeholders agreed that experience in the field and the community are determinants of high-quality care coordination. Many assert that success in care coordination is often based on knowledge, networking, and relationships within the community, which take time to build. However, requiring experience may prove to be a deterrent in filling positions for care coordinators. Many state programs, for example, the California MSSSP waiver, which require experience often have a difficult time recruiting coordinators based on the required experienced—particularly at the salary offered.

Education

There is an inferred consensus among stakeholders that a college education is necessary to successfully fulfill the role of a care coordinator. However, variances in opinion exist about the level and type of degree required. Primarily, the three degrees most commonly mentioned are a bachelor's of science in nursing, bachelor's in social work, and master's degree in social work. Many stakeholders said that the ideal care coordinator would be either a social worker or a nurse, as the underlying skills necessary for either of those professions would lend themselves to effective care coordination. However, regardless of the educational background of the coordinator, many stakeholders believe that the care coordinator should follow a code of ethics. It has been expressed that a code of ethics

helps in making decisions about and prioritizing ethical issues that may arise. An additional idea to consider, as mentioned by one stakeholder and practiced in a Pennsylvania waiver program, is having an experienced consumer carrying out the role of care coordinator in a peer relationship.

Licensure

New York State currently offers two types of social work licensure: LMSW and LCSW. It is important to note that a number of issues have arisen around the implementation of social work licensure, and consequently it is a particularly volatile arena at the moment. Given the climate in the state and the polarizing nature of this topic, it does not seem advisable to require that the care coordinator be a licensed social worker or nurse to carry out the role of care coordinator. Many stakeholders, including the group of care coordinators surveyed in November 2007, agree that some form of certification or credentialing that provides a degree of accountability, standardization, and consistency should be considered a requirement for newer care coordinators in the field. Others are in strong opposition to this notion, stating that a social work or nursing degree is sufficient.

Expressed Wishes for a Care Coordination Program

Finally, we asked roundtable discussion participants to share their vision—what they hoped for—in a care coordination program. Recommendations and wishes were numerous; interestingly, three areas surfaced at each of the three roundtables:

1. Build on the successful programs already in the system.
2. Adequate and specified reimbursement is needed for care coordination services.
3. Common assessment tools should be used across service delivery settings so as not to be duplicative.

In Appendix G, we present the full list of fifteen areas' stakeholders "wishes" for any care coordination program New York State plans to implement. Much of the discussion focused on communication issues in and between service programs, and HIPAA was often a point of debate; all stakeholders agreed that there should be clarification about HIPAA across the board. Also expressed strongly in two of the three roundtables was the notion that any program designed should not be a gatekeeping program and should not be mandatory for all consumers.

As New York works to improve its health and LTC systems, the time is ripe for creating statutory guidelines for care coordination. As demonstrated in Table 3 above, several important elements for quality care coordination are already found in many state programs. Therefore, building off of these existing systems should not pose much difficulty.

Furthermore, as the move to more home- and community-based programs is realized, older adults, people with disabilities, and their caregivers are more at ease when they have the assurance that care is being coordinated by qualified professionals working under well-defined care coordination standards. Quality care coordination should be the backbone of any state program providing care to older adults and the disabled. New York has an opportunity to help lead the way in this area.

Findings and Recommendations

Based on our analysis of both quality and cost measures in care coordination programs across the country, we make the following four recommendations:

1. Develop quality standards for care coordination that incorporate six essential elements (*details on these elements follow the fourth recommendation*):

Assessment Driven

Comprehensive Care Plan

Ongoing Evaluation

Qualified Care Coordinator

Client Centered

Accessible

2. These quality standards should be included in a statutory framework.
3. Strive to develop a qualified workforce to provide care coordination as a foundation to the success of the restructuring movement toward the provision of more home- and community-based care services.
4. Ensure that any state and/or federally funded program that has care coordination as a service explicitly provides for its payment either independently or as a designated portion of an administrative fee.

Essential Elements

As stated above, this analysis of care coordination programs, the standards and guidelines for care coordination developed by other states, and discussions with care coordination professionals in New York has led us to conclude that six elements are necessary for care coordination: that it be assessment driven, include a care plan, incorporate ongoing evaluation, be performed by a qualified care coordinator, be client-centered, and be accessible to all those who need it.

Assessment Driven

Care coordination should begin with a broad assessment of the client's needs. The assessment should include the client and the client's caregiver(s) (if applicable) and should take place in the client's home or other location if the client so desires. The assessment should be culturally relevant and take into account the client's strengths as well as needs.

This element of care coordination is common to most programs and most state standards. In some cases, the assessment is performed using a team approach, with nurses assessing the client's medical needs and social workers assessing the client's social support needs and existing informal support system. It is important that the assessment also measure the client's cognitive functioning and be culturally and linguistically appropriate.

Comprehensive Care Plan

The assessment should result in a comprehensive care plan that addresses all of the client's medical and social needs and supports. The care plan should span all care services and settings.

This element of care coordination is found universally across programs and state standards and is a central element to care coordination. Furthermore, analysis of existing care coordination programs has shown that integrated care planning, which includes both medical and social services, has been most successful. Involvement of an interdisciplinary team is also most desirable.

Ongoing Evaluation

The relationship between the client (and his or her informal caregivers) and the care coordinator should be ongoing. The care coordinator should periodically reassess client needs and modify the comprehensive care plan when necessary. The frequency of ongoing evaluation should be based on the client's social and medical needs, and reevaluation should be triggered by any changes in health status.

