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Medicaid Reimbursement of Title V Care Coordination Services

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Introduction

Care coordination can help children and youth with special health care needs (CYSHCN) and their families navigate the health care system while avoiding unnecessary costs for states and duplicative services.[i] States have longstanding efforts to finance care coordination services for CYSHCN and their families through Medicaid, the state Title V Maternal and Child Health Services Block Grant (Title V), and other federal and state programs.[ii] Some states have leveraged these programs as part of unique health care delivery systems and financing structures, including Medicaid reimbursement of care coordination administered by Title V programs.

Medicaid and the Children's Health Insurance Program (CHIP) cover 45 percent of CYSHCN nationally, playing a significant role in supporting children with chronic and complex health care conditions.[iii] Medicaid programs can reimburse care coordination services for these children through several funding authorities including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, the Targeted Case Management (TCM) benefit, Home and Community-based Services (HCBS) waivers, and Section 2703 Health Homes.[iv] In addition to federal financing authorities, state Medicaid and CHIP programs also leverage their service delivery systems to support care coordination services for CYSHCN including services provided by Medicaid managed care organizations (MCOs) and primary care case management (PCCM) programs.

State Medicaid programs have unique service delivery systems. Under a Medicaid fee-for-service (FFS) delivery system, the state pays providers directly for the provision of services. Medicaid managed care is a delivery system in which a state delivers health benefits and additional services through contracted arrangements with managed care organizations (MCOs). Some states have a blended service delivery system where beneficiaries, often depending on Medicaid eligibility criteria, will either be enrolled in managed care or FFS.

The National Academy for State Health Policy (NASHP) conducted key informant interviews with state Title V CYSHCN program and Medicaid officials in Arkansas, Illinois, and Iowa to understand how partnerships between these programs can improve financing of care coordination for CYSHCN. Each state operates under a unique Medicaid service delivery system but has found opportunities to leverage Medicaid reimbursement for care coordination administered by the state Title V program.

Illinois

Illinois provides care coordination services for certain populations of CYSHCN through the Title V administered Home Care and Connect Care programs. The Division of Specialized Care for Children at University of Illinois Chicago (UIC-DSCC) operates both programs, which are funded by a partnership between Medicaid and Title V.[v] Specifically, Medicaid reimburses for care coordination and Title V funds education and training of care coordination teams serving CYSHCN and their families.[vi]

Most Medicaid-enrolled CYSHCN in Illinois receive services through managed care, except for children enrolled in the HCBS waiver who receive their benefits through a Medicaid fee-for-service model.[vii] The Illinois Home Care program provides supports for children and youth under the age of 21 who are enrolled in the state's Medically Fragile/Technology Dependent HCBS waiver due to a severe physical illness or disability that requires the level of care appropriate to a hospital or skilled nursing facility.[viii] This program provides eligible children with services including care coordination, respite care, coverage for specialized medical equipment, environmental accessibility adaptations, assistance from a Certified Nursing Assistant, nurse training, and placement maintenance counseling services.[ix]

In addition to the state's HCBS waiver, the Home Care program provides care coordination for children who receive in-home, shift-based nursing care under the state's EPSDT benefit.[x] Currently, UIC-DSCC operates as the single point of entry for youth who require this level of care in the home.[xi] The payment for these services occurs via the same reimbursement mechanisms as those for youth enrolled in the state's HCBS waiver.[xii]

An interagency agreement between Illinois Medicaid and UIC-DSCC stipulates that Title V administer care coordination activities to support the Home Care program and Medicaid reimburse for these services. UIC-DSCC uses Title V funds to finance education and training, and other supports not incorporated in the HCBS waiver benefit. A third-party vendor assists UIC-DSCC in both computing a flat monthly rate for services and sending a quarterly report to Med-

icaid.[xiii] Care coordination services and quality oversight initiatives are rolled into the rate calculations determined by the vendor.[xiv] Medicaid staff then review and approve the quarterly reports and reimburse UIC-DSCC for the costs of operating the program.[xv]

UIC-DSCC also operates the Connect Care program which supports care coordination activities for CYSHCN who are enrolled in one of the five Medicaid managed care organizations (MCOs) with which UIC-DSCC has contracted.[xvi] Through this program, UIC-DSCC contracts with MCOs operating in the state to assist in the transition of CYSHCN to Medicaid managed care (MMC) and support various care coordination activities including comprehensive assessments and person-centered care planning for youth and families.[xvii] While MCOs are not mandated to participate in this program, Illinois Medicaid assists in facilitating initial meetings between UIC-DSCC and MCOs.[xviii]

To receive payment for services in the Connect Care program, UIC-DSCC negotiates contracts with the MCOs to establish a capitated per-member, per-month fee for both direct and variable costs including care coordination and quality oversight.[xix] CYSHCN are enrolled in this program on a case-by-case basis with approval from the MCO through which they receive their Medicaid benefits.[xx] MCOs reimburse UIC-DSCC monthly for the number of identified CYSHCN participating in the program.[xxi] Contracts between UIC-DSCC and each MCO are unique and reflect differences in both MCO care coordination models and practices to identify beneficiaries who have special health care needs.

Arkansas

To support care for CYSHCN, the Arkansas Title V program administers fifteen community-based Children with Chronic Health Conditions (CHC) offices that include interdisciplinary staff such as pediatric registered nurses, social workers, and administrative staff.[xxii] These offices assist CYSHCN enrolled in Medicaid in accessing information about community services and referrals to care.[xxiii] Arkansas also provides care coordination services for CYSHCN through its Medicaid program, enrolling the majority of CYSHCN eligible for Medicaid in a primary care case management (PCCM) program.[xxiv]

The state leverages the Medicaid Targeted Case Management (TCM) benefit to reimburse care coordination services administered by the Title V program.[xxv] Services are reimbursed for youth aged 0 – 21 years who meet certain medical eligibility criteria, are currently served by the state's Title V program, are recipients of Supplemental Security Income (SSI), or are children enrolled in Tax Equity and Fiscal Responsibility Act (TEFRA), aged 0 to 16 years, with any diagnosis.[xxvi] In addition to care coordination, providers must conduct a needs assessment, develop a service plan, and maintain case records to be reimbursed by Medicaid.[xxvii]

Title V administrators in the state have a unique process to operationalize billing for these services. Individual employees of the Department of Human Services (DHS), which oversees the state's Title V program, are excluded from the requirement to enroll as Medicaid providers for the Targeted Case Management Program.[xxviii] CHC care coordinators identify via progress notes the billable care coordination services rendered for each CYSHCN enrolled in Medicaid.[xxix] Title V administrators then run monthly reports on all billable services that occurred and submit accompanying claims to the state Medicaid agency.[xxx] Most services provided by CHC staff are reimbursable, including care administered by nurse managers.[xxxi]

Arkansas Medicaid and Title V officials also collaborate to streamline these billing practices. One example of these efforts was through the establishment of a specific Medicaid provider manual to outline billing instructions for services.[xxxii] The manual outlines billing procedures, including technical considerations for claims submission such as required procedure codes and appropriate accompanying modifiers, acceptable place of service (POS), and processes for completion of CMS-1500 claim forms.[xxxiii] The manual also details covered case management services which include assessment, development of an individualized care plan, referrals, assistance with scheduling appointments, in person and telephonic contact with the beneficiary, and assistance in the completion of an application for additional types of assistance.[xxxiv]

In addition to financial relationships to support CYSHCN in the state, the Title V program also partners with Provider-led Arkansas Shared Savings Entities (PASSEs) to provide care coordination for CYSHCN. The state's PASSEs are Medicaid managed care entities that connect members with behavioral health needs and developmental disabilities to medical and behavioral health services within their community.[xxxv] Under the state's full-risk MMC model, the PASSEs

are responsible for integrating physical and behavioral health care along with specialized home and community-based services.[xxxvi] Arkansas Title V CYSHCN care coordination staff educate families on MMC and collaborate with PASSE care coordination teams to support families with activities such as accessing respite care.[xxxvii]

The majority of state Medicaid programs have provider manuals outlining reimbusement requirements for benefits. States can consider the development of a specific provider manual or unqiue section of an existing manual to focus on billing requirements for care coordination administered by Title V programs.