Most programs and state standards recognize that the needs of older adults and people with disabilities are not static. Medical conditions may improve or worsen, as may systems of informal support. The federal government, therefore, requires that participants in federal programs be reassessed annually. Most states, however, have more stringent guidelines that include close monitoring of client needs. An ongoing relationship between the care coordinator and client is also important for establishing trust.

Qualified Care Coordinator

Care coordination should be provided by an appropriately trained professional working with an interdisciplinary team. Care coordinators should receive special training and certification before providing care coordination services to older adults or persons with disabilities. Care coordinators should also receive ongoing training and be held to a professional code of ethics.

Many states have instituted training, certification, and/or licensing requirements for care coordinators to reassure clients and the public that those making decisions about care for older adults and people with disabilities are well qualified to do so. In addition, several states and programs require that care be coordinated with input from an interdisciplinary team. In this way, the varying needs of clients can be addressed by a range of specialists.

Client-Centered

Years ago, clients of health and LTC services were often expected to comply with the recommendations of the providers and payers of those services—clients had limited or no voice in how, when, and even where those services were delivered. There has been a significant shift in this provider-driven approach to care with the movement toward client-centered, even consumer-directed care. This shift can be attributed to a number of factors including consumer group pressure, recent federal legislation (e.g., the New Freedom Initiative), and the Olmstead Supreme Court decision (see History of Care Coordination for more information). Each has called for services that respect the choices and preferences of the clients and their family/informal caregivers. Several states have already adopted this value into programs for LTC consumers and created care coordination guidelines that reflect it.

Care coordination should be client-centered and, where possible, client directed. In this realm of service delivery, care coordination is a dynamic—some aspects of the decision making regarding care and services will be made by the care coordinator/ team (e.g., the number of home care hours allotted), while others can and should be made by the client and his/her family (e.g., the time frame in which a direct care worker is present in the home).

The care coordinator and care coordination team should seek to know the client's preferences, wishes, goals, and needs and work toward meeting each as best and as close to the ideal as possible. Furthermore, provisions should be made to allow for clients to refuse certain care and services without fear of or actual retribution.

Accessible

Care coordination should be available based on choice or need to all regardless of insurance coverage. There should be outreach and education to older adults, people with disabilities, and their caregivers so that all who may need care coordination are aware of it.

In most cases, older adults and people with disabilities receive care coordination simply based on the types of programs in which they are enrolled. The vast majority of the time, older adults and people with disabilities receive care coordination only if it is available in a Medicaid waiver program for which they are qualified. Other individuals who are not eligible for Medicaid may also benefit from care coordination services and would in fact be able to avoid utilizing Medicaid for their LTC needs if care coordination services were widely available. Furthermore, several states are examining new ways of delivering health care that includes care coordination, such as the medical home model being considered in New York.

Educating consumers about their current insurance coverage, especially Medicare, their possible future LTC needs, and the benefits of care coordination may help consumers plan for the future. Too often consumers or their families do not think about these issues until a medical emergency occurs. Entering the health and LTC system under these circumstances may make an already confusing system that much more difficult to navigate. An education program that informs consumers about the need to plan for the

future and where care coordination fits into overall planning for LTC may spare consumers from expensive hospitalizations and premature and inappropriate institutionalization.

~In Closing~

In summation, care coordination has been an important part of programs serving older adults and people with disabilities for several decades and will become even more important as states rebalance their LTC systems. As states move toward home- and community-based services in response to federal mandates and budgetary concerns, care coordination will be central to the success of many programs. Programs including care coordination have been demonstrated to improve outcomes for older adults and their caregivers and have the potential to save states Medicaid dollars. However, ensuring that care coordination efforts are successful depends on setting standards for these services, as several states have already done.

New York is at a critical juncture, and major improvements will soon be made to the state's health and LTC care system. Establishing standards for care coordination should be one of these improvements. Steps should be taken to establish a statutory framework governing care coordination and the credentialing requirements for individuals providing these services. This analysis has identified the elements that should be included in any care coordination standards that the state adopts. Care coordination should be assessment driven, include a care plan, incorporate ongoing evaluation, be performed by a qualified care coordinator, be client-centered, and be accessible to all those who need it. *New York has the opportunity to be a leader in care coordination.*

Methodology

This analysis was based on examination of large-scale programs for older adults and the disabled that have, or currently do, provide care coordination or case management as a core element. Therefore, small research and/or demonstration projects that focused on one disease, usually called disease management programs, and programs that focused on a small population, such as those visiting one hospital, were not included. Similarly, models of care coordination or case management that are in development but not yet implemented in any meaningful way were not analyzed. For current state-level programs, we sought to describe those that are viewed as prime examples of their program type. Therefore, this analysis should not be considered exhaustive in that it does not describe all programs that include care coordination or case management in all states. Instead, we sought to describe models of care coordination using the research and evaluation literature.

Information about state care coordination and case management guidelines/standards and qualifications for case managers and care coordinators were gathered from state government Web sites and by interviewing officials in some states. Again, officials from all states were not interviewed; instead, we sought to gather prime examples of state standards and guidelines. Decisions about which state officials to interview were based on discussions with experts in this field.

The purpose of the four roundtable discussions was to obtain information about care coordination from those currently providing the service to older adults and people with disabilities and those who have an active stake in how care coordination programs operate. We sought to discover the types of barriers that exist in New York for providing care coordination. We also elicited input from these professionals regarding the essential elements of care coordination. These discussions helped us to better define the essential elements of care coordination.

Appendix A: A Comparison of Essential Features of Approaches to Care Coordination

A Comparison of Essential Features of Approaches to Care Coordination



DEFINITIONS OF CARE

	Goals	Components/Tools	Population(s)	Setting	Coordinator	Unique Features	Policy Goals	Funding
Care Coordination (as envisioned by the New York Academy of Medicine)	Older adults and people with disabilities will experience a seamless system of social, mental health, and health support and care services that are both high in quality and cost-effective to the payer(s)	Assessment driven Comprehensive care plan that addresses social, physical, and mental health needs Ongoing evaluation Qualified care coordinator Client-centered Accessible	Older adults (aged sixty-five-plus) People with disabilities and in need of LTC services	The client lives primarily in the community; however, CC follows the person across settings until permanent residence is established in a long-term setting	The comprehensive care coordinator plays a leadership role while working in a client-centered way with an interdisciplinary team (the makeup of which is determined by the client's needs)	Care coordination spans the health and social service delivery systems Team approach Client-centered	Care coordination will be available to all who seek it or are assessed to be in need of it in a timely manner Care coordination will be a reimbursable service through insurance, Medicare, or Medicaid	Potential funding: Miscellaneous human (social service) funding - OAA - SSIBG - Foundations - DHHS - State HCBS Medicaid waivers future: - Medicaid - Medicare
Care Coordination, Definition National Quality Forum	Ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time	Health care or medical home Proactive plan of care and follow-up Communication available to all team members (including patients and families) Integrated patient information systems Special attention paid to transitions between care settings	All	Medical group, solo practitioner's office, community health center, or hospital	Team approach in which all are accountable for their role in implementing the care plan	Routine, acute, and chronic care coordination Health care "home" Shared decision making with family	Consumer choice and direction honored in development and implementation of care plan	NA, as this is solely a definition
Care Management CMS	Optimize client functioning by providing services in efficient and effective manner Minimize utilization of high-cost services	Client-level intervention System-level intervention Patient advocacy	All	Variable	Generally done by a social worker or a nurse in many state-based programs	Varies by program Usually done in a social or a medical setting	Optimize client functioning Minimize utilization of high-cost services	Medicaid waivers Medicare demos OAA Foundations Private insurance

A Comparison of Essential Features of Approaches to Care Coordination



PROGRAMS OF OR RELATED TO CARE

	Goals	Components/Tools	Population	Setting	Coordinator	Unique Features	Policy Goals	Funding
Disease Management CMS	Improve and maintain the health of large populations <hr/> Reduction of complications associated with chronic diseases <hr/> Improve quality of life and ADLs	Tools, experts, and equipment are supplied at the population level <hr/> Clinical guidelines and best practices <hr/> Health risk assessments	Those who suffer from chronic disease (such as heart disease, hypertension, obesity, diabetes, asthma, depression, etc.)	Public health areas	Self	Aimed at improving the health of entire populations	Reducing costs in the health care system by redirecting funds to education and prevention	Medicare and Medicaid demonstrations
Transitions in Care Mary Naylor Eric Coleman	Ensure the continuity of health as people transfer between different settings and different levels of care	Consumer (and family) education <hr/> Coordination among providers involved in the transition	Patients transferring between settings	Institutional settings and patients' homes	Transition coach and self	Focus on consumer's goals and preferences <hr/> Consumer education	Save money in the medical system by reducing rehospitalizations	Medicare and Medicaid demonstrations
Patient Navigator National Cancer Institute	To reduce the time of delivery of standard cancer services, cancer diagnosis, and treatment after diagnosis <hr/> To reduce disparities in underserved populations	Trained professional or volunteer who coordinates services across the continuum, including social services such as counseling and childcare	Cancer patients initially, but model is used with other conditions such as HIV and other chronic illnesses	Medical setting and home	Nurse or social worker; sometimes trained volunteers or cancer survivors	Navigator serves as an ally; provides advice, support and direction; seeks to understand patients' hopes and fears	Reduce disparities <hr/> Prevent mortality <hr/> Provide help accessing appropriate care and treatment	NCI dimes Philanthropic organizations such as Susan G. Komen For the Cure Foundation
Medical Home (Used by: American Academy of Pediatrics, The American Academy of Family Physicians, and the American College of Physicians)	To improve care quality by promoting and guaranteeing a system that coordinates continuous, comprehensive care for preventive services, acute and episodic illness, and chronic, complex problems	Personal and ongoing relationship with the physician <hr/> Information technology <hr/> Focus on preventative care	Idea began in pediatrics but has spread to other populations (including Medicare)	Primary care setting	Physician is responsible for coordinating all patient care needs with a practice-level team	Shift in thinking about the role of the physician	Physicians reimbursed for these care management services <hr/> Save money in the medical system	Medicare demos <hr/> Medicaid managed care <hr/> SCHIP

DECEMBER 2008

Appendix B: Case Manager Educational and Training Requirements for Select States

The programs described below are all associated with 1915(c) or 1115 Medicaid Waiver Programs.