Iowa

In Iowa, most CYSHCN who are enrolled in Medicaid receive their benefits through managed care.[xxxviii] However, depending on their Medicaid eligibility category, some youth are enrolled in Medicaid fee-for-service.[xxxix] Along with access to Medicaid benefits to support their care, the state also has a variety of programs offered through its Title V CYSCHN program. The University of Iowa, Division of Child and Community Health administers the state Title V CYSHCN program which includes support for care coordination activities. Iowa Medicaid and Title V have unique partnerships to provide these care coordination services to CYSHCN through the Pediatric Integrated Health Home (PIH) and Care for Kids programs along with children awaiting placement on the state's Health and Disability Waiver.[xl]

States are required to provide Medicaid and CHIP coverage for certain groups of children and youth including families who meet financial eligibility guidelines, qualified pregnant people, and individuals receiving SSI, among others. States that operate with a blended MMC and fee-for-service delivery system will sometimes leverage these eligbility categories to determine how Medicaid and CHIP beneficiaries access coverage.

From the start of the program, PIH services have been reimbursed on a per-member per month basis. Prior to the state's transition to MMC, services were reimbursable directly by the state's Medicaid program. Currently, PIH centers are reimbursed by Medicaid MCOs with the goal of delivering personalized, coordinated care for individuals meeting program eligibility criteria.[xli] Partners within the University of Iowa Health Care have worked with Medicaid MCOs and PIH staff serving families to establish reimbursement procedures including the enhancement of center technology systems to aid in the billing process.[xlii]

Iowa also provides care coordination services for CYSHCN enrolled in Medicaid as part of the EPSDT benefit through the Care for Kids program. Under this program, Title V CYSHCN care coordination services are billable for Medicaid beneficiaries served in the state's fee-for-service delivery system.[xliii] As of early 2022, the state's Title V CYSHCN program and Medicaid were still in the process of operationalizing this benefit with plans to integrate the billing of these services into their reimbursement systems.

The University of Iowa, Division of Child and Community Health also provides care coordination and supports for children awaiting placement placement on the Health and Disability (HD) waiver. These services are supported directly by the Iowa Medicaid Enterprise through a contract with the Division of Child and Community Health.[xliv]

State Strategies

Improving the structure, financing, and delivery of care coordination for CYSHCN is a priority for many states. Financing strategies such as those used by the state Title V and Medicaid programs in Arkansas, Illinois, and Iowa offer important considerations for states interested in leveraging these federal programs. State Title V programs play a critical role in assuring high quality, equitable care coordination for CYSHCN and their families. Part of that role can involve collaboration with state Medicaid programs to finance and support care coordination for Medicaid enrolled CYSHCN. Regardless of a state's unique Medicaid service delivery system or Title V program, there are a variety of potential considerations that can assist states in operationalizing unique care coordination financing strategies to support CYSHCN.

Enhance Title V and Medicaid Partnerships

Strong partnerships between the state Title V and Medicaid programs were critical to establishing and operationalizing

the systems, methods, and structures necessary to finance care coordination for CYSHCN in these states. For example, state officials in Illinois emphasized that strong partnerships between Title V and Medicaid was key to financing of care coordination in both the Home Care and Connect Care programs.[xlv] State Medicaid programs can partner with Title V programs to identify the best approach to finance these services while sharing information about what funding authorities are currently available to pay for care coordination within a state.

Collaboration with Managed Care Organizations

Forty-one states operate with some form a MMC delivery system, making collaboration with Medicaid MCOs essential to operationalize reimbursement for Title V administered care coordination.[xlvi] Title V programs that operate in a state that serves CYSHCN via MMC delivery systems can consider collaborating with Medicaid officials to initiate partnership with MCOs. Collaboration with MCOs can help Title V programs navigate unique billing operations, MCO care coordination programs, and, when applicable, negotiate specific reimbursement rates. These partnerships can also serve to enhance overall quality of care coordination provided to CYSHCN while avoiding duplication of services.[xlvii]

> Often MCOs have specific provider contracting teams that are unique to the clinical care coordination teams with which Title V programs often partner. Title V programs building administrative processes to bill for these services can partner with Medicaid to ensure they are outreaching MCO teams who oversee and support the provider networking process. Often the first step to be eligible to submit a claim for reimbursement will be enrolling as a provider with an MCO.

MCOs also often have unique provider networks along with specific provider enrollment requirements, something that can be of consideration for Title V programs developing partnerships with Medicaid agencies and their contracted MCOs.[xlviii] Partnership can include opportunities to identify potential provider contracting leads at each MCO operating in the Title V program's service area, which is often a first step to initiate the billing process. For example, Title V officials in Iowa noted that working with the state's two MCOs in tandem with their Medicaid partners to understand the state's Medicaid service delivery system was essential to the advancement of the PIH program.[xlix]

Streamline Billing Operations

Streamlined billing processes can help states operationalize reimbursement for Title V care coordination services. Navigating the complexities of unique billing requirements can be an important consideration, especially if a Title V program is newly implementing Medicaid reimbursement into their administrative workflow. Medicaid and MCO provider enrollment requirements, staff time and expertise to process billing paperwork, service documentation, and appropriate usage of diagnosis and CPT codes, are essential technical aspects of the Medicaid reimbursement process to consider.