	Education		Licensure or Certificate Related to Degree	Experience	State Training and/or Certification
	Preferred	Educational Waiver			
California MPSSP	<p>Social work care manager Master's in social work, nursing, psychology, counseling, rehabilitation, gerontology, sociology, or a BA in same fields</p> <p>Nurse care manager BSN in public health, health education, health administration, gerontology</p>	None	<p>Nurse must pass federal nursing exam and hold a current license within the state</p> <p>Social workers are not required to be licensed or certified</p>	<p>One year with master's degree</p> <p>Two years with bachelor's degree</p> <p>Three years for a nurse case manager title</p>	None
Illinois Case Coordination Units for CCP Program	An RN or a BSN, or a BA/BS degree in social science, social work, or related field; or be a licensed practical nurse (LPN) (experience required for LPN)	<p>One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly; may replace one year of college education up to and including four years of experience replacing a bachelor's degree</p> <p>Persons hired/serving in this capacity prior to December 13, 1991, may be waived</p>	Nurse must pass federal nursing exam and hold a current license within the state	LPNs must have one year of program experience (as defined earlier)	Prior to performing CCP eligibility determinations and developing plans of care, each case manager and each supervisor acting as a case manager shall successfully complete: Department-sponsored three-day CCP training on the DON, eligibility determination, care planning, nursing home prescreening, and OBRA-1 (Level I ID Screen). Successful completion of the above training shall be established by preliminary certification, which shall expire six months from completion of training. At the end of the three-day training, there is an exam. The new case manager must pass the exam to obtain case manager certification. The Illinois Department on Aging is the certifying agency
Ohio Passport	Bachelor's degree in nursing or bachelor's degree in social work	None	<p>Nurse must pass federal nursing exam and hold a current license within the state</p> <p>Social workers must be licensed</p>	At least one year of prior experience in medical social work and/or geriatrics	<p>Case managers and AAA coordinators must receive six hours of LTC or aging-related training per year. CEU training required for maintenance of licensure can be used to meet the CMPFE training requirement; there are approval guidelines.</p> <p>To fulfill the training requirements of this section, any training course or event must be approved by the CMPFE program manager unless the course or event is:</p> <ul style="list-style-type: none"> • A conference sponsored by the DEA, such as the Governor's Conference on Aging • Caregiver or Elder Rights Conference • Conferences sponsored by N4A, NCOA, ASA, AOA, or the Alzheimer's Association • Training sponsored by the DHS

					<ul style="list-style-type: none">• A conference sponsored by a university, college, community college, or state agency other than the DEA if the conference content is related to LTC or aging issues
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	Education		Licensure or Certificate Related to Degree	Experience	State Training and/or Certification
	Preferred	Waiver			
Pennsylvania PA Independence Waiver	Bachelor's degree in social work, social science, or related field	Person with a physical disability with a high school diploma who has successfully transitioned to living independently	None required	Person with a disability must have one year of experience working with individuals with disabilities in a home- and community-based setting	Person with a disability must pass an oral and/or written review All supports coordinators must complete CORE, service, and annual training requirements
Utah Medicaid Waiver for Individuals Aged Sixty-Five and Over	Bachelor's degree in nursing or bachelor's degree in social work	Case manager certification from the National Academy of Certified Care Managers	Nurse must pass federal nursing exam and hold a current license within the state	Case managers must have a minimum of one year of experience working with the aging population before they can be hired to work with waiver clients	Prior to performing case management services, each case manager is trained on the requirements necessary to perform this service for the Aging Waiver
New Jersey CCPED	Bachelor's degree in nursing or bachelor's degree in social work	Certified case manager—must be certified through an exam and must take training (see training requirements)	Certified social worker (BSW and passing ASWB bachelor's-level exam) Nurse must pass federal nursing exam and hold a current license within the state	None noted	CSW: Twenty hours of continuing education (5=ethics) over two-year period Certified case manager training: Division of Aging and Community Services Training Academy: Care Management Training (eight days) offered by the state Topics covered: NJEASE, home- and community-based services, confidentiality and ethics, caregiving, sources and patterns of care, caregiver stress and burnout, cultural diversity, Adult Protective Services, legal issues related to care managers, ways to ensure the safety of the workers, Universal Precautions (standard precautions), the fundamentals of care management: introduction; goals; components of the care management process; history; care management today and future trends; care management models and care manager's role. The training covers assessment and care planning. Two days of training are devoted to health and aging

	Education		Licensure or Certificate related to degree	Experience	State Training and/or Certification
	Preferred	Waiver			
South Carolina CC	<p>Bachelor's degree in social work or nursing</p> <p>Master's degree in social work</p> <p>Licensed professional counselor. Licensure must be maintained</p>	<p>An individual who is not a licensed social worker, BSW/MSW with experience, RN, or LPC, but was enrolled and active or hired through a provider agency prior to July 1, 2007. All individuals enrolled or hired through a provider agency on or after July 1, 2007, must be an LSW, BSW/MSW with experience, RN, or LPC</p>	<p>BSW/MSW; must be licensed</p> <p>Nurse must pass federal nursing exam and hold a current license within the state</p>	<p>Unlicensed BSW/MSW must have two years of experience in health- or social-related field</p>	<p>Case managers are required to attend the first CLTC Case Managers' Orientation Program after becoming employed to provide services under contract and shall attend ongoing Medicaid-sponsored case management training and SCDHHS/CLTC in-service programs. All training requirements must be adhered to</p> <p>CMs are required to attend any other training required by CLTC staff</p> <p>Unlicensed case managers must have a minimum of ten hours relevant in-service training per calendar year (the annual ten-hour requirement will be on a prorated basis during the first year of employment). Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, location, and outcomes of training. Topics for specific in-service training may be mandated by CLTC</p>
Iowa Case Management Program for the Frail Elderly (CMPFE)	<p>Bachelor's degree in a human service field or bachelor's degree in nursing</p>	<p>The case manager may substitute up to two years' full-time equivalent work experience in a human services field involving direct contact with people in overcoming social, economic, psychological, or health problems for two years of the educational requirement</p>	<p>Nurse must pass federal nursing exam and hold a current license within the state</p>	<p>None noted</p>	<p>The case manager shall attend case management orientation established by the department within six months of employment</p> <p>The case manager shall: (1) receive formal training in completion of the CMPFE assessment tool and (2) attend six hours of LTC or aging-related training per year</p>
Vermont Choices for Care	<p>Bachelor's degree in arts or science</p>	<p>At least two years experience in human services or nursing or At least three years' experience working with elders or adults with disabilities or On a case-by-case basis, the Department may approve staff to provide services when they have an equivalent combination of education, experience, and skill specific to working with elders with functional limitations or individuals with disabilities</p>	<p>None noted</p>	<p>See Education</p>	<p>The case manager must complete Case Management Foundation Training during the first year of employment and follow the Case Management Certification requirements of the Department of Aging and Disabilities</p> <p>Certification exam administered by the state. This must be passed within one year of employment and after the initial probation period</p>

Appendix C: NY State Waiver Program Comparison

Select NY State Waiver Programs for Adults

	NYSDOH Long Term Home Health Care Program - LTHHCP (Lombardi)	NYS HCBS - TBI	NYS Nursing Home Transition and Diversion Waiver
Dates Effective	4/1/1978 (renewal 12.31.08)	1994	Effective 9/1/2007, expect to begin enrolling shortly
Service Coordination	Yes—"coordinated plan of care" of medical, nursing, rehab, and support services	Yes—called service coordination	Service coordination
Scope	The LTHHCP is overseen by the NYS DOH and administered by Local Social Services Districts. Reflects a coordinated plan of nursing, medical, rehabilitation, and support services at home for individuals eligible for a nursing home. Services provided at home, at an adult assisted living facility, or at the home of a responsible adult	This legislation charged the NYSDOH "to develop a comprehensive statewide program...with primary emphasis on community-based services and to develop outreach services and to utilize existing organizations with demonstrated interest and expertise in serving persons with TBI"	
Range of Services	Medical social services; nutritional counseling/education; respiratory therapy; home maintenance; home improvements; social day care (includes transportation to social day care services); home-delivered and congregate meals; moving assistance; personal care emergency response system and respite care	Service coordination; independent living skills training and development; structured day program; substance abuse programs; intensive behavioral health programs; community integration counseling; home and community support services; environmental modifications; respite care; assistive technology; transportation; community transition services. The TBI waiver program funds housing and services separately and strongly promotes an unbundled service delivery system	
Waiver Authority	1915(c)	1915(c)	1115
Rate Established		In 2007, a revised service reimbursement rate package was implemented for TBI waiver providers that includes a COLA and a downstate differential. Cost neutral in the aggregate	Upstate for assessment \$500
Who Gets Paid		Every year, five RFAs go out for services—bring in and blend services and costs among OASIS, DOH, etc.	The Regional Resource Development Centers (RRDC) were awarded contracts to manage applicant nonfinancial waiver eligibility determination, assessment, participant service plans, and coordinate waiver activities with local departments of social services, local government entities, service providers, and other stakeholders. Three contracted quality Management Specialist (QMS) will support DOH staff, RRDCs, and providers statewide
Title	Case manager	Service coordinator	
Who's Qualified to Develop a Plan	RN at the provider agencies	Service coordinator	

of care			
Qualifications	RN at the provider agencies	Masters + one year of experience (social worker, nurse, physical therapist, occupational therapist) or BA + two years of experience	
Assessment			Because services are unbundled, there is a different package for each participant. Each subpopulation has different service needs—vets, educational needs, nursing homes, etc. Complicates the financial issues
MA Eligibility Required	Agency must be Medicare eligible	Yes	Yes
Cost Sharing and How It Is Established	Rate setting incorporates administrative cost of care		\$3.5 million in the enacted budget for Y1

Select NY State Waiver programs for Children

	Care at Home—General	CAH III, IV, and VI (OMRDD)	Bridges to Health Home- and Community-Based Medicaid Waiver (B2H)
Dates Effective	12/1/2003-11/30/08	III: 8/1/1991-9/30/09 IV: 9/1/1994-9/30/2007 VI: 3/1/2000-2/28/2010	1/1/2008 DOH monitoring agency, OCFS administering
Service Coordination	Yes		Yes—"Health Care Integration"
Scope	Case management, home modifications, vehicle modifications, respite, assistive tech (IV and VI)		B2H will provide community-based services to children who are in the care and custody of a Local Social Services District (LDSS) or OCFS; who have significant mental health, developmental disabilities or health care needs; and who require an institutional level of care. Administered as three separate waivers: B2H/Serious emotional disturbance; B2H/DD; and B2H/Medically Fragile
Range of Services	Case management, home modifications, vehicle modifications, respite	Case management, home modifications, vehicle modifications, respite, and assistive technology	
Waiver Authority	1915(c)	1915(c) 1915(c) 1915(c)	1915(c)
Rate Established	\$80 per hour		Aggregate cap—budget neutral
Who Gets Paid	Usually agencies get reimbursed (not individuals). If a local district does the assessment and/or case management, they claim via administrative mechanism. No certification for agencies, but there is an enrollment process for all agencies under all waivers.		Monthly or semimonthly preference is for MSW or psychologist but not mandatory
Title	Case manager		Health care integrator
Who Is Qualified to Develop a Plan of Care	RN		See Qualifications below