Medicaid billing guidance, such as that offered through provider manuals, can assist administrative staff and providers in navigating the complexities of Medicaid reimbursement. Title V programs reported that strong partnerships with Medicaid officials can also assist in establishing efficient workflows and implement key billing processes.

Conclusion

Care coordination plays an essential role in the system of care for CYSHCN. As state Title V programs continue to support these services for Medicaid enrolled CYSHCN and their families, they can consider leveraging the Medicaid financing strategies utilized by states such as Arkansas, Illinois, and Iowa. These partnerships can occur within a variety of Medicaid service delivery systems and through various Medicaid federal funding authorities. They also have the potential to not only support the family-centered, community-driven care coordination that is a focus of Title V programs, but also advance state initiatives to promote quality and equitable care for CYSHCN and their families.

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Appendix

Definitions of Key Terms.

Term	Description
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides low-cost health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. In some states, CHIP covers pregnant people. Each state has its own eligibility requirements for CHIP beneficiaries to provide comprehensive coverage.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	The EPSDT benefit provides preventive health care services for children under age 21 enrolled in Medicaid. This benefit helps ensure that youth enrolled in Medicaid have access to services that can "correct or ameliorate" medical or behavioral health conditions. Services covered under the EPSDT benefit include, but are not limited to, an array of medical and developmental screenings, vision, dental, hearing, diagnostic, and other necessary health care services.
Home and Community-Based Services (HCBS) waivers	Home and community-based services waivers (HCBS waivers) allow states to tailor services to meet the needs of a particular group of people to access long-term care services and supports in their home or community. States are permitted to establish criteria to target the population to be served from the HCBS waiver. Under an HCBS waiver program, states can provide a combination of standard medical services (including case management) and non-medical services. States can utilize HCBS waivers to target specific populations, such as children who are deemed "medically fragile" and/or technology dependent. In FY 2020, 20 states pursued this waiver to target services for this population.
Medicaid Managed Care	Medicaid managed care is a health care delivery system in which Medicaid health and behavioral health benefits along with additional services are provided through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs). MCOs accept a set per member per month (capitation) payment for these services. States can combine Medicaid managed care with other Medicaid financing pathways to support care coordination services that support populations with unique needs such as CYSHCN.
Primary Care Case Management (PCCM)	PCCM programs incorporate aspects of both managed care and fee-for-service delivery systems. In a PCCM program, states contract directly with primary care providers (PCPs) and pay them a monthly case management rate for care coordination provided to each enrollee.

Section 2703 Health Homes	Section 2703 health homes provide targeted care coordination services to Medicaid beneficiaries with chronic conditions. States that implement section 2703 health homes receive a 90% Federal Medical Assistance Percentage (FMAP) for the first eight quarters or two years of the program. Through health home provider requirements, states may limit who can provide the health home service (e.g., pediatric providers).
Supplemental Security Income (SSI)	Supplemental Security Income (SSI) provides monthly cash payments to people with limited income and resources who are 65 years or older, blind, or who have a qualifying disability. Children under 18 can also qualify if they have a physical or mental condition that very seriously limits their activities. In most states, SSI recipients are automatically eligible for Medicaid. An estimated 21% of children with disabilities covered by Medicaid/CHIP receive SSI.
Targeted Case Management (TCM)	The targeted case management (TCM) Medicaid benefit is comprised of case management services provided only for people with specific needs, or to individuals who reside in specified areas of the state (or both). States can pursue the TCM benefit to receive Medicaid matching dollars for services such as care coordination for CYSHCN.
Tax Equity and Fiscal Responsibility Act (TEFRA)	TEFRA includes an option for states to create an additional pathway to Medicaid for children under 19 with a disability to receive care in their homes instead of in an institution. To qualify, a child must meet the Social Security Administration's requirements and require institutional level of care. TEFRA has an additional option that allows family income to be disregarded for children who meet criteria so they qualify for Medicaid to cover the services they need while living at home.

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