Qualifications	SW does coordination, RN does assessment (although no need for prior approval for private-duty nursing.) CM gets CHA to do an in-home assessment; CM coordinates care; if no CHA in place, the CM contacts local district, which sends a nurse to do assessment.		<p>The preferred qualifications for an HCI are:</p> <ul style="list-style-type: none"> • a master's degree in social work, psychology, or other related field, or to be licensed as a qualified health care practitioner, a registered nurse, or a special education teacher; <i>and</i> • a minimum of one year of experience providing service coordination and information, linkages, and referrals for community-based services to children with special needs, individuals with disabilities, or seniors. <p>The minimum qualifications for an HCI are:</p> <ul style="list-style-type: none"> • a bachelor's degree in social work, psychology, or other related field; <i>and</i> • four years of experience providing service coordination. <p>Note: An HCI working with children enrolled in the B2H Waiver Program for the Medically Fragile population must be an RN.</p>
Training	Unknown		<p>Prior to providing services:</p> <ul style="list-style-type: none"> ▪ First aid/CPR ▪ Mandated reporting on suspected child abuse and neglect ▪ Basic crisis intervention and de-escalation techniques ▪ Overview of B2H Waiver Program documentation requirements <p>Within 3 months:</p> <ul style="list-style-type: none"> ▪ Universal Precautions and hazardous materials ▪ Recognizing and understanding cultural differences and diversity interaction of the B2H Waiver Program and foster care communication skills and advocacy ▪ Understanding and managing behaviors ▪ Advanced crisis intervention/avoidance ▪ Child and adolescent development
Licensing/ Certification	RN or "licensed social worker"—unclear whether LCSW or LMSW		No outside requirements for nurse to be licensed in frail children waiver
Assessment	Home health abstract		The child is sent to the Healthcare Integrator Agency for assessment of criteria. Individual health plan is developed at this point. The HCI is responsible to implement/OMRDD uses to place

Eligibility	Aged younger than eighteen years; disabled according to SSA standards; ineligible for Medicaid due to parents' income or resources; Medicaid eligible when not counting parent resources/income; can be cared for at home safely at no greater cost than facility care	CAH General plus institutional stay requirement of thirty consecutive days; SSI disability must be physical in nature	The child can remain in the waiver once adopted with a special budgeting formula that disregards adoptive parents income and assets
MA Eligibility Required	Ineligible for Medicaid due to parents' income or resources; Medicaid eligible when not counting parent resources/income		Yes, with a special formula once child is adopted that disregards the adoptive parents' income and assets
Cost Sharing and How It is Established			As of April 2008, six children enrolled with eighty-five applications pending, mostly from New York City

Appendix D: Care Coordinator Competencies/Responsibilities

These competencies and responsibilities of care coordinators were obtained from the programs found in Appendix B. Information on competencies/responsibilities of Care Coordinators in Vermont, California, and Utah was not available. We included the competencies/responsibilities of Care Coordinators in Alaska's Older Alaskan's Waiver, Maine's Elder Independence of Maine, and Texas' Star+Plus program for comparison.

Competency/Responsibility↓	State:	AK	IL	IA	ME	NJ	OH	PA	SC	TX
Ability to develop a care and/or service plan			✓	✓		✓		✓	✓	✓
Ability to organize/coordinate medical, social, and educational services that are and that are not covered by Medicaid and make appropriate referrals			✓	✓	✓	✓		✓	✓	✓
Knowledge of available local and statewide resources		✓			✓		✓	✓	✓	
Knowledge of requirements for HCBS Waiver Care Coordination Services and the care coordination process		✓						✓		
Knowledge of the medical, behavioral, habilitative, and rehabilitative conditions		✓								
Knowledge of laws, rules, regulations, and precedents, including IDEA (Act) and the ADA; terminology used in ADA; terminology used in the work		✓								
A good working knowledge and understanding of issues related to the elderly population							✓			
Knowledge of the individual, family, social systems, and the individuals functioning in the aging process.							✓			
Ability to follow up, monitor, and ensure services are provided as prescribed in the enrollee's plan of care				✓	✓	✓			✓	
Ability to authorize services			✓		✓				✓	✓
Ability to reassess, evaluate outcomes and terminate/transfer; ability to assess level of care review			✓	✓				✓	✓	
Ability to work with professional and support staff in an interdisciplinary team		✓					✓			✓
Ability to organize, evaluate and present information effectively, both orally and in writing; ability to maintain case records, including documentation of follow-up		✓	✓				✓			
Ability to organize, evaluate and present information effectively, both orally and in writing; ability to maintain case records, including documentation of follow-up		✓	✓				✓			
Ability to assess treatment needs of individuals who experience physical and/or intellectual disabilities		✓		✓						
Administration of the appropriate intake form, including a comprehensive needs assessment				✓						
Ability to guide enrollees through the health care system										
Ability to advocate on behalf of the elder/client				✓				✓		
Ability to conduct skills training					✓					
Ability to process claims					✓					
Ability to oversee and assure compliance and conduct; utilization review activities					✓					
Ability to provide good customer service							✓			
Good interpersonal communication skills							✓			
Ability to adapt to frequent change							✓			
Excellent computer skills, including the Windows operating systems, MS Word, MS Excel, data entry, and the ability to learn new software applications as needed							✓			
Provide ongoing monthly monitoring of the provision of services included in the participant's ISP and any risk agreements negotiated by the participant to assure the health and welfare of the participant								✓		
Ensure caseload is maintained								✓		
Ability to problem solve to address client needs									✓	
Service counseling with participant and families									✓	
Willing to try new approaches							✓			
Tolerant, empathetic, good interviewing capability							✓			
Respect the cultural, spiritual, racial, ethnic beliefs of others							✓			

Appendix E: Select State Policies and Guidelines for Care Coordination/Case Management Reimbursement

Alaska: Older Alaskans Waiver

- One screening per calendar year (exception: a second screening is allowed if the applicant was determined, based on the first screening, as ineligible for waiver services)
- One development of a plan of care per calendar year (Note: care coordinators MAY NOT bill for a separate plan of care when the client is a transfer if the plan of care has already been billed for during the calendar year—it does not matter if the client transfers care coordinators two or three times during that year—only one POC per year is allowed)
- Ongoing care coordination beginning with the first month that the recipient is enrolled under 7AAC 43.1010(e) and has a plan of care approved under 7AAC 43.1010(f)(1). The department will reimburse a care coordinator for one new assessment under 7 AAC 43.1030(g) during the twelve-month period following the month that the recipient is enrolled under seven AAC 43.1010(e), and for no more than two new assessments during each subsequent twelve-month period
- Care coordination services that are provided by the recipient, a member of the recipient's immediate family, the recipient's guardian, a holder of power attorney for the recipient, or the recipient's PCA are **NOT** reimbursable {*Title 7 Health and Social Services Part 3 Public Assistance and Medical Assistance Chapter 43 Medical Assistance Article 28 Home and Community-Based Waiver Services; Nursing Facility and ICF/MR Level of Care*}

Maximum billing amount according to the *Alaska Medicaid Provider Billing Manual (proposed in 2008)*

Screening: \$79.50

Monthly care coordination: \$212

Plan of care development: \$339.20

www.hss.state.ak.us/apps/publicnotice/ViewDocument.aspx?FileInfo=2df4a588-b8b3-4448-82a2-8c88bf24d425

California: Multipurpose Senior Services Program (MSSP)

- Funded by State General Funds and Federal Medicaid Funds
- Waiver agencies assume full financial risk for administering the program, providing care-management services, managing the subcontractor billing process, and disbursing payments to subcontractors for any authorized waiver services provided to clients
- The Department of Health Care Services (DHCS) reimburses waiver providers for administrative and care-management services on the basis of monthly administrative flat fees per eligible-enrolled-waiver-client. All other waiver services are reimbursed at cost but not in excess of the established MSSP waiver rates. All requests for reimbursement of waiver services are submitted by waiver agencies to EDS. The current MSSP annual reimbursement per client is \$4,285

Illinois: Case Coordination Units

- Section 240.1960 Case Management Fixed Unit Reimbursement Rates Case Coordination Units under contract with the Department shall be uniformly reimbursed for the provision of Community Care Program (CCP) case management services at the rates established by the Department. The reimbursable CCP case management service activities upon adoption of this

Section and subsequent to a procurement conducted under 89 Ill. Adm. Code 220.610 et seq. shall be as follows:

- a) completion of each initial eligibility determination for Community Care Program services;
- b) completion of each redetermination of Community Care Program eligibility not to exceed one redetermination per month per client;
- c) completion of each face-to-face prescreening of an applicant;
- d) completion of each Illinois Department of Public Aid Interagency Certification of Results and Determination of Imminent Risk form, following prescreening by hospital discharge staff;
- e) completion of each Illinois Department of Mental Health and Developmental Disabilities (IDMHDD) OBRA-1 (Level I ID Screen);
- f) availability to receive client inquiries and requests, by telephone or in person, and to respond to such requests and inquiries for each active client per month; and
- g) completion of each deinstitutionalization (Source: Added at 15 Ill. Reg. 18568, effective December 13, 1991).

Iowa: Case Management Program for the Elderly Waiver

- Under the Elderly Waiver, the average client cost was \$518 per month, far less than the average monthly nursing home cost of under \$3,688 per month (Source: June 30, 2005, DHS/Medicaid B1 reports)
- Statewide, the cash resources supporting the operation of the CMPFE Program total approximately \$5 million, of which approximately 18% to 20% comes from federal Older Americans Act funds, 66% to 70% is from state General Fund and Senior Living Trust funding, and 10% to 12% is from local community resources
- Medicaid Cost Report data released in August 2005 cover the time period of March 31, 2004, through March 31, 2005, and show that the average allowable cost for Iowa nursing facilities was \$112.06 per day. With a monthly average of 6,746 Medicaid recipients on the elderly waiver, the cost for just one month of institutionalization of these recipients would have been \$22,678,702 (combined state and federal dollars.) An average monthly investment of \$114 for case management and \$536 for other elderly waiver services (combined state and federal dollars) represents a dramatic savings to the state. Delaying institutionalization by only twelve days would pay the cost of case management services for an entire year

Maine: Elder Independence of Maine (EIM)

- The Home Care Coordination Agency, Elder Independence of Maine (EIM), receives a monthly per-person payment from Bureau of Elder and Adult Services to:
 - arrange services;
 - coordinate and monitor care;
 - calculate consumer co-payments
 - contract with service providers
 - pay claims;
 - audit providers; and
 - participate in quality improvement activities.
- FY03-estimated per-month/per-person cost: \$120.05
- According to a Maine legislative report done by the State Ombudsman's office: The Legislature appropriated \$900,000 (over the next two years) to be used to increase

the number of caseworkers at Elder Independence of Maine (EIM). Without this funding, the caseloads of EIM's home care coordinators were projected to increase by 35% to 40%.

Utah: Medicaid Waiver: Individuals Aged Sixty-Five and Older

- Services ordered on the care plan are billed to directly to Medicaid, and Utah has a maximum allowable rate (MAR) for all waiver services. The rate for case management is \$18.11 per fifteen-minute unit or the enhanced rate of \$31.69 per fifteen-minute unit if the client lives twenty-five miles or more from the home office of the provider.

Vermont

- In FY2000, 703 consumers used 1,322 hours of case management—projections of this for the year 2010 are 1,716 users, 3,228 hours.
- Case management services are limited to a maximum of forty-eight hours per individual per year. The state may approve higher volumes of case management services on a case-by-case basis via the plan of care approval process. The case manager must submit a brief written justification of the need for a higher volume of case management with the plan-of-care document. Case management services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing home or hospital when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing home as a single claim.

Wisconsin: Partnership

- Partnership combines all health and LTC services offered under Medicare, Medicaid, and the Medicaid Home and Community-Based Waiver programs. As such, it provides a very comprehensive benefit package. Two capitation payments, Medicare and Medicaid, are paid to one of four community-based organizations that coordinate and manage all aspects of care for program enrollees.
- Partnership Medicaid capitation payments are a blend of institutional and home and community-based care costs. Rates are risk-adjusted by age cohort, level of care, and Medicare eligibility (dually eligible/Medicaid eligible only). The risk-adjusted, blended cost is then subject to a managed care efficiency adjustment of 5%. After the end of the year, DHFS staff reviews the actual enrollment experience of each Partnership organization against the assumptions made in rate development and adjusts the capitation payment retroactively.

Appendix F: The Qualified Care Coordinator: Stakeholder Responses to the Definition and Qualifications of the Ideal Care Coordinator

Credentials	Training Needs	Qualifications/ Personal Characteristics	Systemic Changes Needed/Solutions Suggested
<ul style="list-style-type: none"> ▪ Care coordinators should be licensed ✓ ▪ Need to specialize within the social work (SW) field ▪ Case managers should be social workers, registered nurses (RNs), or licensed professionals, following a code of ethics ▪ Bachelor's-level nurses are better suited for care management than LPNs ▪ You should not regulate certification of one kind of care manager (do not limit certification to one kind of profession, e.g., nursing or social work) ▪ There should be a team approach to care coordination (CC) ▪ Certification for CC should be available, but not limited, to master's-level providers ▪ Consider peer models of care coordination (consumers doing CC for other consumers) ▪ Nurses and social workers are well prepared for this role ▪ It is presumptuous to assume social workers can do case management without additional training ▪ There is no need for additional division in social work profession ▪ Social work generalists have the skills needed—no need for specialization ✓✓✓✓ 	<ul style="list-style-type: none"> ▪ There needs to be more coursework in aging—for all professionals (including social workers) ✓✓✓✓ ▪ Care coordinators should be trained to be culturally competent ✓✓✓✓ ▪ There needs to be more in-service training ✓✓ ▪ Care coordinator should be fluent in medical terminology ▪ Educate people on continuum of care for well-to-frail elderly 	<ul style="list-style-type: none"> ▪ Problem-solving skills ✓✓ ▪ Excellent listening skills ▪ Good judgment is essential ▪ Need good communication skills ▪ Good assessment skills ▪ Group facilitation skills ▪ Ability to synthesize information ▪ Appreciate and be knowledgeable in both social and medical sides (be able to empathize and know medical terminology) ▪ Experience in a medical setting, communicating with medical professionals ▪ Positive work attitude ▪ Creative ▪ Planning ability ▪ Grant writing skills ▪ Objective thinker ▪ Tenacity—family focused ▪ Financial specialty ▪ Appreciation of and knowledge about family dynamics ▪ Understand the community in which the client lives ▪ Adaptive to change ▪ Flexible ▪ Should not perform financial planning services 	<ul style="list-style-type: none"> ▪ There is a need to increase social work students' interest in aging ▪ Government should recognize geriatric case management certification ▪ Aging coursework should be infused into curriculum (SW, RN, MD, etc.) ✓✓✓ ▪ Need career ladders for social service profession ▪ Utilize older professionals in the workforce in mentoring capacity ▪ Strong recruitment efforts and screening for care coordinators to assess the desire to work with older adults ▪ Care coordination done by social workers should be reimbursed ▪ Expect the cost to go up when finding someone to bridge the worlds (health, mental health, and social services) ▪ Geriatric social work should be incentivized ▪ Loan forgiveness programs should be available ▪ Job satisfaction is critical for professionals to remain in the field ▪ Increase salaries ▪ Make the job more attractive ▪ Structure positions so they are not impossible/do not lead to burn out ▪ Decrease paperwork and increase face time ▪ Build in time for reflection and assessment ▪ Workplace culture is important to retention ▪ Consider case mix evaluation and "score" the difficulty of the case to help manage workload

Appendix G: Expressed Wishes for a Care Coordination Program

The following statements reflect stakeholder perspectives on the elements and processes necessary to implement a care coordination program in New York State. Of the stakeholders surveyed, no one outwardly disagreed with what was shared.

1. Build on the successful programs already in the system.
2. Adequate and specified reimbursement for care coordination services.
3. Common assessment tools should be used across delivery settings so as not to be duplicative.
4. Loan forgiveness programs for all who choose to work in the aging system.
5. Avoid setting up a system that is driven by paper and regulation compliance.
6. Any care coordination program designed should not be mandatory and should not be a gatekeeping system.
7. A community needs assessment with potential funding to close gaps in and between systems, for example, transportation.
8. Continue funding and promote House-Call doctors' programs.
9. For all providers to have knowledge about and apply HIPAA appropriately so it does not become/remains a hindrance to coordinating services.
10. Physician education on potential community resources that may help his/her patient more easily navigate the system.
11. An intelligently financed system.
12. Look to change parts of the system that make it more difficult to coordinate care—money should not be spent on wading through unnecessary, illogical processes.
13. Create a program that helps the family caregiver navigate the system.
14. Begin a program with known consumers through predictability models, possibly through the medical home or disease management programs.
15. Establish career ladder programs for care coordinators.

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